Health Plan Accreditation Guide, Version 7.3

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NOTE: This document was composed in American-standard English. Readers accustomed to British-standard English spelling and terminology should be mindful of the differences.

Dear interested party or applicant:

Quality-based operations should be the centerpiece of any company doing business in today's health care system. Quality improvement activities promote a wide range of benefits such as increasing operational efficiencies, reducing business risks and improving patient health outcomes. However, health care professionals must identify and implement a quality improvement methodology that really works for their particular business model and health care setting.

Through its modular approach to accreditation, URAC works with the industry and other key stakeholders to benchmark URAC standards against key organizational structures and business functions. Now in its 24th year of operation, URAC offers over 25 different accreditation and certification programs and has issued more than 10,000 accreditation certificates to companies operating in all 50 states and internationally. URAC is also recognized as part of the regulatory process in five federal agencies, 47 states, and the District of Columbia.

URAC, as a nonprofit, independent accreditation agency, provides a nationally- and internationally-recognized accreditation process and seal of approval. URAC's success is tied in large part to the broad-based, consensus-driven approach by which hundreds of volunteers assist with drafting and updating URAC's standards, measures and surveys. These volunteers represent the interests of a wide variety of stakeholders including purchasers, regulators, consumers, providers and industry representatives.

All companies that apply for URAC accreditation make improvements to their operations as a result of the review process. The desktop review of the application identifies issues early on in the process and streamlines the onsite review, which is designed to confirm compliance with the standards. During the onsite visit, accreditation reviewers exchange information with applicants in what often becomes a mutual learning experience. URAC's goal is to identify and promote best practices for each market segment that it accredits.

Receiving the accreditation certificate signifies a job well done and distinguishes the organization as having met a standard of excellence. As a result, URAC-accredited organizations join the ranks of a select community who have documented and verified their commitment to quality health care.

Please contact URAC if you would like to find out more about the accreditation process or to become involved with one of our committees, educational programs, research initiatives, or other projects. We look forward to hearing from you.

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M E M O R A N D U M

TO:	**URAC Colleagues and Clients**
FROM:	**Marybeth Farquhar, PhD, MSN, RN Vice President, Research & Measurement**
RE:	**URAC Measures—Health Plans and Health Insurance Marketplace**
DATE:	**March 9, 2015**
ACTION:	**Informational**

Thank you for your interest in URAC and its accreditation programs! In its efforts to constantly improve the quality of its accreditation programs and adapt our programs to meet the challenges of today's rapidly evolving health care landscape, URAC has opted to include performance measures in several of its products based on key market trends and the relevant policy issues of the Patient Protection and Affordable Care Act (PPACA). Our programs address areas such as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, patient information programs, measures and the CAHPS$^{®}$ Surveys.

Our vision of measurement begins with collecting data on a concise set of performance measures that align with national and state initiatives and that provide information about the quality of care delivered to patients. For measures to be valuable, they must be based on the most recent scientific evidence, incorporate rigorous measurement methodology and be easy to implement to produce accurate, relevant and timely information to guide efforts aimed at improving the health and well-being of patients.

Performance measures are either mandatory or exploratory. Organizations are expected to produce the mandatory performance measures as designated by URAC and report them via a specified reporting platform to maintain their ongoing accreditation status. The terms *mandatory performance measures* and *exploratory performance measures* are defined in URAC's Health Accreditation Guides and Standards glossary and the Pharmacy Quality Management® Programs glossary. Measures reporting is addressed in standards RPT 1 and RPT 2 in the URAC accreditation or certification programs that include measures.

In order to keep pace with the changing evidence base and the latest methods of measuring performance, URAC has chosen to evaluate and update its measure set specifications in collaboration with the relevant measure developers or measure stewards on an annual basis. Performance measure updates are critical to assuring that our measures remain relevant and useful. Measure changes will be evaluated by URAC and those that have minor changes i.e., changes to ICD-9-CM codes, will be properly versioned and posted to the URAC website on an annual basis by October 1. URAC reserves the right to include additional measures to conform to national, state and local regulatory and quality initiatives. Clients are required to report the most current version of the URAC measures by June 30 of each year.

Supporting information and performance measure values will be entered into a web-based measures reporting platform as designated by URAC. The platform is accessed using an assigned, unique username and password, provided by the Research & Measurement department at URAC. *Please note that URAC will be phasing out its web-based measures reporting platform. In the future, all required measure reporting for URAC accreditation compliance will be done through Inovalon, a leading technology firm. Information about Inovalon can be found at: www.innovalon.com.*

To learn more about URAC and its accreditation programs, please visit www.urac.org

Health Plan Standards Florida Addendum

In addition to the Health Plan Standards, the following standards shall apply to health maintenance organizations (HMOs) that wish to use URAC accreditation to meet Florida's requirement for accreditation.

Please note that the *italicized* words are defined in the "Definitions" section of URAC's Health Plan Standards.

SCORING INFORMATION

Standards FL 1 through FL 9 are mandatory standards where all elements are designated "[M]" for "Mandatory." For more on URAC's scoring system, please review the "Scoring Methodology" section of the "Accreditation Guide" for the Health Plan Standards.

Standard FL 1 – Medical Records Review

The *organization* implements policies and procedures to ensure that *consumers'* medical records:
   (a) Are complete and organized;
   (b) Are maintained consistently; and
   (c) Contain the following elements:
      (i)   The patient's name and identification number of each page;
      (ii)   A list of significant illnesses and medical conditions;
      (iii) Allergies and adverse reactions to medications;
      (iv)   Past medical history;
      (v)   Diagnoses that are consistent with findings; and
      (vi)   Treatment plans that are consistent with diagnoses.

   ➤ **Note**: Before the onsite review, applicant organizations must submit a list of the organization's health care consumers to URAC. Then URAC review staff will select 50 medical records for audit during the onsite review.

Standard FL 2 – Credentialing of Allied Health Professionals

As part of its credentialing program (see standards P-CR 1 through P-CR 17), the *organization* implements mechanisms to verify the qualifications of all allied health professionals that may provide clinical services to *consumers* through a *written agreement* with the *organization*.

   ➤ **Note**: In many cases, the allied health professional will not have a direct *written agreement* with the *organization*, but will see *consumers* through an intermediary. Example: a physical therapist that works in a contracting physician's office.

   ➤ **Note**: This standard does not apply to *practitioners* who practice in a *facility* that is certified by the Centers for Medicare and Medicaid Services (CMS) or accredited by an *organization* recognized by URAC or the Florida Agency for Health Care Administration.

Standard FL 3 – Review of Network Physician Offices

As part of the initial credentialing process, the *organization* performs a review of each office or *facility* in which a primary care physician (PCP) or a high volume specialist may provide clinical services to *consumers*.

> ➤ **Note**: This standard does not apply to *practitioners* who practice in a *facility* which is certified by the Center for Medicare and Medicaid Services (CMS) or accredited by an *organization* recognized by URAC or the Florida Agency for Health Care Administration.

> ➤ **Note**: Only one type of high volume specialty need be chosen. The *organization* may choose the specialty type, which may include obstetricians/gynecologists (OB/GYNs).

Standard FL 4 – Reviewer Requirements and Tools

When reviewing the office or *facility* of a *participating provider*, the *organization*:
(a) Ensures the review is conducted by organization representatives who:
    (i)   Carry a picture identification with full name;
    (ii)   Carry identification that includes the name of the organization;
    (iii) Schedule reviews at least five business days in advance unless otherwise agreed;
(b) Relies on a review tool that clearly defines the criteria to conduct an onsite review to address at least the following:
    (i)   *Patient* access, including physical access for the disabled and access to appointments and to medical advice in a timely manner;
    (ii)   The office's public health policies and procedures concerning infection control, hazardous materials, and medication; and
    (iii) The office's safety standards concerning policies and procedures for fire safety, emergency procedures, laboratory, and medical equipment maintenance.

Standard FL 5 – Review Summary

The *organization*, upon request by the *participating provider*, supplies a summary of the onsite review standards and process.

Standard FL 6 – Review Sample

The *organization* ensures that onsite reviewers conduct a review of a random sample of at least one (1) *consumer* medical record to ensure:
   (a) Organization, completeness, and consistency in format;
   (b) Evidence of proper documentation; and
   (c) Relevant information concerning patients' history, diagnosis, treatment, and allergies.

   ➢ **Note**: If *consumer* medical records are not available – for example, because the *provider* is new to *organization* – then the onsite reviewers may examine "blinded" medical record(s) of other patients.

Standard FL 7 – Preventive Health QIP

At any given time, at least one of the three *quality improvement projects* required by standard P-QM 7 focuses on the prevention of acute or chronic health conditions.

Standard FL 8 – Preventive Health QIP Focus

When selecting preventive care quality improvement projects, the *organization* focuses on areas where:
   (a) *Consumers* have the greatest needs; and
   (b) The *organization* has the potential to improve quality.

Standard FL 9 – Preventive Health

In addition to the specific preventive health projects required by standard FL 7, the *organization* implements programs to promote preventive health care among the *organization's* entire population of *consumers,* to include:
   (a) Preventive health guidelines developed or adopted by the *organization* that are age-specific for the *organization's* entire population of consumers; and
   (b) Dissemination of the guidelines required by standards FL 9(a) to *participating providers.*

   ➢ **Note**: Programs that meet standard FL 9 include preventive health guidelines and protocols, and direct *consumer* communication and education, and may include financial incentives for the use of preventive services.

Introduction to URAC Accreditation Guides and Standards

URAC offers two references addressing standards. The Standards publication provides a copy of the standards produced by URAC and defined terms, which are italicized within the standards. It is a resource for government agencies and private entities wanting to examine the standards for their own purposes. For organizations contemplating accreditation, URAC's Accreditation Guide provides, in addition to the standards, information about the documentation to submit as evidence for meeting the intent of the standards as well as the types of materials and activities URAC's accreditation reviewers will be examining during an onsite visit. Both the Accreditation Standards and Guide are available through URAC's Business Development Department at (202) 216-9010 or send an e-mail to BusinessDevelopment@urac.org. For detailed information about how to prepare an application for accreditation, please go to https://accreditnet.urac.org/Resources for a copy of the AccreditNet Application Instruction Booklet, designed to complement the Accreditation Guide for applicant organizations.

The Accreditation Standards and Accreditation Guide are intended to provide guidance only. The URAC Accreditation Committee and Executive Committee hold the final authority to make determinations regarding interpretation and application of standards, and an applicant's compliance with standards.

The Accreditation Guide is provided to assist applicants understand the meaning or intent of the standards. That being said, it cannot cover all possible situations and subsequent interpretations that may apply. Therefore, applicants should be aware that the standards are subject to ongoing interpretation and as such, changes can be made to the Accreditation Guide.

Each company applying for accreditation should carefully review URAC's accreditation standards and the defined terms italicized within the standards, then use the Accreditation Guide and AccreditNet Instruction Booklet to prepare an application for submittal to URAC.

Modular Concept
URAC uses a "modular accreditation system" that is adaptable to the continuing evolution of the health care system. A module is a set of standards established for a particular health care function. The collection of standards contained within modules are unique to that health care service or function. The Core Standards incorporate the basic elements necessary to promote quality for any type of health care organization and were designed for two purposes: 1) to act as a "foundation" for function-specific accreditation programs, and 2) to act as a "stand-alone" accreditation program for companies not delivering services under one of the specific functions or modules.

Each accreditation will include Core and the module(s) covering the functions.

- Core Standards + Module(s) = Specific Accreditation
- Core "stand-alone" accreditation will only consist of Core Standards.
- Core Standards Only = Core "Stand-Alone" Accreditation

Eligibility to apply for Core "stand-alone" accreditation is determined on the basis of how a company markets itself. If a health care organization markets any of the services addressed under one of URAC's modules, Core "stand-alone" accreditation is not an option. An example of an organization that would be eligible for Core "stand-alone" accreditation is an organization that provides health care educational services.

Introduction to URAC Accreditation Guides and Standards

For applicants, the modular system provides the flexibility to choose from a variety of accreditation programs. For example, an applicant may choose to apply for Utilization Management (UM) accreditation initially, and when up for reaccreditation, add the Case Management (CM) module.

- Core with Single-Module Application (Example: Core & UM only)
- Core with Multi-Module Application (Example: Core & UM + CM)

With several choices available, an applicant can tailor the accreditation to its current needs and business goals. If you are not sure what modules would best fit your organization, URAC's Business Development Department can be reached at BusinessDevelopment@urac.org or at (202) 216-9010 to answer questions, provide pricing information and help organizations decide the best course of action.

Compliance with State and Federal Law

The Accreditation Guide provides information on URAC's expectations regarding compliance with each standard. Some standards require applicants to attest to compliance with specific state regulations regarding operational policy and procedure. Prior to submitting an application the applicant should conduct a review of its legal obligations, including those addressed in the standards. Although it is not indicated for each standard, URAC expects that the applicant will be in compliance with all applicable state and federal laws that pertain to relevant operations. State and federal laws supersede URAC Standards if the laws or regulations are more rigorous than URAC Standards. Conversely, an applicant must comply with URAC Standards if the standards are more stringent. If an applicant is required by law to carry out its business in a manner not consistent with URAC Standards, then the applicant may request a variance from a URAC Standard. A copy of the relevant statute or regulation must accompany the request submitted for that standard in the application.

Standards and Interpretation

The standards are grouped together into modules, with each module representing various health care functions. Individually, the standards address the structures and processes that need to be in place for performing the function to be accredited according to national standards. For the most part, an applicant is expected to be in compliance with all applicable standards at the time of application for accreditation.

In the Accreditation Standards, you will find:

- **Definitions**. All italicized terms found in the standards are defined in this section.
- **Standards with assigned Weights**. Standard elements include assigned weights for scoring. If an element in and of itself does not contain enough information to evaluate compliance without the following sub-element, then it is noted as "Not Weighted."

In the Accreditation Guide, you will find:

- **Definitions**. All italicized terms found in the standards are defined in this section.
- **Standards with assigned Weights and Interpretive Information for each Standard**.
- **Points to Remember and Scope of Standards**. These bullet points identify important issues to consider when documenting your organization's compliance with the standard. In some cases, additional details are provided that will help your compliance efforts and in other cases, these details will alert you to potential pitfalls.

Introduction to URAC Accreditation Guides and Standards

- **Evidence for Meeting the Standards: Desktop Materials and Onsite Review Materials and Activities.**
- **Bright Ideas**. This section is not used for every standard and contains common industry practices that may be helpful to the applicant organization. (Note: adoption of a "bright idea" is not required for compliance with a standard, nor does adoption of the "bright idea" guarantee compliance with that standard.)
- **Related Standards**. This section is not used for every standard, but helps to identify relationships between standards that are not always obvious and helpful to know about.

Scoring Methodology

Policy Regarding "Not Applicable" Elements and Standards

If a mandatory standard element is determined to be *not applicable*, then it does not count against the applicant when determining an accreditation category; however, applicant organizations must have a policy that meets the intent of a mandatory standard element even if it is not currently being implemented. The only exception to this policy is the collection of mandatory standard elements in Core that apply to delegation where if an applicant organization is not delegating, then documentation on delegation for these standards is *not required* even though some of the standard elements are mandatory (e.g., Core 8(b), Core 8(h) and Core 9(b) in version 3.0 of Core).

An applicant may choose not to meet any or all leading indicator standard elements (i.e., leading indicators are *optional*); therefore, a leading indicator standard element, which is not weighted, cannot be made *not applicable.* Not all accreditation standard sets have leading indicators.

If a weighted standard element or an entire standard is determined to be *not applicable*, then they are not included in the scoring calculations (i.e., deducted from the denominator). This includes the rare instance when a "variance" is granted by the requisite URAC committee. As a result, applicants are not penalized when a standard element or standard is not applicable.

Standard Element Weights

URAC's Scoring System has six (6) distinct categories of standard elements:
- Weight = 1: Emerging Practice
- Weight = 2: Basic Infrastructure
- Weight = 3: Promotes Quality
- Weight = 4: Key Stakeholder Right / Empowers Consumers
- Mandatory = M: Non-weighted, mandatory element with a direct or significant impact on consumer safety and welfare
    - All mandatory elements must be met at 100% compliance in order to achieve a Full accreditation
    - If determined to be not applicable, applicant must have a policy and procedure in place that meets the intent of the element should the organization need to implement it in the future
- Leading Indicator = L: Non-weighted, optional element highlighting effective practices not yet widely adopted in health care
    - Potential forecast of where the health care industry may be heading
    - Provides a way for an organization to distinguish itself from other accredited companies
    - **Leading indicators are not reported to URAC's Accreditation or Executive Committees and do not influence an applicant's final accreditation score or category**
    - Cannot be designated "not applicable" given that they are optional
    - Before URAC will acknowledge that an applicant has met a leading indicator:
        - Full accreditation must be achieved, <u>and</u>
        - Element must be met at 100% compliance
        - Initially URAC will list leading indicators in the Accreditation Summary Report (ASR)
    - Other types of marketing exposure may be considered in the future (e.g., Website, conferences, etc.)

Scoring Methodology

Definitions for the standard element categories are listed on the following pages. As you analyze the standard elements to assign a weight, keep in mind the following:

- Standards are no longer weighted, but standard elements are. Elements are the components of a standard that are evaluated through the accreditation review process.
- Standard elements are no longer designated as "primary" or "secondary."

Computing an Accreditation Score

- Scoring an Element
    - Element weight x Compliance

- Scoring a Standard
    - Total points achieved ÷ Total points possible

- Scoring a Module
    - Total points achieved ÷ Total number of standards

- Scoring a multi-Module accreditation
    - (Core score x .30) + (Module score x .70)

- Scoring a multi-Site accreditation
    - Lowest site score determines the application score

Determining an Accreditation Category

- If one Mandatory standard element is not met Conditional
- If two Mandatory standard elements are not met Corrective Action
- If three Mandatory standard elements are not met Denial
- If all Mandatory standard elements are met:
    - ≥ 94 points/100 <u>and</u> complies 100% on at least one "Leading Indicator" standard → Include compliance with Leading Indicator(s) on the Accreditation Summary Report (ASR)
    - ≥ 94 points/100 Full Accreditation
    - ≥ 90, but < 94 points/100 Conditional Accreditation
    - ≥ 85, but < 90 points/100 Corrective Action
    - < 85 points/100 Denial

Rating Compliance with a Standard Element

Standard elements are individually rated at 100% (full compliance), 50% (partial compliance) or 0% (no compliance) as follows:

For elements that require a file/record audit, the audit must reveal:

- % Compliance with Element
    - 100% Compliance (Full Compliance) = Audit score ≥ 80%;
- **Note**: A mandatory element must be met at 100% compliance with an audit score of ≥ 90%; if not, then the mandatory element is considered *not met*. Credentials verification must be met at 100%. Applicants must meet all applicable mandatory elements in order to achieve Full accreditation.
- **Note**: A leading indicator element must be met at 100% compliance; if not, then the leading indicator is considered *not met*. Applicants do not have to meet leading indicators since these types of elements are *optional*, acting as "extra credit."

Scoring Methodology

- **Note**: A minimum of 30 files will be pulled for file review, but if the applicant does not have 30 files, then all files will be reviewed. For initial accreditation, the file selection date range will begin from the date that the application was submitted for accreditation up to the date of the onsite. For reaccreditation reviews, files will be pulled from the time period since the last URAC accreditation onsite visit.
    - 50% Compliance = Audit score ≥ 65%, but < 80%, or for
    - contracts the audit score is < 80%, but the applicant has an internally approved, compliant contract template.
    - 0% Compliance = Audit score < 65%, or for contracts the applicant does not have an internally approved, standards-compliant contract in place.

For elements that do not require a file/record audit:
- % Compliance with Element
    - 100% Compliance (Full Compliance) = Element documented pursuant to the standard element and upon verification is found to be fully implemented.
    - **Note**: A mandatory element must be met at 100% compliance; if not, then mandatory element is considered *not met*. Applicants must meet all applicable mandatory elements in order to achieve Full accreditation.
- **Note**: A leading indicator element must be met at 100% compliance; if not, then the leading indicator is considered not met. Applicants do not have to meet leading indicators since these types of elements are optional, acting as "extra credit."
    - A standard element is implemented, where at least one of the following onsite activities is verified:
        - Staff is observed conducting the procedure correctly; or
        - Staff verbalizes the procedure correctly; or
        - Documented examples of implementation are surveyed; or
        - Documentation of oversight is reviewed; or
        - Management attests to its implementation and provides supporting documentation (i.e., sign-in sheets showing staff training session occurred, CV of newly hired medical director, sample of revised and distributed documentation such as a provider directory, notification letters, etc.)
            - 50% Compliance (Partial Compliance) = Element documented pursuant to the standard element, but not consistently or completely implemented.
            - One or more incidences of non-compliance in implementation will lower the compliance rating to 50%. This would include:
        - Errors implementing work processes during onsite observation by the URAC Reviewer.
        - Mistakes during interviews. If staff catches the error – misspoke – and corrects it, then this will not count as evidence of non-compliance.
        - Reports with data or analysis demonstrating non-compliance (e.g., not meeting timelines, wrong staff conducted the procedure, provider listed in a directory prior to credentialing, etc.)
        - Meeting minutes revealing decisions contrary to meeting the intent of the standards or lacking documentation indicating that a key activity did not take place (e.g., vote to eliminate provider appeal mechanism, minutes do not reflect review and update of the quality management program, etc.)
        - 0% Compliance (No Compliance) = No evidence or incomplete evidence of compliance with the standard element in documentation or, regardless of documentation, applicant has not implemented the structures or processes

needed to comply with the standard element. No compliance is exemplified when any one of the following statements is true.

- The standard element is:
  - Not addressed in documentation,
  - Only partially addressed in documentation,
  - Addressed in documentation, but does not meet the intent of the standard element,
  - Not implemented, which does not include situations where:
  - The organization did not have the opportunity to implement. An example of this would be where an organization has an appeal process in place, but is either not contracted to do appeals or simply has not had an appeal of the type addressed by the standard.
  - The organization has been in business < six (6) months and is therefore eligible for a provisional accreditation.
  - Implemented in a non-compliant manner, or
  - Implemented, but one or more staff shows a pattern (≥ 4 occurrences) of non-compliance with an element over a period of time (within six (6) consecutive months), regardless of any warnings, corrective action taken (including training or procedural changes), or relative improvement over time.

Scoring a Weighted Standard Element
- To score a weighted standard element ("element"),
  - Multiply the element weight by the compliance factor achieved (e.g., 0 for *no compliance*, .50 for *partial compliance* or 1.0 for *full compliance*).
- Calculation for Standard Element Score
  - (Compliance factor) × (Weight of standard element) = Score for an Element

Scoring a Standard
- To score a standard with weighted elements,
  - Sum the score achieved for each element.
  - Divide by the number of points possible (sum of the element weights) for the entire standard.
  - Weights for the elements determined to be not applicable are not included in the denominator and as such do not count against the applicant.
    - Multiply by 100; this provides a percentage score for the standard.

- Calculation for Standard Score
  - [(Sum of all applicable element scores) ÷ (Total possible points for the standard)] × 100 = Standard Score

Calculating a Final Total Accreditation Score for Core-only Applications and Accreditations that do not include Core

- To calculate a final score for Core-only and non-Core Module Applications,
  - Sum the scores for each standard.
  - Divide by the total number of applicable standards.
    - Standards determined to be not applicable are not included in the denominator and as such do not count against the applicant.

Scoring Methodology

- Calculation for Core and non-Core Module Score
    - [(Sum of all applicable standard scores) ÷ (Total number of applicable standards)] = Module Score = Final Total Score (round to nearest tenth)
- **Note**: For purposes of calculating an accreditation score, the number of standards possible is the total count of standards that have at least one weighted element; standards that do not have any weighted elements (i.e., only mandatory and/or leading indicator elements) are not included in the count since they do not contribute a standard score towards the module score. It is not logical to include standards in the denominator when it has no points to contribute to the score and to include such a standard in the denominator would unfairly penalize the applicant.
- **Note**: If all weighted elements in a standard are determined to be not applicable, then the standard does not count towards the total number of applicable standards for purposes of scoring a module. To count them would unfairly penalize the applicant and is contrary to the URAC policy on standards determined to be not applicable.

Calculating a Final Total Accreditation Score for Multi-Module Accreditations
- To calculate a final total accreditation score for multi-module accreditations, which includes:
    - Core + a single Module (e.g., Health UM, IRO, CES, etc.)
    - Core + multiple Modules (e.g., Health Plan, Health Network, etc.)

- For Core:
    - Sum all of the Core standard scores.
    - Divide by the total number of applicable standards.
        - Standards determined to be not applicable are removed from the denominator and as such do not count against the applicant.
    - Multiply the Core score by .30 since Core is 30% of the final score for multi-module accreditations that include Core.

- For non-Core module score:
    - Sum all of the standard scores from all of the non-Core modules.
    - Divide by the total number of applicable standards.
        - Standards determined to be not applicable are removed from the denominator and as such do not count against the applicant.
    - Multiply the non-Core score by .70 since the non-Core modules collectively contribute to 70% of the final score.
    - Sum the percentage score for Core and the modules; a perfect score would be 100%.

- Final Total Score

    - (Core score × .30) + (non-Core score × .70) = Final Total Score for One or Multiple Sites (round to nearest tenth)

- Final Total Score if all Sites achieve a Full (≥ 94)
    - (Sum of all Full onsite scores) ÷ (Number of sites that had an onsite
    - review) = Final Full Accreditation Score (round to nearest tenth)
- **Note**:
    - Each site that has an onsite review receives its own score; however, the lowest of these scores determines the score for the overall application.

Scoring Methodology

- o If all sites receiving an onsite review achieve a Full, the average score for these sites is the final score for the application. (See calculation above.)
- o If there is a trend of three (3) or more sites that achieve less than a Full accreditation, then the URAC Reviewer has the discretion to visit all of the sites in the application.

Determining How Many Mandatory Elements are Met and Not Met
- Mandatory elements are non-weighted elements and all applicable mandatory elements must be met at 100% compliance in order for an applicant to achieve Full accreditation.
    - o Mandatory elements that are determined to be not applicable are subtracted from the total count of mandatory elements and do not count against an applicant.
    - o Mandatory elements with a compliance level less than 100% (e.g., partial compliance [.5] and no compliance [0]) are considered not met and count against an applicant when determining an accreditation level. (See "Determining an Accreditation Level.")

Glossary for Health Accreditation Standards

Reviewing these definitions and becoming familiar with them is critically important to an accurate understanding of URAC's health accreditation standards. Readers are encouraged to refer to the glossary section each time they encounter an unfamiliar *italicized* term, which will help to clarify the intent of the standards.

Note: Defined terms appear in *italics* throughout the standards.

Abandonment Rate: The percentage of calls offered into a communications network or telephone system — i.e., automatic call distribution (ACD) system of a call center — that are terminated by the persons originating the call before answer by a staff person.
 ➢ **Interpretive note:** Abandonment rate is measured as the percentage of calls that disconnect after 30 seconds when an individual (live person) would have answered the call. For example, if there is a pre-recorded message or greeting for the caller, the 30-second measurement begins after the message/greeting has ended. (On ACD reports, monitor calls that "drop" after 30 seconds.)

Access: The consumer's or client's ability to obtain services in a timely manner.
 ➢ **Interpretive Note**: The measures of access for consumers are determined by components such as the availability of services, their acceptability to the consumer, consumer wait time, and the hours of operation.

  The measures of *access* for clients are determined by components such as turn-around time and other metrics as they may be defined in written business agreements, etc.

Accessible/Accessibility: Easy to obtain for the *consumer*; in the context of written materials, capable of being read with comprehension (e.g. educational materials are developed so that the target population will have the ability to understand the materials provided by the organization, such as through the process of generating and distributing multi-lingual or reading-level appropriate editions.
 ➢ **Interpretive Note:** See definition of "access". The measures of access for consumers are determined by components such as the availability of services, their acceptability to the consumer, consumer wait time, and the hours of operation.

Adverse benefit determination: A denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:
 • A determination of an individual's eligibility to participate in a health benefit plan or insurance coverage;
 • A determination that a benefit is not a covered benefit;
 • The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
 • A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

Adverse benefit determination includes a rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time. The regulations restricting rescissions generally define a rescission as a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.
Source: Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act; Interim Final Rule [HHS 45 CFR Part 147]

Adverse Event: An occurrence that is inconsistent with or contrary to the expected outcomes of the Organization's functions.

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Advisory Board of Osteopathic Specialists (ABOS): American Osteopathic Association (AOA) certification agent organized in 1939 for the purpose of establishing and maintaining standards of osteopathic specialization and pattern of training.

Annually (or "yearly"): Occurs every 12 months to the month (not the day of the month). In other words, it is a month/year to month/year requirement.

Appeal: A written or verbal request by a prescriber, ordering provider, or consumer to contest an organizational determination, such as, services have been denied, reduced, etc.
> **Interpretive Note:** Specific terms used to describe appeals vary, and are often determined by law or regulation. URAC's drug management standards apply to first-level appeal.

Appeals Consideration: Clinical review conducted by appropriate clinical peers, who were not involved in peer clinical review, when a decision not to certify a requested admission, procedure, or service has been appealed. Sometimes referred to as "third level review."

Appropriate utilization: appropriate care at the appropriate setting

Assessment: A process for evaluating individual consumers that have been identified as eligible for a medical management program, such as disease management or case management, to identify specific needs relating to their clinical condition and associated co-morbidities.

Attending Physician: The doctor of medicine or doctor of osteopathic medicine with primary responsibility for the care provided to a patient in a hospital or other health care facility.

Attending Provider: The physician or other health care practitioner with primary responsibility for the care provided to a consumer.

Automated review: A computerized process whereby a validated algorithm is used for drug management.

Average Speed of Answer: The average delay in seconds that inbound telephone calls encounter waiting in the telephone queue of a call center before answer by a staff person.
> **Interpretive note**: The speed of answer is measured starting at the point when an individual (live person) would have answered the call. For example, if there is a pre-recorded message or greeting for the caller, the time it takes to respond to the call (i.e., average speed of answer) begins after the message/greeting has ended.

Behavioral Health/Behavioral Health Care: An umbrella term that includes mental health and substance abuse. Services are provided by those who are licensed by the state and whose professional activities address a client's behavioral issues. Licensed mental health practitioners include psychologists, psychiatrists, social workers, psychiatric nurse practitioners, marriage and family counselors, professional clinical counselors, licensed drug/alcohol abuse counselors and mental health professionals. (Behavioral Healthcare: The Practical Resource for the Field's Leaders - www.behavioral.net/ME2/Default.asp).

Benefit Calculation: An adjustment or calculation by the Organization of the financial reimbursement for a claim under the terms of the applicable benefit plan, provisions, criteria, provider contracts, or state rules.

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Benefits Program: An arrangement to pay for health care services provided to a consumer. "Benefits program" includes, but is not limited to, health and medical benefits provided through the following organization types:
- Health maintenance organizations (HMOs);
- Preferred provider organizations (PPOs);
- Indemnity health insurance programs;
- Self-insured plans;
- Public programs, such as Medicare and Medicaid; and
- Workers' compensation insurance programs.

Blockage Rate: The percentage of incoming telephone calls "blocked" or not completed because switching or transmission capacity is not available as compared to the total number of calls encountered. Blocked calls usually occur during peak call volume periods and result in callers receiving a busy signal.

Board-certified: A certification – approved by the American Board of Medical Specialties, the American Osteopathic Association, or another organization as accepted by URAC – that a physician has expertise in a particular specialty or field. To the extent that future URAC standards include other certifications, URAC will specify further approved boards.

> **Interpretive Note:** URAC recognizes that ABMS- and AOA-approved board certifications may not be the only certification programs that may be acceptable for health professionals in URAC-certified organizations. For example, non-physician professionals will have appropriate certifications that are not ABMS- of AOA-approved. Any applicant wishing to have URAC recognize another board certification program should notify URAC early in the certification process. URAC will then take this recommendation to URAC's Accreditation Committee.
>
> The Accreditation Committee will review all requests, and will decide to approve or reject the certification. The Accreditation Committee will consider the following criteria in judging whether a certification is acceptable:
> - Is the certification accepted within its target community of health professionals?
> - Was the certification developed through an open, collaborative process?
> - Does the certification reflect accepted standards of practice?
> - Is the certification administered through an objective process open to all qualified individuals?

Caller: The consumer inquiring to obtain health care information. This may also be a representative inquiring on behalf of the consumer.

Care Coordination: Care Coordination is the deliberate organization of patient care activities among two or more participants (including the patient and/or the family) to facilitate the appropriate delivery of health care services. Organizing care involves marshaling personnel and other resources to carry out all required patient care activities, which is often managed by the exchange of information among participants responsible for different aspects of the care.

Caregiver: A caregiver includes family member(s), personal caregiver, significant other, or friend who cares for the *consumer*.

Source: http://www.ntocc.org

Care Transitions/Transitions of Care: refers to the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness. For example, in the course of an acute exacerbation of an illness, a patient might receive care from a PCP or specialist in an outpatient setting, then transition to a hospital physician and nursing team during an inpatient admission before moving on to yet another care team at a skilled nursing facility. Finally, the patient might return home, where he or she would receive care from a visiting nurse. Each of these shifts from care providers and settings is defined as a care transition."

Source: http://www.ntocc.org

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Case: A specific request for medical or clinical services referred to an organization for a determination regarding the medical necessity and medical appropriateness of a health care service or whether a medical service is experimental/investigational or not. It is a non-approval regarding medical necessity and medical appropriateness decisions for services covered under a health benefit plan's terms and conditions or for coverage decisions regarding experimental or investigational therapies that is at issue during the independent review process.

Case Involving Urgent Care: Any request for a utilization management determination with respect to which the application of the time periods for making non-urgent care determinations a) could seriously jeopardize the life or health of the consumer or the ability of the consumer to regain maximum function, or b) in the opinion of a physician with knowledge of the consumer's medical condition, would subject the consumer to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case.

> ➢ **Note**: This definition is derived from the Department of Labor's definition of "claim involving urgent care."
> ➢ **Interpretive Note:** While the URAC standards are silent on the methods by which a claim is determined to be a "case involving urgent care," the Department of Labor claims regulation (29 C.F.R. § 2560.503-1(m)(1)) specifies that whether a claim is a "claim involving urgent care" is to be determined by an individual acting on behalf of the health benefits plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the claimant's medical condition determines is a "claim involving urgent care" shall be treated as a "claim involving urgent care."

Case Management: A collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs using communication and available resources to promote quality cost-effective outcomes.

Case Management Plan of Care (also known "case management plan"): A comprehensive plan that includes a statement of problems/needs determined upon assessment; strategies to address the problems/needs; and measurable goals to demonstrate resolution based upon the problem/need, the time frame, the resources available, and the desires/motivation of the client.

<u>Source</u>: Case Management Society of America (CMSA.org)

Case Management Process: The manner in which case management functions are performed, including: assessment, problem identification, outcome identification, planning, monitoring, and evaluating.

<u>Source</u>: Case Management Society of America (CMSA.org)

Certification:
1) **UM-Specific Definition**: A determination by an organization that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.
> ➢ **Interpretive Note**: "Determination" may vary depending on context.
2) **General Definition**: A professional credential, granted by a national organization, signifying that an individual has met the qualifications established by that organization. To qualify under these standards, the certification program must:
- Establish standards through a recognized, validated program;
- Be research-based; and
- Be based (at least partially) on passing an examination

Claim: Any bill, claim, or proof of loss made by or on behalf of a consumer or health care provider to an Organization (or its intermediary, administrator, or representative) for which the consumer or health care provider has a contract for payment of health care services.
> ➢ **Note**: definition based on Code of Virginia § 38.2-3407.15.

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Claimant: A person or entity who submits a claim, or on whose behalf a claim is submitted. (Includes "consumer" for URAC's Core Standards.)

Claims Administrator: Any entity that recommends or determines to pay claims to enrollees, physicians, hospitals, or others on behalf of the health benefit plan. Such payment determinations are made on the basis of contract provisions. Claims administrators may be insurance companies, self-insured employers, third party administrators, or other private contractors.

Claims Processing Organization: An organization that seeks accreditation under these standards. Examples of organizations that process claims include but are not limited to:
- Health insurance companies;
- Health maintenance organizations (HMOs);
- Preferred provider organizations (PPOs);
- Third-party administrators (TPAs);
- Disability insurance carriers; and
- Workers' compensation insurance carriers.
- ➢ **Interpretive Note**: Throughout this document the term "organization" refers to claims processing organization.

CLAS standards (National Standards for Culturally and Linguistically Appropriate Services in Health Care): The collective set of CLAS mandates, guidelines, and recommendations issued by the HHS Office of Minority Health intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services.
> Source: Based on definitions from the Final Report, U.S. Department of Health and Human Services Office of Minority Health (March 2001). 'National Standards for Culturally and Linguistically Appropriate Services in Health Care."

Clean Claim: A claim that has no material defect, impropriety, lack of any required substantiating documentation, or special circumstance(s) – such as, but not limited to, coordination of benefits, pre-existing conditions, subrogation, or suspected fraud – that prevents timely adjudication of the claim.

Clean credentialing application (also known as a "clean credentialing file"): A credentialing application or file is considered "clean" if it meets the criteria listed below; however, the medical or clinical director for credentialing must always have the authority to forward a credentialing file to the credentialing committee at his or her discretion.
- The provider has completed all applicable sections of the credentialing application.
- Where indicated, the provider has signed, initialed and dated the credentialing application.
- All necessary support documentation has been submitted and is included with the credentialing application in the provider's file.
- The provider meets the credentialing criteria as stated in the credentialing plan, which is approved by the credentialing committee.
  - o Credentials verification reveals that the provider meets credentialing criteria and there are no issues to report to the credentialing committee as defined in the organization's credentialing plan.

Client: A business or individual that purchases services from the Organization.
- ➢ **Interpretive Note for term "Client"**: Here are some examples of client relationships:
  - o If a health plan sells health coverage to an employer, the employer is the client.
  - o If a health plan sells health coverage directly to consumers, the consumer is the client.
  - o If a health plan contracts for utilization management services from a utilization management organization, the health plan is the client.
  - o If a PPO contracts for credentialing services with a CVO, the PPO is the client.

Clinical Activities: Operational processes related to the delivery of clinical triage and health information services performed by clinical staff.

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Clinical Decision Support Tools: Protocols, guidelines, or algorithms that assist in the clinical decision-making process.

Clinical Director: A health professional who: (1) is duly licensed or certified; (2) is an employee of, or party to a contract with, an organization; and (3) who is responsible for clinical oversight of the utilization management program, including the credentialing of professional staff and quality assessment and improvement functions.

Clinically Integrated Network (CIN): An active and ongoing program to evaluate and modify practice patterns by the clinically integrated providers and create a high degree of interdependence and cooperation among the clinically integrated providers to control costs and ensure quality.

URAC Clinically Integrated Networks Advisory Committee, 2012

Clinically Integrated Provider: An independent provider that has entered into an agreement with the organization to be part of a clinically integrated network among otherwise independent and competing providers. May include physicians and other health care team members and facilities providing direct care services.

URAC Clinically Integrated Networks Advisory Committee, 2012

Clinical Oversight Body: A body comprised of discipline specific experts such as physicians, pharmacists, *providers*, and content experts who may include non-physician *providers* such as certified health educators, respiratory therapists, nutritionists, nurses, mental *health professionals* or other specialists.

- **Interpretive note for CIN**: A clinical oversight body within a CIN is physician led and comprised of clinically integrated providers. The charter of this body defined by the CIN centers on providing clinical oversight and guidance to CIN programs impacting patient care delivery.

Clinical Peer: A physician or other health professional who holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e., the same licensure category as the ordering provider.

Clinical Practice Guidelines/Protocols: Systematically developed, documented protocols used to assist decision-making about appropriate health care for specific clinical circumstances. Clinical practice guidelines are based on a standard assessment of the body of scientific evidence, whenever such evidence exists. If guidelines are not evidence-based, then the process for coming to a consensus needs to address the absence or paucity of high quality, scientific evidence and the systematic way in which a consensus was reached in order to establish the guidelines.

- ➢ **Interpretive note for CIN:** The identification of benchmarks protocols – to which clinically integrated providers aspire and against which their performance is measured - requires active involvement of physicians.

Clinical Rationale: A statement that provides additional clarification of the clinical basis for a non-certification determination. The clinical rationale should relate the non-certification determination to the patient's condition or treatment plan, and should supply a sufficient basis for a decision to pursue an appeal.

Clinical Review Criteria: The written screens, decision rules, medical protocols, or guidelines used by the organization as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services under the auspices of the applicable health benefit plan.

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Clinical Social Work: Clinical social work shares with all social work practice the goal of enhancement and maintenance of psychosocial functioning of individuals, families, and small groups. Clinical social work practice is the professional application of social work theory and methods to the treatment and prevention of psychosocial dysfunction, disability, or impairment, including emotional and mental disorders. It is based on knowledge of one or more theories of human development within a psychosocial context.

Source: NASW, 1986. www.socialworkers.org

Clinical Staff: Employees or contracted consultants of the health care organization who are clinically qualified to perform clinical triage and provide health information services.

Clinical Triage: Classifying consumers in order of clinical urgency and directing them to appropriate health care resources according to clinical decision support tools.

Comparable: Data about performance is compared to an historical baseline (which may be internal) and ongoing progress is recorded in regular intervals (e.g., monthly, quarterly, or annually). External benchmarks also may be used for purposes of comparison.

Complaint: An expression of dissatisfaction by a consumer expressed verbally or in writing regarding an organization's products or services that is elevated to a complaint resolution system.
   ➢ **Interpretive Note**: This term is sometimes referred to as "grievance." This definition does not include appeals.

Concurrent Review: Utilization management conducted during a patient's hospital stay or course of treatment (including outpatient procedures and services). Sometimes called "continued stay review".

Condition: A diagnosis, clinical problem or set of indicators such as signs and symptoms that an individual consumer may have that define him or her as eligible and appropriate to participate in a medical management program such as a disease management or case management program.

Conflict of Interest: Any relationship or affiliation on the part of the organization or a reviewer that could compromise the independence or objectivity of the independent review process. Conflict of interest includes, but is not limited to:
   • An ownership interest of greater than 5% between any affected parties;
   • A material professional or business relationship;
   • A direct or indirect financial incentive for a particular determination;
   • Incentives to promote the use of a certain product or service;
   • A known familial relationship;
   • Any prior involvement in the specific case under review.

Consumer: An individual person who is the direct or indirect recipient of the services of the Organization. Depending on the context, consumers may be identified by different names, such as "member," enrollee," "beneficiary," "patient," "injured worker," "claimant," etc. A consumer relationship may exist even in cases where there is not a direct relationship between the consumer and the Organization. For example, if an individual is a member of a health plan that relies on the services of a utilization management organization, then the individual is a consumer of the utilization management organization.
   ➢ **Interpretive Note**: In the case of a consumer who is unable to participate in the decision-making process, a family member or other individual legally authorized to make health care decisions on the consumer behalf may be a consumer for the purposes of these standards.

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***Consumer* activation (also known as "*patient* activation")**: An individual's motivation to engage in adaptive health behavior that may, in turn, lead to improved health outcomes.

The motivation to take actions representing adaptive health behaviors emerges from the influence of psychological factors and personal competencies, which include an individual's understanding of his/her role in managing his/her own health care, as well as the knowledge, skill, preferences and confidence for managing his/her own health/health care.

<div align="right">

Source: Based on a definition from Hibbard JH, Stockard J, Mahoney ER, et al. Development of the patient activation measure (PAM): conceptualizing and measuring activation in patients and consumers. Health Serv Res 2004; 39:1005-26.

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Consumer-Centered (also known as patient-centered care): Providing care that is respectful of and responsive to individual patient or consumer preferences, needs, and values, and ensuring that patient or consumer values guide all clinical decisions.

<div align="right">Source: (Adapted from IOM 2001, Crossing the Quality Chasm)</div>

"Consumer or patient and family-centered care" means planning, delivering, and evaluating health care through consumer or patient-driven, shared decision-making that is based on participation, cooperation, trust, and respect of participant perspectives and choices. It also incorporates the participant's knowledge, values, beliefs and cultural background into care planning and delivery. Consumer or patient and family-centered care applies to consumers or patients of all ages. (Adapted from MN HCH Rule)

***Consumer* engagement (also known as "*patient* engagement")**: Actions individuals must take to obtain the greatest benefit from the health care services available to them. These actions fall within the category of adaptive health behaviors.

Consumer or patient engagement is a collaborative process in which enrolled individuals are working or have worked directly with licensed or certified clinical staff in a chronic disease management or health improvement/wellness program. Individuals are interacting with health professionals in reference to their health improvement plan with "bidirectional interaction" meaning an exchange between health professionals and the enrolled individual in both directions, regardless of modality for communication (e.g., telephone, e-mail, texting, online tools, and virtual coaching tools, etc.) Adaptive health behaviors include the use of patient education and virtual behavior change tools provided by health professionals and incorporated into the health improvement plan.

<div align="right">Source: Based on definitions from the Center for Advancing Health. Center for Advancing Health (2010). A new definition of patient engagement: What is engagement and why is it important? Center for Advancing Health, Washington D.C. www.chah.org.</div>

Consumer Experience (also known as "experience of care"): Good *consumer* experience of care is an outcome unto itself; research demonstrates that *consumer*s prioritize communication and other aspects of the provider-*consumer* relationship as key elements of quality. Good *consumer* experience has a well-documented relationship to clinical quality, *consumer* engagement, adherence, and outcomes.

<div align="right">Source: RWJ Foundation 2012</div>

➤ **Interpretive Note**: The CAHPS Clinician and Group Survey provides a nationally standardized, validated tool to measure consumers' experiences in primary care practices. This survey asks consumers to assess their experiences in areas that research has shown consumers value, including ease of scheduling appointments, availability of information, communication with clinicians, responsiveness of clinic staff, and coordination between care providers.

Contractor: A business entity that performs delegated functions on behalf of the Organization.
➤ **Interpretive Note**: For the purposes of these standards, the term "contractor" includes only those contractors that perform functions related to the key processes of the Organization. It is not URAC's intent to include contractors that provide services unrelated to key processes. For example, a contractor that provides catering services would not fall within the definition of "contractor" in these standards. Conversely, a company that provides specialty physician reviewers to a UM organization would clearly fall within the definition of "contractor."

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Covered Benefits: The specific health services provided under a health benefits program, including: cost-sharing and other financial features; claims submission and reimbursement processes; requirements and processes (if any) for prior authorization or other approval of health services.

Covered Person: Means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan. For Workers' Compensation, this would include the injured worker.

Covered Service: A health care service for which reimbursement or other remuneration is provided to a consumer or on behalf of a consumer under the terms of the consumer's benefits program.

Credentials Verification: A process of reviewing and verifying specific credentialing criteria of a practitioner.

Credentials Verification Organization (CVO): An organization that gathers data and verifies the credentials of health care practitioners.

Criteria: A broadly applicable set of standards, guidelines, or protocols used by the organization to guide the clinical processes. Criteria should be:
- Written;
- Based on professional practice;
- Literature-based;
- Applied consistently; and
- Reviewed, at a minimum, annually.

Cultural Competence: Having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by consumers and their communities.
> Source: Based on definitions from the Final Report, U.S. Department of Health and Human Services Office of Minority Health (March 2001). 'National Standards for Culturally and Linguistically Appropriate Services in Health Care."

Culture: "The thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Culture defines how health care information is received, how rights and protections are exercised, what is considered to be a health problem, how symptoms and concerns about the problem are expressed, who should provide treatment for the problem, and what type of treatment should be given. In sum, because health care is a cultural construct, arising from beliefs about the nature of disease and the human body, cultural issues are actually central in the delivery of health services treatment and preventive interventions. By understanding, valuing, and incorporating the cultural differences of America's diverse population and examining one's own health-related values and beliefs, health care organizations, practitioners, and others can support a health care system that responds appropriately to, and directly serves the unique needs of populations whose cultures may be different from the prevailing culture" (Katz, Michael. Personal communication, November 1998).
> Source: Based on definitions from the Final Report, U.S. Department of Health and Human Services Office of Minority Health (March 2001). 'National Standards for Culturally and Linguistically Appropriate Services in Health Care."

Culturally and Linguistically Appropriate Services: Health care services that are respectful of and responsive to cultural and linguistic needs.
> Source: Based on definitions from the Final Report, U.S. Department of Health and Human Services Office of Minority Health (March 2001). 'National Standards for Culturally and Linguistically Appropriate Services in Health Care."

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Cultural and Linguistic Competence: "Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities" (Based on Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). *Towards A Culturally Competent System of Care Volume I*. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center).
    <u>Source</u>: Based on definitions from the Final Report, U.S. Department of Health and Human Services Office of Minority Health (March 2001). 'National Standards for Culturally and Linguistically Appropriate Services in Health Care."

Cultural Sensitivity: The ability to be appropriately responsive to the attitudes, feelings, or circumstances of groups of people that share a common and distinctive racial, national, religious, linguistic or cultural heritage
    <u>Source</u>: Based on definitions from the Final Report, U.S. Department of Health and Human Services Office of Minority Health (March 2001). 'National Standards for Culturally and Linguistically Appropriate Services in Health Care."

Data Integrity: The quality or condition of being accurate, complete and valid, and not altered or destroyed in an unauthorized manner.

Data Liquidity: data that is no longer confined to databases or data silos in health systems so that it flows to where it is needed and when it is needed.

Adapted from: Paul K. Courtney, M.S
Cancer J. 2011 ; 17(4): 219–221
doi:10.1097/PPO.0b013e3182270c83

Date of Receipt: The date on which a claim arrives at an Organization (or, for claims that arrive on a non-business day, the date of the first business day thereafter).

Decision support tools: A paper or electronic aid, or both, to help people make informed decisions by providing and managing information and presenting the trade-offs involved in various possible choices by arraying comparative information. The various types of aids used in health care include protocols, guidelines, or algorithms that assist in the clinical decision-making process.
<u>Source</u>: Carlisle, E. et al. "Empirical Studies of Decision Aids for Consumers,"
Santa Monica: The RAND Corporation, 2003. As cited in: Shaller Consulting,
"Consumers in HealthCare: Creating Decision-Support Tools That Work"
California HealthCare Foundation, June 2006. Also see
http://www.chcf.org/publications/2006/06/consumers-in-health-care-creating-decisionsupport-tools-that-work

Delegation (includes delegate/delegated): The process by which an organization contracts with or otherwise arranges for another entity to perform functions and to assume responsibilities covered under these standards on behalf of the organization, while the organization retains final authority to provide oversight to the delegate.

Discharge Planning: The process that assesses a patient's needs in order to help arrange for the necessary services and resources to affect an appropriate and timely discharge or transfer from current services or level of care.

Discrimination: The unjust or prejudicial treatment of different categories of people or things, especially on the grounds of race, age, or sex.

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Disease Management: According to the Disease Management Association of America, "Disease management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. Disease management: supports the physician or practitioner/patient relationship and plan of care, emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health. Disease management components include: population identification processes; evidence-based practice guidelines; collaborative practice models to include physician and support-service providers; patient self-management education (may include primary prevention, behavior modification programs, and compliance/surveillance); process and outcomes measurement, evaluation, and management; routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling."

Disease Management Program: A program or entity that provides the scope of functions and activities necessary to provide disease management.

Downstream Risk: Acceptance of financial insurance risk and accountability for health services utilization and quality of care outcomes by a provider service organization from a health plan or employer / plan sponsor for the provision or arrangement of health care services.

Adapted from: US Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation,
June , 1997
aspe.hhs.gov/health/pso-6.htm

Drug Management: Evaluation of patients' drug profiles related to covered benefits, clinical appropriateness and safety for patients' use of medications.

Drug Utilization Management & Drug Utilization Review: Evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, products, and facilities under the provisions of the applicable health benefits plan; sometimes called "drug review."

Electronic: Mode of electronic transmission including the Internet (wide-open), Extranet (using Internet technology to link a business with information only accessible to collaborating parties), leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media. (Final Rule, Department of Health and Human Services, "Health Insurance Reform: Standards for Electronic Transactions," Federal Register (Aug. 17, 2000).)

Electronic Health Record (EHR): An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.

Electronic Medical Record (EMR): An electronic record of health-related information on an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization.

Eligible population (same as) eligible consumers - Eligible population (also "eligible consumers"): The pool of consumers who are entitled or qualified to receive program services and interventions.

Engagement: Proactive outbound contact with consumers, by phone or mail, within some specified time frame of identification of eligible consumers, with tracking of interactions.

Evidence-based: Recommendations based on valid scientific outcomes research, preferably research that has been published in peer reviewed scientific journals. Evidence-based information can be used to develop protocols, pathways, standards of care or clinical practice guidelines and related educational materials.

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Evidence Based Medicine: "Evidence based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients." David L. Sackett, William M. C. Rosenberg, J.A. Muir Gray, R. Brian Haynes, W. Scott Richardson. Evidence based medicine: what it is and what it isn't. British Medical Journal 1996; 312:71-72. Reproduced with permission from BMJ Publishing Group.

Expedited Appeal: An appeal of a non-certification of a case involving urgent care. See definition of "Case Involving Urgent Care."

Exploratory Performance Measures: A measure designated as "Exploratory" means that URAC will include measures with specifications that are considered "experimental" within the industry. These measures are "on the cutting edge" of the performance measurement know-how and need further refinement and evaluation before becoming a requirement of a program.

External review: A review of an adverse benefit determination (including a final internal adverse benefit determination) conducted pursuant to an applicable State or Federal external review process.
> Source: Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act; Interim Final Rule [HHS 45 CFR Part 147]

Facility: An institution that provides health care services.

Facility Rendering Service: The institution or organization in or by which the requested admission, procedure, or service is provided. Such facilities may include, but are not limited to: hospitals; outpatient surgical facilities; individual practitioner offices; rehabilitation centers; residential treatment centers; skilled nursing facilities; laboratories; imaging centers; and other organizational providers of direct services to patients.

Family: Individuals whom the consumer chooses to involve in the decision-making process regarding the consumer's health care. In the case of a consumer who is unable to participate in the decision-making process, "family" shall include any individual legally authorized to make health care decisions on the consumer's behalf.

Final external review decision: A final external review decision means a determination by an independent review organization at the conclusion of an external review.
> Source: Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act; Interim Final Rule [HHS 45 CFR Part 147]

Final internal adverse benefit determination: An adverse benefit determination that has been upheld by a plan or issuer at the completion of the internal review (appeals) process or upon exhaustion of the internal appeals process.
> Source: Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act; Interim Final Rule [HHS 45 CFR Part 147]

Governing Body: a group of people appointed or elected to supervise and regulate a field of activity or institution.
> Source: Adapted from the Encarta English Dictionary

Group health plan: An entity providing health insurance coverage, including insured and self-insured group health plans.
> Source: Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act; Interim Final Rule [HHS 45 CFR Part 147]

Glossary for Health Accreditation Standards

Health benefit plan: A policy, contract, certificate or agreement offered or issued by a health issuer to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.
<u>Source</u>: 2008 NAIC Health Carrier Uniform External Review Model Act

Health content: Health information that is intended to provide general, user non-specific information or advice about maintaining health or the treatment of an acute or chronic illness, health condition, or disease state.

Health Content Reviewer: An individual who holds a license or certificate as required by the appropriate jurisdiction in a health care field (where applicable), has professional experience in providing relevant direct patient care or has completed formal training in a health-related field.

Health Education: Educational resources designed to enhance the knowledge and understanding of health topics to promote wellness and self-care.

Health Information: Educational resources designed to enhance the knowledge and understanding of health topics to promote wellness and self-care.

Health Information Exchange: The electronic movement of health-related information among organizations according to nationally recognized standards.

Health Information Organization: An organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards.

Health Information Technology: The technology to create, transmit, store and manage individuals' health data.
URAC Clinically Integrated Networks Advisory Committee, 2012

Health Literacy: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate decisions regarding their health.

Health Professional: An individual who: (1) has undergone formal training in a health care field; (2) holds an associate or higher degree in a health care field, or holds a state license or state certificate in a health care field; and (3) has professional experience in providing direct patient care.

Health-Related Field: A professional discipline that promotes the physical, psychosocial, or vocational well-being of individual persons.

Health Risk Assessment Process: A process of collecting and interpreting health data and risk factors, gathered from the *health risk assessment tool* and other sources about the *target population*, to evaluate potential *participants* for inclusion in the *wellness program*.
  ➤ **Note:** The term "health risk assessment" and its corresponding acronym "HRA" are not the only terms that define an acceptable assessment process.
URAC Health Accreditations Glossary 2/21/2012

Health Risk Assessment Tool (HRAT): A health risk assessment tool is a systematic approach to collecting information from individuals that identifies risk factors, which can be determined through biometric and other methods, and provides individualized feedback, such as through a health risk score, to increase overall awareness of risk. Definition adopted from the Centers for Medicare and Medicaid Services – CMS).

Healthy Behavior A specific action, taken at the individual level, associated with improved health outcomes and the reduction of *risk factors*. Healthy behavior may include:
  • Seeking appropriate health care or tests (e.g., getting a cholesterol screening)
  • • Avoiding risky behavior (e.g., quitting smoking)
  • • Engaging in lifestyle changes (e.g., getting more exercise)

Glossary for Health Accreditation Standards

Individually Identifiable Information: Any information that can be tied to an individual consumer, as defined by applicable laws.

Individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) That identifies the individual; or (ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual. (65 Fed. Reg. at 82,804 (to be codified at 45 C.F.R. pt. 164.501))
  ➤ **Note**: This definition is derived from the federal Health Insurance Portability and Accountability Act (HIPAA).

Independent Review: A process, independent of all affected parties, to determine if a health care service is medically necessary and medically appropriate, experimental/investigational or to address administrative/legal issues. Independent review typically (but not always) occurs after all appeal mechanisms available within the health benefits plan have been exhausted. Independent review can be voluntary or mandated by law.

Independent Reviewer: See definition for "Reviewer."

Information System: Any written, electronic, or graphical method of communicating information. The basis of an information system is the sharing and processing of information and ideas. Computers and telecommunication technologies have become essential information system components.
<div align="right">Barron's Business Dictionary</div>

Initial Clinical Review: Clinical review conducted by appropriate licensed or certified health professionals. Initial clinical review staff may approve requests for admissions, procedures, and services that meet clinical review criteria, but must refer requests that do not meet clinical review criteria to peer clinical review for certification or non-certification. Sometimes referred to as "first level review."

Initial Screening (formerly "pre-review screening" and "scripted clinical screening"): Automated or semi-automated screening of requests for authorization that may include: (1) collection of structured clinical data (including diagnosis, diagnosis codes, procedures, procedure codes); (2) asking scripted clinical questions; (3) accepting responses to scripted clinical questions; and (4) taking specific action (certification and assignment of length of stay explicitly linked to each of the possible responses). It excludes: (1) applying clinical judgment or interpretation; (2) accepting unstructured clinical information; (3) deviating from script; (4) engaging in unscripted clinical dialogue; (5) asking clinical follow-up questions; (6) issuing non-certifications; and (7) verification of insurance coverage or eligibility.

Inreach: use of *consumer* interactions inside the primary care / medical home setting to discover gaps in care and identify opportunities for and act on *consumer* targeted interventions promoting preventive care
<div align="right">Adapted from Yabroff KR, et al.
J Am Med Womens Assoc. 2001 Fall;56(4):166-73, 188.</div>

Internal review: Review, including appeal review, by an insurance issuer or group health plan or their designee (i.e., such as a TPA) of an adverse benefit determination.
<div align="right">Source: Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal
Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care
Act; Interim Final Rule [HHS 45 CFR Part 147]</div>

Interoperability: Ability of two or more systems or components to exchange information and to use the information that has been exchanged.

Glossary for Health Accreditation Standards

Key work processes: An organization's most important internal value creation processes that produce customer/ student/ stakeholder/ stockholder/ market value.
> Source: Baldrige Glossary for Business, Government (Public Sector) and other Nonprofit (2009).

Knowledge Domains: Areas of specific expertise.

Licensure/license: A license or permit (or equivalent) to practice medicine or a health profession that is (1) issued by any state or jurisdiction in the United States; and (2) required for the performance of job functions.
> ➢ **Interpretive Note**: In this definition, the word "equivalent" includes certifications, registrations, permits, etc. Specific terms will vary by state and health profession.

Mandatory Performance Measures: A measure classified as "Mandatory" means that URAC will designate a set of unique measures with their specifications that have undergone URAC's evaluation and vetting process and that have been approved by the URAC Board of Directors. These measures must be reported to URAC on an annual basis or more frequent as specified by URAC to maintain accreditation status.

Measure: A valid and reliable indicator that can be used to monitor and evaluate the quality of important governance, management, clinical and support functions that affect patient outcomes (The Joint Commission, 2008, p. 129). Includes patient perspective of care, clinical quality and patient outcomes.

Medical Director: A doctor of medicine or doctor of osteopathic medicine who is duly licensed to practice medicine and who is an employee of, or party to a contract with, an organization, and who has responsibility for clinical oversight of the organization's utilization management, credentialing, quality management, and other clinical functions.

Medical Management – A general term encompassing activities such as utilization management, case management, and the clinical aspects of quality management.

Medical or Scientific Evidence: means evidence found in the following sources:
- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
- Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE);
- Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act;
- The following standard reference compendia:
  - o The American Hospital Formulary Service–Drug Information;
  - o Drug Facts and Comparisons;
  - o The American Dental Association Accepted Dental Therapeutics; and
  - o The United States Pharmacopoeia–Drug Information;
- Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:
  - o The federal Agency for Healthcare Research and Quality;
  - o The National Institutes of Health;
  - o The National Cancer Institute;
  - o The National Academy of Sciences;
  - o The Centers for Medicare & Medicaid Services;
  - o The federal Food and Drug Administration; and
  - o Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

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- Any other medical or scientific evidence that is comparable to the sources listed in paragraphs (1) through (5).

Medication Reconciliation: The process of creating the most accurate list possible of all medications a patient is taking - including drug name, dosage, frequency, and route - and comparing that list against the physician's admission, transfer and/or discharge orders, with the goal of providing correct medications to the patient at all transition points.
  - ➢ **Note**: This definition comes from the Institute for Healthcare Improvement (IHI), Reconcile Medication at All Transition Points, available through the following Web site: http://www.ihi.org.

Messenger Contracting Model: The "classic" messenger model is a contracting arrangement wherein the payer communicates about fee schedules through a messenger while each provider individually accepts or rejects the terms wherein networks do not enter into agreements among competitors on prices or price-related terms.

<div align="right">

Adapted from
1996 "Statements of Antitrust Enforcement Policy in Health Care"
issued jointly by the DOJ and FTC
</div>

Multiple chronic conditions: Chronic illnesses are "conditions that last a year or more and require ongoing medical attention and/or limit activities of daily living." More than one in four Americans has multiple (two or more) concurrent chronic conditions.
  - ➢ **Note**: In 2001, the IOM noted that there was evidence that patients receiving care for one chronic condition may not receive care for other, unrelated conditions. The IOM articulated that a challenge of designing care around specific conditions is to avoid defining patients solely by their disease or condition. 66% of total healthcare spending is directed toward care for the approximate 27% of Americans with Multiple Chronic Conditions.

<div align="center">

Source: U.S. Department of Health and Human Services. Multiple Chronic Conditions –
A Strategic Framework: Optimum Health and Quality of Life for Individuals with
Multiple Chronic Conditions. Washington, DC. December 2010.
</div>

Multi-provider Joint Ventures: a multi-provider network joint venture is a provider-controlled venture in which the network's participating providers collectively agree on prices or price-related terms and jointly market their services.

<div align="right">

Adapted from
1996 "Statements of Antitrust Enforcement Policy in Health Care"
issued jointly by the DOJ and FTC
</div>

Negotiated Contract Model: a strategy in which individual providers delegate to a multi-provider joint venture the authority to contract prices and/or price-related terms with payers and employer purchasers on their behalf. The provider's direct contract is between the provider and the multi-provider organization.

<div align="right">

Adapted from
1996 "Statements of Antitrust Enforcement Policy in Health Care"
issued jointly by the DOJ and FTC
</div>

Non-Certification: A determination by an organization that an admission, extension of stay, or other health care or pharmacy service has been reviewed and, based on the information provided does not meet the clinical requirements for medical necessity, appropriateness, or effectiveness under the applicable health benefit plan.

Non-Clinical Administrative Staff: Staff who do not meet the definition of health professional (including intake personnel).

Non-Clinical Staff: Employees or contracted consultants of a health care organization who do not perform clinical assessments or provide callers with clinical advice. They may be responsible for obtaining demographic information, providing benefit information, and re-directing callers.

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Normalize: Map data elements to a standard hierarchy for accurate analytics.

URAC Clinically Integrated Networks Advisory Committee 2012

Off-shoring: The relocation of an organizational function to a foreign country under the same organizational control (ownership).
- ➢ **Note**: In health care management, outsourcing distinct functions to a foreign subcontractor is the more common trend. See the definition for "outsourcing."

Opt-in: Affirmative consent actively provided by a consumer to participate in an activity or function of the program, provided after the program has fully disclosed the terms and conditions of participation to the consumer.
- ➢ **Note**: Auto enrollees are not considered "opt-in" enrollees of the program.

Opt-out: A process by which an enrolled consumer declines to participate in an activity or function of the program.

Ordering Provider: The physician or other provider who specifically prescribes the health care service being reviewed.

Organization: A business entity that seeks accreditation under these standards.
- ➢ **Interpretive Note**: This can include a program or department and can be geographically defined.

Organizational Conflict of Interest: A conflict that affects objectivity between the organization's financial interests and the organization's obligations to the client.

Outcome(s): A consumer's health status following services.

Outsourcing: The delegation of services or functions from internal production to an external entity outside of the United States.

Oversight: Monitoring and evaluation of the integrity of relevant program processes and decisions affecting consumers.

Palliative care: Palliative care is a specialized area of health care that focuses on relieving and preventing the suffering of patients, but that does not serve to halt or cure a disease. Unlike hospice care, palliative medicine is appropriate for patients in all disease stages, including those undergoing treatment for curable illnesses and those living with chronic diseases, as well as patients who are nearing the end of life. Palliative medicine utilizes a multidisciplinary approach to patient care, relying on input from physicians, pharmacists, nurses, chaplains, social workers, psychologists, and other allied health professionals in formulating a plan of care to relieve suffering in all areas of a patient's life. This multidisciplinary approach allows the palliative care team to address physical, emotional, spiritual, and social concerns that arise with advanced illness.

Source: Based on a definition from the World Health Organization (March 2006) and the Center to Advance Palliative Care [http://www.capc.org/building-a-hospital-based-palliative-care-program/case/definingpc].

Participant (participating): An eligible consumer or treating provider that has had one or more inbound or outbound contacts with the disease management program, and if a consumer, has not opted out of the program.

Participating Provider: A provider that has entered into an agreement with the organization to be part of a provider network.

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Patient: The enrollee or covered consumer for whom a request for certification may or may not have been filed.
> - **Interpretive Note**: In the case of a patient who is unable to participate in the decision-making process, a family member or other individual legally authorized to make health care decisions on the patient's behalf may be a patient for the purposes of these standards.
> - **Interpretive Note for CIN**: Use of the term "patient" implies an established relationship between consumer and provider.

Patient Centered: In a patient-centered model, patients become active participants in their own care and receive services designed to focus on their individual needs and preferences, in addition to advice and counsel from health professionals.

Source: http://www.ahrq.gov
Research In Action, Issue 5

Patient-centered care (see "consumer-centered")
> - **Note**: "consumer" and "patient" are defined terms.

Patient engagement (see "consumer engagement")
> - **Note**: "consumer" and "patient" are defined terms.

Patient experience: (see" consumer- experience")
> - **Note:** "consumer" and "patient" are defined terms.

Peer Clinical Review: Clinical review conducted by appropriate health professionals when a request for an admission, procedure, or service was not approved during initial clinical review. Sometimes referred to as "second level review."

Peer-to-Peer Conversation: A request by telephone for additional review of a utilization management determination not to certify, performed by the peer reviewer who reviewed the original decision, based on submission of additional information or a peer-to-peer discussion.

Performance Measures: Please reference the definition for the term "measures" included in this glossary.
> - **Note definition of Performance Measurement**: processes using performance measures for program, provider or practice evaluation purposes**.**

Personal Health Record: An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the individual.

Personally-identifiable Information: Any information that can be tied to an individual identifier.

Pharmacist: A licensed health professional who practices the art and science of pharmacy.

Plain Language: Communication that uses short words and sentences, common terms instead of (medical) jargon, and focuses on the essential information recipients need to understand.

Point of Care: the location at which patient services are delivered.
URAC Clinically Integrated Networks Advisory Committee, 2012

Population: Depending on the model of the program, the population for which an organization is responsible may be all of the consumers assigned by virtue of a contract, or the population may be only those consumers who enroll.
> - **Interpretive Note for CIN**: If the CIN advances to the stage where it assumes business or medical risk, or becomes an accountable care organization the population may be those consumers who are assigned or enroll.

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Potential Enrollees: Employees and eligible dependents of employer/purchasers who are offering enrollment in the organization's products as part of the employee benefits package. In the case of organizations that offer products in the individual market, potential enrollees include individuals from the general public in the geographic area where the organization offers the products.

Practitioner: An individual person who is licensed to deliver health care services without supervision.

Predictive risk modeling; Predictive risk modeling is a useful technique with practical application for organizations to anticipate who may need more intense intervention (i.e., stratifying interventions) with the consequence of potentially avoiding preventable utilization while facilitating cost containment.
> **Note**: Approximately two-thirds of healthcare costs are accounted for by 10% of the patients. Identifying such high-cost patients early can help improve their health and reduce costs. Risk modeling foundations include such data as: Adjusted Clinical Groups (ACG), Diagnostic Cost Groups (DCG), Global Risk-Adjustment Model (GRAM), RxRisk, and Prior Expense.

To predict whether a patient is high-risk or not, these models use healthcare utilization information and disease-related features or morbidity indicators based on diagnoses codes and other administrative claims-based data. Demographic variables like age and sex are known to impact healthcare costs. Disease-related predictors from various utilization classes such as inpatient, outpatient and pharmacy have also been used to predict cost outcomes. Other risk modeling foundations include comorbidity indices, number of prescriptions and number of claims.
Source: Excerpt from reference Moturu, S.T., Johnson, W.G. and Liu, H. (2010) 'Predictive risk modeling for forecasting high-cost patients: a real-world application using Medicaid data', Int. J. Biomedical Engineering and Technology, Vol. 3, Nos. 1/2, pp.114-132.

Prescriber: A licensed health professional who writes prescriptions for consumers within their scope of practice.

Primary Physician (also known as "(PCP) Primary Care Physician"): The physician who is primarily responsible for the medical treatment and services of a consumer.

Primary Source Verification: Verification of a practitioner's credentials based upon evidence obtained from the issuing source of the credential. Also known as "Primary Source."

Principal Reason(s): A clinical or non-clinical statement describing the general reason(s) for the non-certification determination ("lack of medical necessity" is not sufficient to meet this).

Professional Competency: The ability to perform assigned professional responsibilities.

Prospective Review: Utilization management conducted prior to a patient's admission, stay, or other service or course of treatment (including outpatient procedures and services). Sometimes called "precertification review" or "prior authorization," prospective review can include prospective prescription drug utilization review.

Protected Health Information: Individually identifiable health information: (1) Except as provided in paragraph (2) of this definition, that is: (i) Transmitted by electronic media; (ii) Maintained in any medium described in the definition of electronic media at Sec. 162.103 of this subchapter; or (iii) Transmitted or maintained in any other form or medium. (2) Protected health information excludes individually identifiable health information in: (i) Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (iii) Employment records held by a covered entity in its role as employer. (67 Fed. Reg. at 53,267 (Aug. 14, 2002); 65 Fed. Reg. at 82,805 (Dec. 28, 2000) (to be codified at 45 C.F.R. pt. 164.501)).

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Provider: A licensed health care facility, program, agency, or health professional that delivers health care services.

Provider Network: A group of providers with which the organization contracts to provide health services to consumers.

Provider-Specific Information: Information that is sufficient to allow identification of the individual provider.

Quality Management (QM)/Quality Improvement (QI)/Performance Improvement (PI) program: A systematic data-driven effort to measure and improve consumer and client services and/or health care services.

Quality Review Study: A scientific and systematic measurement of the effects or results of treatment modalities or practices for a particular disease or condition. The goal of quality measurement is to improve health care services by monitoring and analyzing the data and modifying practices in response to this data.

Rationale: The reason(s) or justification(s) – commonly based on criteria – for a specific action or recommendation.

Re-assessment: Re-evaluation of an individual consumer participating in a medical management program, such as disease management or case management, on a specified frequency using the same or similar tools that were used in the initial assessment. Re-assessment may also include re-stratification.

Referral
The recommendation by a physician, other clinician health care team member, or case manager for a consumer to receive care from a different physician, service or facility for a specific health related issue.
Adapted from Delaware Healthcare Association
Glossary of Health Care Terms and Acronyms
http://www.deha.org/Glossary

Referring Entity: The organization or individual that refers a case to an organization. Referring entities may include insurance regulators, health benefits plans, consumers, and attending providers. Some states may limit by law which individuals or organizations may be a referring entity.

Regional Health Information Organization: A health information organization that brings together health care stakeholders within a defined geographic area and governs health information exchange among them for the purpose of improving health and care in that community.

Retrospective Claim: A claim presented after services have been provided (i.e., a post-service claim) and presented for consideration under a contract or policy.

Retrospective Review: Review conducted after services (including outpatient procedures and services) have been provided to the patient.
 ➢ **Interpretive Note**: Retrospective medical necessity determinations are considered utilization management (and subject to these standards).

Review of Service Request: Review of information submitted to the organization for health care services that do not need medical necessity certification nor result in a non-certification decision.

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Reviewer(s): The individual (or individuals) selected by the organization to consider a case.
  - ➢ Note: Selection of the reviewer(s) for a case must be conducted in accordance with standards IR 1 through IR 6.
  - All reviewer(s) who are health care practitioners must have the following qualifications:
    - o Active U.S. licensure;
    - o Recent experience or familiarity with current body of knowledge and medical practice;
    - o At least five (5) years of experience providing health care;
  - If the reviewer is an M.D. or D.O., board certification by a medical specialty board approved by the American Board of Medical Specialties or the American Osteopathic Association.
  - If the reviewer is a D.P.M., board certification by one of the following:
    - o American Board of Podiatric Surgery (ABPS)
    - o American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM)
    - o American Board of Multiple Specialties in Podiatry (ABMSP)
  - All reviewer(s) who are health insurance lawyers conducting rescission, benefit interpretation, reimbursement or other administrative/legal review, must have the following qualifications:
    - o Active U.S. licensure as a lawyer, which may need to be specific to the state with jurisdiction over review;
    - o Recent experience or familiarity with current body of knowledge and health insurance practice;
    - o At least five (5) years' experience providing legal services regarding health insurance matters.

Risk factor: Any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease or injury. Some examples of the more important risk factors are underweight, overweight, unsafe sex, high blood pressure, tobacco and alcohol consumption, and unsafe water, sanitation and hygiene. Other risk factors include diet, pregnancy, low birth weight, sedentary lifestyle, family history, and inappropriate drug use.

<u>Source</u>: Based on the World Health Organization (WHO) definition.

Risk-type: An individual's likelihood of developing an acute or chronic health condition. Risk types may be specific (e.g., at risk to develop diabetes) or general (e.g., overweight).

Safe Transitions: Effective and efficient movement of *consumer*s from one health care provider or setting to another without an adverse event. An adverse event during transition is defined as an injury resulting from medical management rather than the underlying disease and an event that can be avoided or mitigated, Transition adverse events include such occurrences as readmission within 30 days, medication error, follow-up failures, and DME related events resulting from poor communication and poor coordination between providers.

Adapted from: http://www.healthcare.gov

Second Opinion: Requirement of some health plans to obtain an opinion about the medical necessity and appropriateness of specified proposed services by a practitioner other than the one originally making the recommendation.

Secondary Source Verification or Secondary Source: Verification of a practitioner's credentials based upon evidence obtained by means other than direct contact with the issuing source of the credential (e.g., copies of licenses and certifications and data base queries).

Self-Management: Self-management is defined as the tasks that individuals must undertake to live well that include having the confidence to deal with medical management, role management, and emotional management of their chronic and/or complex conditions. Health care staff provides self-management support, defined as the systematic provision of education and supportive interventions to increase consumer's skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support.

<u>Source</u>: Based on definitions from the 1st Annual Crossing the Quality Chasm Summit: A Focus on Communities Published in 2004 – Publication of Institute of Medicine. Definition from Institute of Medicine 2003.

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Service Requests: Screening callers to determine the services that are necessary at the time of the call. This is usually performed by a non-clinical staff person to determine if the call is clinical and requires transfer to a clinical staff person.

Shared Decision-Making: Shared decision-making is a collaborative process that allows consumers and their provider(s) to make health care decisions together, taking into account the best scientific evidence available, as well as the consumer's values and preferences.

<u>Source</u>: Based on definitions from the Informed Medical Decision Foundation - http://informedmedicaldecisions.org/what-is-shared-decision-making

Staff: The Organization's employees, including full-time employees, part-time employees, and consultants.
   ➢ **Interpretive Note for CIN:** this refers to staff of the organization or network, not to practice staff.
   ➢ **Note:** May include physicians.

Standard Appeal: An appeal of a non-certification that is not an expedited appeal. In most cases, standard appeals will not relate to cases involving urgent care. However, standard appeals may also include secondary appeals of expedited appeals.

State market conduct survey: an audit by a state or series of cooperating states to verify the behavior of a particular market segment. By way of example, in the context of the healthcare market states will complete a market conduct survey to verify whether health insurance companies are following the state's health insurance laws and regulations.
   ➢ **Note:** During the course of an onsite review for Health Plan accreditation, if a Medicaid line of business is within the scope of the application for accreditation, questions for the compliance officer related to standard Core 4 – Regulatory Compliance – would often include one about his or her role during a state market conduct survey and the outcome of the most recent survey for the health plan's Medicaid line of business.

Statistically valid: Based on accepted statistical principles and techniques.

Stratification: A process for sorting a population of eligible consumers into groups relating to the need for disease management interventions. Stratification and assessment are inter-related, and both provide data used to assign interventions. Stratification may use a variety of data sources, including but not limited to claims, pharmacy, laboratory, or consumer-reported data.

Structured Clinical Data: Clinical information that is precise and permits exact matching against explicit medical terms, diagnoses or procedure codes, or other explicit choices, without the need for interpretation.

Target Population The group of individuals, as defined by the purchaser, who are eligible to become participants. The target population may be defined broadly (e.g., all eligible consumers regardless of health status) or narrowly (e.g., all eligible consumers who smoke).

Therapeutic: Of or relating to the treatment of disease or disorders by remedial agents or methods.

Therapeutic Interchange: Authorized exchange of therapeutic alternatives.

Adapted from Academy of Managed Care Pharmacy's (AMCP)
Principles of a Sound Drug Formulary System, 2000.

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Transitional Care: A broad range of time-limited services designed to ensure health care continuity, avoid preventable poor outcomes among at-risk populations, and promote the safe and timely transfer of patients from one level of care to another or from one type of setting to another. Transitional care is complementary to, but not the same as primary care, care coordination, discharge planning, disease management, or case management. Transitional care focuses on educating patients and family caregivers to address root causes of poor outcomes and avoid preventable re-hospitalizations.
Source: MD Naylor, LH Aiken, ET Kurtzman, DM Olds and KB Hirschman.
The Importance of Transitional Care in Achieving Health Reform.
Health Affairs, 30, no.4 (2011):746-754.

Transitions of Care (also known as "Care Transitions"): Transitions of care is the movement of patients from one health care practitioner or setting to another as their condition and care needs change.
Source: Case Management Society of America (CMSA.org)

Transparency/Transparent Reporting: is the belief that providing information about quality or value will be useful to both providers and consumers of health care services. Patients and their families have the right to the information that will help them make informed choices about health care services. If relative value information is made available to health care purchasers, the expectation is that they will make more informed decisions and may perhaps reward higher value providers of care with their business. In this way, the market will drive the provision of higher-value health care.
Source: The Measurement of Health Care Performance: A Primer from the CMSS
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Treating Provider: The treating provider is the individual or provider group who is primarily managing the treatment for a consumer participant in the disease management program. The treating provider is not necessarily the consumers' primary care physician. The consumer may have a different treating provider for different conditions.

Urgent Care: See "Case Involving Urgent Care."

User Organization: An organization seeking to use a previously designated functional site for the purposes of achieving accreditation.

Utilization Management (UM): Evaluation of the medical necessity, appropriateness, and efficiency of use of health care services, procedures, and facilities. Utilization management encompasses prospective, concurrent and retrospective review; it does not include claims review, even if the organization chooses to conduct utilization review on a claims submission, unless a specific request from the claimant for retrospective review accompanies the claims submission. UM is sometimes called "utilization review."
  ➢ **Interpretive Note:** For the Clinically Integrated Organization, "utilization management" may include a variety of structural strategies and practice processes designed to improve care coordination and delivery of the right service by the right provider, at the right time, at the right level of care.

Worker: An ill or injured individual (or representative acting on behalf of the worker) who is eligible for workers' compensation benefits and who files for, or for whom a workers' compensation claim has been filed.

Written Agreements (also referred to as "agreements"**):** A document – including an electronic document – that specifies the terms of a relationship between the Organization and a client, consumer, or contractor. This term includes contracts with or without attachments or addenda.

Written Notification: Correspondence transmitted by mail, facsimile, or electronic medium.

Crosswalk between Core v2.1 & v3.0

Std # (v) 3.0	Std # (v) 2.1	Notes		Std # (v) 2.1	Std # (v) 3.0	Notes
1	1			1	1	
2	2			2	2	
3	3			3	3	
4	19			4	25	
5	12			5	26	
6	15			6	30	
7	16			7	27	
8	17			8	28	
9	18			9	29	
10	21	Old 21(a), (c) & (d) in new Core 10		10	31	
11	14			11	32	
12	24	Client satisfaction brought from Core 24		12	5	
13	13(a) & (d)	New: Interoperability [Leading Indicator]		13	13, 14 & 15	
14	Core 13(c)	Comes from Core 13(c) in v2.1		14	11	
15	Core 13(b)	Comes from Core 13(b) in v2.1		15	6	
16	23			16	7	
17	29			17	8	
18	30			18	9	
19	31			19	4	
20	32			20	33	
21	33			21	10 & 34	
22	Core 35 (stem)	Comes from stem of Core 35 in v2.1		22	38	
23	34			23	16	
24	35			24	39	Consumer Satisfaction
25	4			25	34	
26	5			26	35	
27	7			27	35	
28	8			28	35	
29	9			29	17	
30	6			30	18	
31	10			31	19	
32	11			32	20	
33	20			33	21	
34	25			34	23	
35	26, 27 & 28			35	24	
36	new std	External Coordination		---	36	
37	Core 21(e)	Comes from Core 21(e) in v2.1		---	40	
38	22					
39	24	Consumer satisfaction				
40	new std	Health Literacy				

Crosswalk: Health Plan v7.2 to 7.3 &
Health Plan with Health Insurance Marketplace, v7.2 to 7.3

Changes were made to three (3) standards: P-OPS 12, P-HUM 18, and P-HUM 35.

P-OPS 12 - Breach Handling

Upon notification or discovery of a potential breach, the organization will: (No Weight)

(a) Record the date that the suspected breach was known, or should have reasonably been known, to the organization (i.e., date of knowledge); (Mandatory)

(b) Notify its privacy and security official; (Mandatory)

(c) Determine if an actual breach occurred; **and** (Mandatory)

(d) If ~~one~~ a breach occurred~~, then~~: (No Weight)

   (i) Record the date that the breach occurred; (Mandatory)

   (ii) To the extent practicable, mitigate the cause of the breach; (Mandatory)

   (iii) If the organization is acting as a business associate, ~~then~~ notify the covered entity as soon as possible, but no later than the time frame stipulated in the applicable business associate agreement, which cannot be more than the 60 calendar days from the date of knowledge as required by federal law ~~of the breach within three (3) business days~~; (Mandatory)

   (iv) Provide notice, as required by federal law, to the individuals affected by the breach; (Mandatory)

   (v) Provide notice, as required by federal law, to the Department of Health and Human Services; **and** (Mandatory)

   (vi) Conduct post-breach evaluation and remediation. (Mandatory)

P-HUM 18 - Peer-to-Peer Conversation Alternate

When a determination is made to issue a non-certification and no peer-to-peer conversation has occurred: (No Weight)

(a) The organization provides, within one business day of a request by the attending physician or ordering provider, the opportunity to discuss the non-certification decision: ~~(No Weight)~~ (4)

   (i) With the clinical peer reviewer making the initial determination; **or** ~~(4)~~ (No Weight)

   (ii) With a different clinical peer, if the original clinical peer reviewer cannot be available within one business day; **and** ~~(4)~~ (No Weight)

(b) If a peer-to-peer conversation or review of additional information does not result in a certification, the organization informs the provider and consumer of the right to initiate an appeal and the procedure to do so. (4)

Crosswalk: Health Plan v7.2 to 7.3 &
Health Plan with Health Insurance Marketplace, v7.2 to 7.3

P-HUM 35 - Appeal Peer Reviewer Qualifications

Individuals who conduct appeal considerations are clinical peers who: (No Weight)

(a) Hold an active, unrestricted license or certification to practice medicine or a health profession in a state or territory of the United States; (Mandatory)

(b) Unless expressly allowed by state or federal law or regulation, are located in a state or territory of the United States when conducting appeal considerations; (Mandatory)

(c) Are in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate; (Mandatory)

(d) Are neither the individual who made the original non-certification, nor the subordinate of such an individual; and (Mandatory)

(e) Are board-certified (if applicable) ~~by:~~ (3)

   (i) ~~A specialty board approved by the American Board of Medical Specialties (doctors of medicine); or (No Weight)~~ → addressed in the Interpretive Information/Commentary

   (ii) ~~The Advisory Board of Osteopathic Specialists from the major areas of clinical services (doctors of osteopathic medicine); or (No Weight)~~ → addressed in the Interpretive Information/Commentary

   (iii) ~~The American Dental Association's (ADA) specialty boards or the American Board of General Dentistry (ABGD); or (No Weight)~~ → addressed in the Interpretive Information/Commentary

   (iv) ~~The American Board of Podiatric Surgery (ABPS) or the American Board of Podiatric Medicine (ABPM). (No Weight)~~ → addressed in the Interpretive Information/Commentary

Applicability of Core Standards for URAC Health Accreditation Products

Health Accreditation Products that Include Core	Basic Infrastructure Core 1-16	QM Program Core 17-21	2 QIPs Core 22-23	Consumer Safety QIP Core 24	Staff Qualifications/ Management Core 25-29	Senior/ Clinical Staff Core 30-32	Financial Incentive Policy Core 33	Consumer-Focused Standards Core 34-40
Health Plan	✓	N/A[1]	N/A[1]	N/A[1]	✓	✓[6]	✓	✓
Health Plan with Health Insurance Marketplace	✓	N/A[1]	N/A[1]	N/A[1]	✓	✓[6]	✓	✓
Dental Plan	✓	N/A[1]	N/A[1]	N/A[1]	✓	✓[7]	✓	✓
Dental Plan with Health Insurance Marketplace	✓	N/A[1]	N/A[1]	N/A[1]	✓	✓[7]	✓	✓
Consumer Education and Support	✓	✓	✓	✓	✓	✓	✓	✓
Wellness	✓	✓	✓	✓	✓	✓	✓	✓
Health Call Center	✓	✓	✓	✓	✓	✓[6]	✓	✓
Case Management	✓	✓	✓	✓	✓	✓	✓	✓
Disease Management	✓	✓	✓	✓	✓	✓	✓	✓
Health Utilization Management	✓	✓	✓	N/A[5]	✓	✓[6]	✓	✓[2]
Workers' Compensation Utilization Management	✓	✓	✓	N/A[5]	✓	✓[6]	✓	✓[2]
Health Network	✓	✓	N/A	N/A	✓	✓[6]	✓	N/A
Dental Network	✓	✓	N/A	N/A	✓	✓[7]	✓	N/A
Independent Review Organization	✓[3]	✓	N/A	N/A	✓[3]	✓[6]	✓	N/A
Provider Credentialing	✓	✓	N/A	N/A	✓	✓[6]	N/A	N/A
Credentials Verification Organization	✓	✓	N/A	N/A	✓	✓[4,6]	N/A	N/A
Core	✓	✓	✓	✓[8]	✓	✓[8]	✓[8]	✓[8]

Key/ Footnote	Description
✓	Applicable Core Standards Version 3.0
N/A	Not Applicable
1	The QM standards for these accreditations are incorporated into the main module; therefore, the QM standards in Core are not applicable.
2	Standards Core 34-40 are not applicable to a UM or WCUM applicant organization when prohibited by contract to have contact with the consumer. In addition, these Core standards do not apply to certain types of UM or WCUM vendor certification applicant organizations that do not have contact with the consumer by virtue of the services they provide.
3	For IRO, Core 2, 5, 10, and 29 are not applicable and standards addressing quality management oversight of the IRO process are incorporated into the main module.
4	Core 30-32 apply if a CVO is conducting physician office reviews per standard CVO 11.
5	For Health UM (HUM) and Workers' Comp UM (WCUM), the safety QIP required by Core 24 is not applicable; however, consumer safety is addressed in standards HUM 26 and WCUM 26. The costs associated with the activities supporting these standards may be included in the MLR ("Medical Loss Ratio") calculation.
6	For these accreditations, the senior clinical staff person must be a physician (MD or DO).
7	For Dental Plan, Dental Plan with Health Insurance Marketplace, and Dental Network, the senior clinical staff person must be a dentist (DDS or DMD).
8	For a Core-only applicant or Core with designation applicant (such as the Transitions of Care designation), Core 24 and Core 30-40 may, or may not apply depending on the type of business conducted by the organization. URAC reviewers will work with these applicants to determine which standards are applicable and which ones are not.

Medical Loss Ratio (MLR) Applied to
URAC Application Fees and Standards Compliance Expenses

Section 2718 of the Public Health Service Act as added by Section 1001 of the Patient Protection and Affordable Care Act (PPACA) requires "health insurance issuers" to report to the Department of Health and Human Services (HHS) the amount of premium revenues spent on clinical services, quality improvement activities and all other non-claims costs as defined by the National Association of Insurance Commissioners (NAIC) and certified by HHS. The new law requires issuers to meet specified Medical Loss Ratios (MLRs) – or calculations of the percentage of premiums collected by insurers spent on health care, including quality improvement activities, as opposed to administrative costs and profits.

In October 2010, the NAIC adopted the PPACA MLR Regulation (NAIC Model Regulation), which included language delineating specified application fees as quality improvement expenses. The NAIC delivered the Model Regulation to HHS for certification by the Secretary and HHS issued the MLR Interim Final Rule (HHS Interim Final Rule) in December 2010. The HHS Interim Final Rule closely resembles the NAIC recommendations.

In response to the NAIC Model Regulation and the HHS Interim Final Rule, URAC has developed an analytical framework and methodology that issuers or their delegees may utilize to assist in the allocation of URAC application fees between quality improvement expenses (QI expenses) and administrative expenses for purposes of the MLR calculation. URAC submitted a letter to HHS to inform regulators of URAC's new MLR methodology. Please note: the final determination of the appropriate category for a certain expense needs to be made by the accredited organization in light of the latest guidance available in its jurisdiction.

URAC believes that the expenses related to many of its accreditation, certification, and designation programs may qualify as QI expenses. Please see the following table showing the categories of expenses supported by these various programs. In addition, specific standard elements are identified in supporting guide information and tables found in URAC's standards and guide publications.

Medical Loss Ratio (MLR) Applied to
URAC Application Fees and Standards Compliance Expenses

This table outlines the URAC programs where related (non-fee) standards compliance expenses may qualify as QI expenses. The last five columns identify the specific MLR quality improvement activities for which the QI expenses may qualify. Accreditation, certification, and designation application fees that may be included in the MLR calculation are addressed on the following page.

Program Category	URAC Program	Outcomes	Readmissions	Safety or Reduction of Errors/Mortality	Wellness	HIT
Care Management[1]	Health Call Center	X	X	X	X	X
	Comprehensive Wellness	X	X	X	X	X
	Case Management	X	X	X	X	X
	Disease Management	X	X	X	X	X
	Health Utilization Management[2]	X	X	X	X	X
	Transitions of Care Designation[3]	X	X	X	X	X
Health Care Operations[1]	Core (stand-alone)	X	X	X	X	X
	Consumer Education and Support	X	X	X	X	X
	Health Plan	X	X	X	X	X
	Health Plan with Florida Addendum	X	X	X	X	X
	Health Plan for Health Insurance Marketplace	X	X	X	X	X
	Patient Centered Medical Home Program Designation[4]	X	X	X	X	X
	Health Network	X	X	X	X	X
	Dental Plan	X	X	X	X	X
	Dental Plan for Health Insurance Marketplace	X	X	X	X	X
	Dental Network	X	X	X	X	X
Pharmacy[1]	Pharmacy Benefits Management	X	X	X	X	X
	Drug Therapy Management	X	X	X	X	X
	Mail Service Pharmacy	X	X	X	X	X
	Specialty Pharmacy	X	X	X	X	X
	Community Pharmacy	X	X	X	X	X
Health IT	Health Website	X	X	X	X	X
	Health Content Provider	X	X	X	X	X
	URAC HIPAA Privacy[3]					X
	URAC HIPAA Security[3]					X
Health Care Provider	URAC Patient Centered Medical Home Certification[3]	X	X	X	X	X
	Clinical Integration Accreditation	X	X	X	X	X
	Accountable Care Accreditation	X	X	X	X	X

1. Even though the Care Management, Health Care Operations, and Pharmacy programs support all five of the categories for MLR quality improvement activities, with the exception of the Transitions of Care designation (see footnote 3), not all of the standards within these programs would include activities that support MLR.

2. For Health Utilization Management, only prospective review activities apply to MLR.

3. All activities and resources used to meet the intent of the standards in the URAC Transitions of Care designation, HIPAA accreditation, and Patient Centered Medical Home certification may constitute MLR quality expenses.

4. Only the organizations applying for Health Plan or Health Plan with Health Insurance Marketplace accreditation are eligible to apply for the Patient Centered Medical Home Program Designation. There is no additional fee for this designation.

Medical Loss Ratio (MLR) Applied to
URAC Application Fees and Standards Compliance Expenses

When All Application Fees may be Included in the MLR Calculation

By the nature of the function covered by an accreditation, certification, or designation, there are some URAC programs where all of the standards and their related activities may support MLR quality improvement activities. In the standards and guide publications for these particular programs, URAC did not include a separate table of standard elements and there are no "Points to Remember" notations for individual standards.

The following URAC programs may have all standards support MLR quality improvement activities:

- HIPAA Privacy Accreditation

- HIPAA Security Accreditation

- Patient Centered Medical Home Certification

- Transitions of Care Designation

Application Fees Excluded from the MLR Calculation

There are circumstances when a health insurance issuer *may not include any of the application fees* for an accreditation, certification, or designation in the MLR calculation, such as:

1. When none of the standards for a given program qualify as a quality improvement activity:

    - Claims Processing Administration Accreditation

    - Claims Processing Administration with Claims Review and Appeals Accreditation

    - Credentials Verification Organization Accreditation

    - Independent Review Organization Accreditation

    - Provider Credentialing Accreditation

2. When the program is limited to a line of business that is not within the scope of the MLR Interim Final Rule ("IFR") (e.g., Medicare, Medicaid, and Workers' Compensation):

    - Medicare Advantage Health Plan Accreditation

    - Workers' Compensation Utilization Management Accreditation

    - Workers' Compensation and Property and Casualty Pharmacy Benefit Management Accreditation
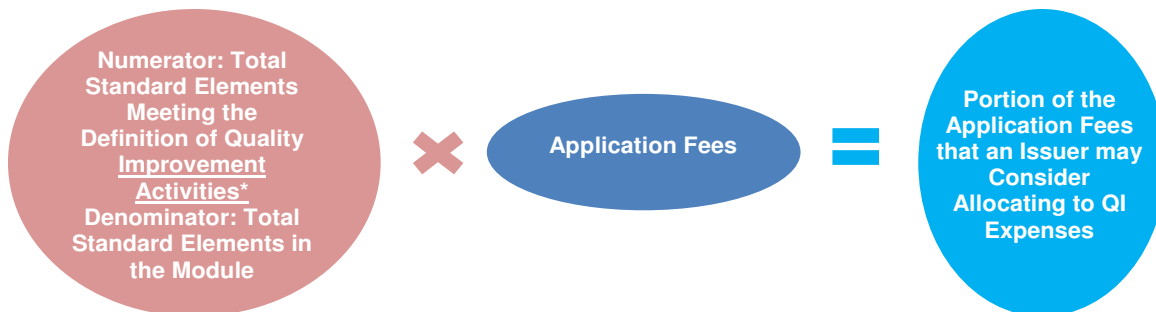
Medical Loss Ratio (MLR) Applied to
URAC Application Fees and Standards Compliance Expenses

For some applications, the accreditation, certification, or designation may apply to both a line of business within the scope of the MLR IFR and a line of business that is not within the scope of the MLR IFR. If this is the case, then the issuer should consider seeking the counsel of appropriate professionals to ensure the allocation methodology it utilizes is appropriate.

An example would be when an organization includes commercial and Medicaid lines of business in its application for Health Plan accreditation. Given this example, the portion of expenses and application fees related to the Medicaid line of business would not be included in the MLR calculation.

URAC's Proposed MLR Methodology for Allocation of Application Fees

URAC's proposed methodology is based upon the percentage of met standards that qualify as quality improvement activities. The calculation described below determines the portion of application fees that qualifies as quality improvement activities. If a particular standard is not met or is not applicable to an issuer for any reason, then based upon this proposed methodology, the percentage of the application fee included in the category of QI expenses is reduced.*

Numerator: Total Standard Elements Meeting the Definition of Quality Improvement Activities* / Denominator: Total Standard Elements in the Module **×** Application Fees **=** Portion of the Application Fees that an Issuer may Consider Allocating to QI Expenses

*Under URAC's proposed methodology, standard elements that are not met, not applicable, or ones that an issuer chooses not to meet, should not be included in the count of MLR standard elements met in the numerator and should not be removed from the denominator. Application fees encompass application submission, measures reporting, and onsite review charges.

MLR Standard Elements in URAC Program Guides

Within its standards and program guide publications, URAC includes a table identifying the standard elements that may be consistent with the definition of quality improvement activities. This is the case unless it is a program where none of the standard elements are likely to qualify as MLR quality improvement activities. These programs are listed in part 1 of the section titled, "Application Fees Excluded from the MLR Calculation."

Medical Loss Ratio (MLR) Applied to
URAC Application Fees and Standards Compliance Expenses

Disclaimer

This document has been provided for informational purposes only and is not intended and should not be construed to constitute legal or accounting advice. Furthermore, this document, and the proposals contained herein have not been approved by any federal or state regulatory body. While in preparing this document, URAC has reviewed then available national guidance, the accredited organization should consider any guidance that may become available from the applicable regulators. When making determinations regarding whether certain expenses qualify as QI expenses, URAC encourages each entity to consult with their accountant/CPA, actuary, attorney, and other professionals to calculate the MLR in accordance with the applicable laws and regulations. URAC does not guarantee or warrant that the approach contained in this document will result in an entity appropriately calculating and reporting its MLR and does not assume any liability, in whole nor in part, for an issuer's calculation of its MLR ratio or the categorization of URAC-related fees within that ratio.

If you have any questions, please contact URAC by phone at 202-216-9010, by email at businessdevelopment@urac.org, or visit our website at www.urac.org.

CORE, Version 3.0: Medical Loss Ratio (MLR) Table

√ = Included		MLR Column				
Standard Number	Weight	Outcomes	Readmissions	Safety/Errors	Wellness	HIT
CORE - 1	2					
CORE - 2	No Weight					
CORE - 2.a	2					
CORE - 2.b	2					
CORE - 2.c	2					
CORE - 2.d	2					
CORE - 3	No Weight					
CORE - 3.a	Mandatory					
CORE - 3.b	2					
CORE - 3.c	3					
CORE - 3.d	No Weight					
CORE - 3.d.i	2					
CORE - 3.d.ii	2					
CORE - 4	No Weight					
CORE - 4.a	Mandatory					
CORE - 4.b	Mandatory					
CORE - 4.c	4					√
CORE - 5	3	√	√	√	√	√
CORE - 6	3					
CORE - 7	No Weight					
CORE - 7.a	3					
CORE - 7.b	3					
CORE - 8	No Weight					
CORE - 8.a	2					
CORE - 8.b	Mandatory					
CORE - 8.c	4					
CORE - 8.d	2					
CORE - 8.e	3					
CORE - 8.f	2					
CORE - 8.g	4					
CORE - 8.h	Mandatory					
CORE - 9	No Weight					
CORE - 9.a	2					
CORE - 9.b	Mandatory					
CORE - 9.c	3				√	
CORE - 10	No Weight					
CORE - 10.a	3					
CORE - 10.b	3					
CORE - 10.c	3					

CORE, Version 3.0: Medical Loss Ratio (MLR) Table

√ = Included		MLR Column				
Standard Number	**Weight**	**Outcomes**	**Readmissions**	**Safety/Errors**	**Wellness**	**HIT**
CORE - 10.d	4					
CORE - 11	2					
CORE - 12	3	√	√	√	√	
CORE - 13	No Weight					
CORE - 13.a	Mandatory	√	√	√		√
CORE - 13.b	2					
CORE - 13.c	No Weight					
CORE - 13.c.i	Leading Indicator					
CORE - 13.c.ii	Leading Indicator					
CORE - 14	No Weight					
CORE - 14.a	3					√
CORE - 14.b	3					√
CORE - 14.c	3					√
CORE - 14.d	3					√
CORE - 15	No Weight					
CORE - 15.a	3					√
CORE - 15.b	Mandatory	√	√	√		√
CORE - 15.c	Mandatory	√	√	√		√
CORE - 16	No Weight					
CORE - 16.a	Mandatory	√	√	√		√
CORE - 16.b	Mandatory	√	√	√		√
CORE - 16.c	Mandatory	√	√	√		√
CORE - 16.d	Mandatory	√	√	√		√
CORE - 16.e	Mandatory	√	√	√		√
CORE - 16.f	Mandatory	√	√	√		√
CORE - 17	Mandatory	√	√	√		
CORE - 18	3	√	√	√	√	
CORE - 19	No Weight					
CORE - 19.a	2					
CORE - 19.b	2					
CORE - 19.c	2					
CORE - 19.d	2					
CORE - 19.e	3	√	√			
CORE - 20	No Weight					
CORE - 20.a	3	√	√	√	√	
CORE - 20.b	3	√	√	√	√	
CORE - 20.c	3	√	√	√	√	
CORE - 20.d	2					
CORE - 20.e	4	√	√		√	

CORE, Version 3.0: Medical Loss Ratio (MLR) Table

√ = Included		MLR Column				
Standard Number	**Weight**	**Outcomes**	**Readmissions**	**Safety/Errors**	**Wellness**	**HIT**
CORE - 20.f	3	√	√	√	√	
CORE - 20.g	3	√	√	√	√	
CORE - 20.h	3	√	√	√	√	
CORE - 20.i	3	√	√	√	√	√
CORE - 21	No Weight					
CORE - 21.a	3			√	√	
CORE - 21.b	Mandatory	√	√	√	√	√
CORE - 21.b.i	3	√	√	√	√	
CORE - 21.b.ii	3	√	√	√	√	
CORE - 21.b.iii	3	√	√	√	√	
CORE - 21.c	Mandatory	√	√	√		√
CORE - 21.d	Mandatory	√	√	√		√
CORE - 21.e	Mandatory	√	√	√		√
CORE - 21.f	Mandatory	√	√	√		
CORE - 21.g	3	√		√	√	
CORE - 21.h	3	√		√	√	
CORE - 22	Mandatory	√	√	√		
CORE - 23	No Weight					
CORE - 23.a	3	√	√	√	√	
CORE - 23.b	3	√	√	√	√	
CORE - 23.c	3	√	√	√	√	
CORE - 23.d	3	√	√	√	√	
CORE - 23.e	3	√	√	√	√	
CORE - 23.f	3	√	√	√	√	
CORE - 24	No Weight					
CORE - 24.a	Mandatory	√	√	√		
CORE - 24.b	Mandatory	√		√		
CORE - 25	No Weight					
CORE - 25.a	2					
CORE - 25.b	2					
CORE - 25.c	2					
CORE - 25.d	2					
CORE - 26	3					
CORE - 27	No Weight					
CORE - 27.a	2					
CORE - 27.b	2					
CORE - 27.c	4					
CORE - 27.d	Mandatory					
CORE - 27.e	2					

CORE, Version 3.0: Medical Loss Ratio (MLR) Table

√ = Included		MLR Column				
Standard Number	**Weight**	**Outcomes**	**Readmissions**	**Safety/Errors**	**Wellness**	**HIT**
CORE - 27.f	2					
CORE - 28	No Weight					
CORE - 28.a	2					
CORE - 28.b	2					
CORE - 28.c	2					
CORE - 29	No Weight					
CORE - 29.a	2					
CORE - 29.b	3					
CORE - 30	No Weight					
CORE - 30.a	Mandatory					
CORE - 30.b	Mandatory					
CORE - 30.c	Mandatory					
CORE - 30.d	Leading Indicator					
CORE - 31	No Weight					
CORE - 31.a	Mandatory					
CORE - 31.b	Mandatory					
CORE - 31.c	Mandatory					
CORE - 31.d	3					
CORE - 32	No Weight					
CORE - 32.a	3	√		√		
CORE - 32.b	Mandatory	√				
CORE - 32.c	3	√		√		
CORE - 32.d	Mandatory	√				
CORE - 33	Mandatory			√		
CORE - 34	Mandatory	√	√		√	
CORE - 35	No Weight					
CORE - 35.a	Mandatory	√		√	√	
CORE - 35.b	4	√		√	√	
CORE - 35.c	4	√		√	√	
CORE - 35.d	4	√		√	√	
CORE - 35.e	3	√	√	√	√	
CORE - 36	1					
CORE - 37	4	√		√	√	√
CORE - 38	Mandatory	√	√	√	√	√
CORE - 39	3	√	√	√	√	√
CORE - 40	No Weight					
CORE - 40.a	Leading Indicator					
CORE - 40.b	Leading Indicator					
CORE - 40.c	Leading Indicator					

MLR Table: Health Plan, Version 7.3

√=included		MLR Column				
Standard Number	Weight	Outcomes	Readmissions	Safety/Errors	Wellness	HIT
P-NM - 1	No Weight					
P-NM - 1.a	4					
P-NM - 1.b	4					
P-NM - 2	No Weight					
P-NM - 2.a	3					
P-NM - 2.b	4					
P-NM - 2.c	3					
P-NM - 3	No Weight					
P-NM - 3.a	Mandatory					
P-NM - 3.b	Mandatory					
P-NM - 3.c	4					
P-NM - 4	No Weight					
P-NM - 4.a	Mandatory					
P-NM - 4.b	Mandatory					
P-NM - 5	No Weight					
P-NM - 5.a	4					
P-NM - 5.b	4					
P-NM - 6	No Weight					
P-NM - 6.a	No Weight					
P-NM - 6.a.i	4					
P-NM - 6.a.ii	4					
P-NM - 6.a.iii	4					
P-NM - 6.a.iv	4					
P-NM - 6.a.v	4					
P-NM - 6.a.vi	4					
P-NM - 6.b	4					
P-NM - 6.c	3					
P-NM - 6.d	3					
P-NM - 7	Mandatory					
P-NM - 8	No Weight					
P-NM - 8.a	Mandatory					
P-NM - 8.b	Mandatory					
P-NM - 9	No Weight					
P-NM - 9.a	2					
P-NM - 9.b	4					
P-NM - 9.c	Mandatory					
P-NM - 9.d	4					
P-NM - 9.e	4					
P-NM - 9.f	Mandatory					
P-NM - 9.g	4					
P-NM - 9.h	2					
P-NM - 9.i	Mandatory					
P-NM - 9.j	Mandatory					
P-NM - 9.k	Mandatory					
P-NM - 9.l	Mandatory					
P-NM - 10	Mandatory					

MLR Table: Health Plan, Version 7.3

√=included		MLR Column				
Standard Number	**Weight**	**Outcomes**	**Readmissions**	**Safety/Errors**	**Wellness**	**HIT**
P-NM - 11	No Weight					
P-NM - 11.a	4					
P-NM - 11.b	4					
P-NM - 12	No Weight					
P-NM - 12.a	4					
P-NM - 12.b	4					
P-NM - 13	4					
P-NM - 14	No Weight					
P-NM - 14.a	Mandatory					
P-NM - 14.b	4					
P-NM - 14.c	4					
P-NM - 14.d	4					
P-NM - 14.e	4					
P-NM - 14.f	4					
P-NM - 14.g	Mandatory					
P-NM - 15	Mandatory					
P-NM - 15.a	Mandatory					
P-NM - 15.b	Mandatory					
P-NM - 15.c	4					
P-NM - 16	Mandatory					
P-NM - 17	No Weight					
P-NM - 17.a	Mandatory					
P-NM - 17.b	Mandatory					
P-NM - 17.c	Mandatory					
P-CR - 1	No Weight					
P-CR - 1.a	Mandatory					
P-CR - 1.b	No Weight					
P-CR - 1.b.i	Mandatory					
P-CR - 1.b.ii	Mandatory					
P-CR - 1.b.iii	Mandatory					
P-CR - 1.b.iv	Mandatory					
P-CR - 2	Mandatory					
P-CR - 3	No Weight					
P-CR - 3.a	Mandatory					
P-CR - 3.b	3					
P-CR - 3.c	4					
P-CR - 3.d	4					
P-CR - 3.d.i	Mandatory					
P-CR - 3.d.ii	4					
P-CR - 3.e	4					
P-CR - 3.f	3					
P-CR - 3.g	3					
P-CR - 3.h	4					
P-CR - 3.i	3					
P-CR - 4	No Weight					
P-CR - 4.a	3					

MLR Table: Health Plan, Version 7.3

√=included		MLR Column				
Standard Number	**Weight**	**Outcomes**	**Readmissions**	**Safety/Errors**	**Wellness**	**HIT**
P-CR - 4.b	3					
P-CR - 4.c	3					
P-CR - 4.d	Mandatory					
P-CR - 4.e	4					
P-CR - 4.f	Mandatory					
P-CR - 4.g	Mandatory					
P-CR - 4.h	4					
P-CR - 4.i	2					
P-CR - 4.j	No Weight					
P-CR - 4.j.i	Mandatory					
P-CR - 4.j.ii	Mandatory					
P-CR - 5	No Weight					
P-CR - 5.a	Mandatory					
P-CR - 5.b	Mandatory					
P-CR - 5.c	Mandatory					
P-CR - 5.d	Mandatory					
P-CR - 5.e	Mandatory					
P-CR - 5.f	Mandatory					
P-CR - 5.g	Mandatory					
P-CR - 5.h	Mandatory					
P-CR - 5.i	Mandatory					
P-CR - 5.j	Mandatory					
P-CR - 5.k	Mandatory					
P-CR - 6	No Weight					
P-CR - 6.a	Mandatory					
P-CR - 6.b	Mandatory					
P-CR - 7	3					
P-CR - 8	No Weight					
P-CR - 8.a	4					
P-CR - 8.b	4					
P-CR - 9	No Weight					
P-CR - 9.a	Mandatory					
P-CR - 9.b	Mandatory					
P-CR - 10	Mandatory					
P-CR - 11	Mandatory					
P-CR - 12	No Weight					
P-CR - 12.a	4					
P-CR - 12.b	4					
P-CR - 13	4					
P-CR - 14	No Weight					
P-CR - 14.a	Mandatory					
P-CR - 14.b	Mandatory					
P-CR - 15	Mandatory					
P-CR - 16	No Weight					
P-CR - 16.a	4					
P-CR - 16.b	Mandatory					

MLR Table: Health Plan, Version 7.3

√=included		MLR Column				
Standard Number	Weight	Outcomes	Readmissions	Safety/Errors	Wellness	HIT
P-CR - 16.c	3					
P-CR - 17	No Weight					
P-CR - 17.a	Mandatory					
P-CR - 17.b	4					
P-CR - 17.b.i	4					
P-CR - 17.b.ii	4					
P-CR - 17.c	3					
P-MR - 1	No Weight					
P-MR - 1.a	Mandatory					
P-MR - 1.b	Mandatory					
P-MR - 1.c	Mandatory	√				
P-MR - 1.d	4					
P-MR - 1.e	4					
P-MR - 2	No Weight					
P-MR - 2.a	No Weight					
P-MR - 2.a.i	4	√				
P-MR - 2.a.ii	4	√				
P-MR - 2.b	4	√				
P-MR - 2.c	4					
P-MR - 2.d	4	√	√		√	
P-MR - 2.e	4				√	
P-MR - 2.f	4					
P-MR - 2.g	4	√				
P-MR - 2.h	4	√				
P-MR - 2.i	4	√				
P-MR - 2.j	4	√				
P-MR - 2.k	4				√	
P-MR - 2.l	4	√				
P-MR - 2.m	4					
P-MR - 2.n	Mandatory					
P-MR - 3	No Weight					
P-MR - 3.a	4	√				
P-MR - 3.b	Mandatory	√				
P-MR - 3.c	No Weight					
P-MR - 4	4	√				
P-MR - 4.a	3					
P-MR - 4.b	3					
P-MR - 5	No Weight					
P-MR - 5.a	4	√				
P-MR - 5.b	4	√				
P-MR - 5.c	1					
P-MR - 6	4	√				
P-MR - 6.a	4					
P-MR - 6.b	4					
P-MR - 6.c	Leading Indicator					
P-MR - 7	No Weight					

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MLR Table: Health Plan, Version 7.3

√=included		MLR Column				
Standard Number	**Weight**	**Outcomes**	**Readmissions**	**Safety/Errors**	**Wellness**	**HIT**
P-MR - 7.a	Mandatory	√				
P-MR - 7.b	4	√				
P-MR - 7.c	4	√				
P-MR - 7.d	Mandatory	√				
P-MR - 7.d.i	Mandatory					
P-MR - 7.d.ii	Mandatory					
P-MR - 7.d.iii	Mandatory					
P-MR - 7.d.iv	Mandatory					
P-MR - 7.e	No Weight					
P-MR - 7.e.i	Mandatory					
P-MR - 7.e.ii	Mandatory					
P-MR - 7.e.iii	4					
P-MR - 7.e.iv	Leading Indicator					
P-MR - 7.f	Leading Indicator					
P-MR - 7.g	4					
P-MR - 7.h	4					
P-MR - 7.i	4					
P-MR - 7.j	4					
P-MR - 7.k	Mandatory					
P-MR - 8	4	√				√
P-MR - 9	4	√				√
P-MR - 9.a	3					
P-MR - 9.b	3					
P-MR - 9.c	3					
P-MR - 9.d	Leading Indicator					
P-MR - 9.e	Leading Indicator					
P-MR - 9.f	Leading Indicator					
P-MR - 10	3					√
P-QM - 1	Mandatory	√		√		
P-QM - 2	3					
P-QM - 3	No Weight					
P-QM - 3.a	2					
P-QM - 3.b	2					
P-QM - 3.c	2					
P-QM - 3.d	2					
P-QM - 3.e	3					
P-QM - 3.f	3					
P-QM - 3.g	3					
P-QM - 4	No Weight					
P-QM - 4.a	3					
P-QM - 4.b	3					
P-QM - 4.c	3					
P-QM - 4.d	2					
P-QM - 4.e	4					
P-QM - 4.f	3					
P-QM - 4.g	3					

MLR Table: Health Plan, Version 7.3

√=included		MLR Column				
Standard Number	**Weight**	**Outcomes**	**Readmissions**	**Safety/Errors**	**Wellness**	**HIT**
P-QM - 4.h	3					
P-QM - 4.i	3					
P-QM - 5	No Weight					
P-QM - 5.a	Mandatory					
P-QM - 5.b	Mandatory					
P-QM - 5.c	Mandatory					
P-QM - 5.d	No Weight					
P-QM - 5.d.i	3					
P-QM - 5.d.ii	3					
P-QM - 5.e	3					
P-QM - 5.f	3					
P-QM - 6	No Weight					
P-QM - 6.a	3					
P-QM - 6.b	3					
P-QM - 6.c	3					
P-QM - 7	No Weight					
P-QM - 7.a	Mandatory					
P-QM - 7.b	Mandatory					
P-QM - 7.c	Mandatory					
P-QM - 8	No Weight					
P-QM - 8.a	3					
P-QM - 8.b	No Weight					
P-QM - 8.b.i	3					
P-QM - 8.b.ii	3					
P-QM - 8.b.iii	Leading Indicator					
P-QM - 9	No Weight					
P-QM - 9.a	3					
P-QM - 9.b	3					
P-QM - 9.c	3					
P-QM - 9.d	3					
P-QM - 9.e	3					
P-QM - 9.f	3					
P-QM - 9.g	3					
P-QM - 9.h	1					
P-OPS - 1	4					
P-OPS - 2	4					
P-OPS - 3	No Weight					
P-OPS - 3.a	4					
P-OPS - 3.b	2					
P-OPS - 4	No Weight					
P-OPS - 4.a	4					
P-OPS - 4.b	4					
P-OPS - 4.c	2					
P-OPS - 4.d	Mandatory					
P-OPS - 5	No Weight					
P-OPS - 5.a	No Weight					

MLR Table: Health Plan, Version 7.3

√=included		MLR Column				
Standard Number	**Weight**	**Outcomes**	**Readmissions**	**Safety/Errors**	**Wellness**	**HIT**
P-OPS - 5.a.i	4					
P-OPS - 5.a.ii	4					
P-OPS - 5.b	4					
P-OPS - 5.c	No Weight					
P-OPS - 5.c.i	4					
P-OPS - 5.c.ii	4					
P-OPS - 5.c.iii	4					
P-OPS - 5.d	No Weight					
P-OPS - 5.d.i	4					
P-OPS - 5.d.ii	4					
P-OPS - 6	No Weight					
P-OPS - 6.a	4					
P-OPS - 6.b	No Weight					
P-OPS - 6.b.i	4					
P-OPS - 6.b.ii	4					
P-OPS - 6.c	4					
P-OPS - 7	No Weight					
P-OPS - 7.a	Mandatory					
P-OPS - 7.b	3					
P-OPS - 7.c	4					
P-OPS - 8	No Weight					
P-OPS - 8.a	Mandatory					
P-OPS - 8.b	No Weight					
P-OPS - 8.b.i	Mandatory					
P-OPS - 8.b.ii	Mandatory					
P-OPS - 8.c	Mandatory					
P-OPS - 9	No Weight					
P-OPS - 9.a	3					
P-OPS - 9.b	3					
P-OPS - 9.c	3					
P-OPS - 9.c.i	3					
P-OPS - 9.c.ii	Mandatory					
P-OPS - 9.d	3					
P-OPS - 10	No Weight					
P-OPS - 10.a	Mandatory					
P-OPS - 10.b	4					
P-OPS - 11	No Weight					
P-OPS - 11.a	Mandatory					
P-OPS - 11.b	Mandatory					
P-OPS - 11.c	Mandatory					
P-OPS - 12	No Weight					
P-OPS - 12.a	Mandatory					
P-OPS - 12.b	Mandatory					
P-OPS - 12.c	Mandatory					
P-OPS - 12.d	No Weight					
P-OPS - 12.d.i	Mandatory					

MLR Table: Health Plan, Version 7.3

√=included		MLR Column				
Standard Number	**Weight**	**Outcomes**	**Readmissions**	**Safety/Errors**	**Wellness**	**HIT**
P-OPS - 12.d.ii	Mandatory					
P-OPS - 12.d.iii	Mandatory					
P-OPS - 12.d.iv	Mandatory					
P-OPS - 12.d.v	Mandatory					
P-OPS - 12.d.vi	Mandatory					
P-CP - 1	No Weight					
P-CP - 1.a	4					
P-CP - 1.b	2					
P-CP - 1.c	2					
P-CP - 1.d	No Weight					
P-CP - 1.d.i	2					
P-CP - 1.d.ii	2					
P-CP - 1.e	No Weight					
P-CP - 1.e.i	Mandatory					
P-CP - 1.e.ii	Mandatory					
P-CP - 1.e.iii	Mandatory					
P-MHP - 1	No Weight					
P-MHP - 1.a	4					
P-MHP - 1.b	No Weight					
P-MHP - 1.b.i	4					
P-MHP - 1.b.ii	4					
P-MHP - 1.b.iii	4					
P-MHP - 2	4					
P-MHP - 3	No Weight					
P-MHP - 3.a	4					
P-MHP - 3.b	4					
P-HUM - 1	No Weight					
P-HUM - 1.a	3			√		
P-HUM - 1.b	3			√		
P-HUM - 1.c	3			√		
P-HUM - 1.c.i	3			√		
P-HUM - 1.c.ii	Mandatory			√		
P-HUM - 1.d	Mandatory			√		
P-HUM - 2	4					
P-HUM - 3	No Weight					
P-HUM - 3.a	4					√
P-HUM - 3.b	4					√
P-HUM - 3.c	4					√
P-HUM - 4	No Weight					
P-HUM - 4.a	2					
P-HUM - 4.b	4					√
P-HUM - 5	No Weight					
P-HUM - 5.a	2					
P-HUM - 5.b	4					
P-HUM - 5.c	4					
P-HUM - 6	No Weight					

MLR Table: Health Plan, Version 7.3

√=included		MLR Column				
Standard Number	**Weight**	**Outcomes**	**Readmissions**	**Safety/Errors**	**Wellness**	**HIT**
P-HUM - 7	No Weight					
P-HUM - 7.a	2					
P-HUM - 7.b	2					
P-HUM - 7.c	2					
P-HUM - 7.d	Mandatory					
P-HUM - 8	Mandatory					
P-HUM - 9	Mandatory					
P-HUM - 10	No Weight					
P-HUM - 10.a	Mandatory					
P-HUM - 10.b	Mandatory					
P-HUM - 11	3					
P-HUM - 11.a	No Weight					
P-HUM - 11.b	No Weight					
P-HUM - 11.c	No Weight					
P-HUM - 12	Mandatory					
P-HUM - 13	Mandatory					
P-HUM - 14	No Weight					
P-HUM - 14.a	Mandatory					
P-HUM - 14.b	Mandatory			√		
P-HUM - 14.c	Mandatory					
P-HUM - 14.c.i	No Weight					
P-HUM - 14.c.ii	No Weight					
P-HUM - 15	No Weight					
P-HUM - 15.a	No Weight					
P-HUM - 15.a.i	Mandatory					
P-HUM - 15.a.ii	Mandatory					
P-HUM - 15.b	No Weight					
P-HUM - 15.b.i	Mandatory					
P-HUM - 15.b.ii	Mandatory					
P-HUM - 15.b.iii	Mandatory					
P-HUM - 15.b.iv	Mandatory					
P-HUM - 16	Mandatory					
P-HUM - 16.a	No Weight	√	√	√		√
P-HUM - 16.b	No Weight	√	√	√		√
P-HUM - 16.c	No Weight	√	√	√		√
P-HUM - 16.d	No Weight	√	√	√		√
P-HUM - 16.e	No Weight	√	√	√		√
P-HUM - 16.f	No Weight	√	√	√		√
P-HUM - 16.g	No Weight	√	√	√		√
P-HUM - 16.h	No Weight	√	√	√		√
P-HUM - 16.i	No Weight	√	√	√		√
P-HUM - 16.j	No Weight	√	√	√		√
P-HUM - 16.k	No Weight	√	√	√		√
P-HUM - 16.l	No Weight	√	√	√		√
P-HUM - 16.m	No Weight	√	√	√		√
P-HUM - 16.n	No Weight					

MLR Table: Health Plan, Version 7.3

√=included		MLR Column				
Standard Number	**Weight**	**Outcomes**	**Readmissions**	**Safety/Errors**	**Wellness**	**HIT**
P-HUM - 16.o	No Weight					
P-HUM - 17	4					
P-HUM - 18	No Weight					
P-HUM - 18.a	4					
P-HUM - 18.a.i	No Weight					
P-HUM - 18.a.ii	No Weight					
P-HUM - 18.b	4					
P-HUM - 19	No Weight					
P-HUM - 19.a	4					
P-HUM - 19.b	4					
P-HUM - 19.c	No Weight					
P-HUM - 19.c.i	4					
P-HUM - 19.c.ii	4					
P-HUM - 19.c.iii	4					
P-HUM - 20	No Weight					
P-HUM - 20.a	3					
P-HUM - 20.b	No Weight					
P-HUM - 20.b.i	4					
P-HUM - 20.b.ii	4					
P-HUM - 20.b.iii	4					
P-HUM - 21	No Weight					
P-HUM - 21.a	4					
P-HUM - 21.b	No Weight					
P-HUM - 21.b.i	4					
P-HUM - 21.b.ii	4					
P-HUM - 22	No Weight					
P-HUM - 22.a	4			√		
P-HUM - 22.b	3					
P-HUM - 22.c	4			√		
P-HUM - 23	3					
P-HUM - 24	No Weight					
P-HUM - 24.a	4			√		
P-HUM - 24.b	4			√		
P-HUM - 24.c	No Weight					
P-HUM - 24.c.i	Mandatory					
P-HUM - 24.c.ii	Mandatory					
P-HUM - 25	4			√		
P-HUM - 26	4					
P-HUM - 27	4					
P-HUM - 28	4					
P-HUM - 29	No Weight					
P-HUM - 29.a	2					
P-HUM - 29.b	2					
P-HUM - 29.c	4					
P-HUM - 29.d	4					
P-HUM - 29.e	4					

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MLR Table: Health Plan, Version 7.3

√=included		MLR Column				
Standard Number	**Weight**	**Outcomes**	**Readmissions**	**Safety/Errors**	**Wellness**	**HIT**
P-HUM - 29.f	3					
P-HUM - 30	4					
P-HUM - 31	4					
P-HUM - 32	4					
P-HUM - 32.a	4					
P-HUM - 32.b	4					
P-HUM - 32.c	4					
P-HUM - 33	No Weight					
P-HUM - 33.a	Mandatory					
P-HUM - 33.b	No Weight					
P-HUM - 33.b.i	Mandatory					
P-HUM - 33.b.ii	Mandatory					
P-HUM - 33.b.iii	Mandatory					
P-HUM - 34	No Weight					
P-HUM - 34.a	Mandatory					
P-HUM - 34.b	Mandatory					
P-HUM - 34.c	Mandatory					
P-HUM - 35	No Weight					
P-HUM - 35.a	Mandatory					
P-HUM - 35.b	Mandatory					
P-HUM - 35.c	Mandatory					
P-HUM - 35.d	Mandatory					
P-HUM - 35.e	3					
P-HUM - 36	No Weight					
P-HUM - 36.a	Mandatory					
P-HUM - 36.b	Mandatory					
P-HUM - 36.c	Mandatory					
P-HUM - 36.d	No Weight					
P-HUM - 36.d.i	Mandatory					
P-HUM - 36.d.ii	Mandatory					
P-HUM - 37	No Weight					
P-HUM - 37.a	4					
P-HUM - 37.b	4					
P-HUM - 38	Mandatory					
P-HUM - 39	Mandatory					
P-HUM - 40	No Weight					
P-HUM - 40.a	4					
P-HUM - 40.b	4					
P-HUM - 40.c	4					
P-HUM - 41	No Weight					
P-HUM - 41.a	3					
P-HUM - 41.b	3					
P-HUM - 41.c	3					
P-HUM - 41.d	3					
P-HUM - 41.e	3					
P-HUM - 42	4					

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MLR Table: Health Plan, Version 7.3

√=included		MLR Column				
Standard Number	**Weight**	**Outcomes**	**Readmissions**	**Safety/Errors**	**Wellness**	**HIT**
P-HUM - 42.a	4					
P-HUM - 42.b	Mandatory					
P-HUM - 42.c	4					
P-HUM - 42.d	4					
P-HUM - 42.e	Mandatory					
P-RPT - 1	Mandatory					
P-RPT - 2	Leading Indicator					

CORE, Version 3.0

Organizational Structure

CORE 1 - Organizational Structure

The *organization* has a clearly defined organizational structure outlining direct and indirect oversight responsibility throughout the *organization.* (2)

Interpretive Information/Commentary

- The organizational structure should clearly identify those departments with responsibility for key program functions and their relationship to each other and the overall organization.

Points to Remember

- While the accreditation relates only to the entity seeking accreditation it is often helpful to include information about relevant parent and subsidiary relationships here.
- Be sure to include the quality department and committee in your organizational chart(s).

Scope of Standards

- This standard covers the entire organization (including off-shore operations) and if applicable, this may include parent organizations and their subsidiaries.
- This standard does not include general personnel, accounting, office management, and other such support services for the organization.

Evidence for Meeting the Standard - Desktop Review Materials

- Top-level organization charts depicting key positions and entities, including (as applicable) parent company and subsidiaries, board of directors, senior executive staff, key committees, staff, and departments.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Current Organizational Chart(s) updated for any changes from Desktop submission.
- Interviews with staff about reporting relationships and oversight.

Bright Ideas

- Create an organizational chart that includes all relevant committees and the reporting and accountability structure of the committees. Include a brief description of each committee's purpose.

Related Standards

- CORE 4 - Regulatory Compliance
- CORE 17 - Quality Management Program
- CORE 20 - Quality Management Committee

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- CORE 34 - Access to Services

CORE 2 - Organization Documents

Organization's documents address: (No Weight)

(a) Mission statement; (2)

(b) Organizational framework for program; (2)

(c) The population served; **and** (2)

(d) Organizational oversight and reporting requirements of the program. (2)

Interpretive Information/Commentary

- The organization has a clearly defined mission statement and a vision for how it will provide services to fulfill its mission.

- Service refers to both clinical and non-clinical services.

Points to Remember

- A program description may provide a "snapshot" of the important features of the program submitted to URAC for accreditation. Content may include a corporate overview, corporate mission statement, program goals, authority and responsibility and population served.
- The Mission Statement should be that of the organization seeking accreditation and reflect the goals and mission of the organization seeking accreditation.
- Describe how and where these services are provided, such as telephonically, via the Internet, client's location, organization's location, etc.
- Organizational structure includes a description of the business functions covered by the accreditation conducted through off-shoring or outsourcing performed outside of the United States (see definitions for these terms). Examples of functions that typically fall into this category include administrative call centers and credentials verification.
- Identify the population(s) served by the program. There are various ways to describe a population. One approach would be to identify the age range or group (e.g., pediatric, adult, geriatric), geographic location, clinical areas (e.g., diabetes, behavioral health, chronic illness, etc.). Another would be to identify the ""books of business"" for the program, such as Medicare, Medicaid, self-funded, commercial, etc.
- Organizational oversight and reporting requirements should include quality management reporting as well as senior clinical staff oversight activities. Remember to include both internal (committees, board of directors) and external (clients, government entities) reporting requirements.
- Remember to include both internal (committees, board of directors) and external (clients, government entities) reporting requirements.

Scope of Standards

- This standard covers the entire organization (including off-shore operations) and if applicable, this may include parent organizations and their subsidiaries.

- This standard does not include general personnel, accounting, office management, and other such support services for the organization.

Evidence for Meeting the Standard - Desktop Review Materials

- A Mission Statement, Program Description, Organizational Charts, Committee Structure(s), internal and external reporting requirements (what is reported, to whom, and when).

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview with program management staff regarding program scope and organizational reporting requirements and Meeting minutes/agendas.

Bright Ideas

- Create a program description that includes information that you would want a new employee to know about the organization. The mission and history of the organization, how the program is structured, who are the consumers served by the organization, and how oversight is conducted can all be a useful in the onboarding process.
- Design organizational charts to list positions rather than staff members' names; this will avoid the need to update organizational charts as staff changes are made.

Related Standards

- CORE 4 - Regulatory Compliance
- CORE 17 - Quality Management Program
- CORE 20 - Quality Management Committee
- CORE 34 - Access to Services

Policies and Procedures

CORE 3 - Policy and Procedure Maintenance, Review and Approval

The *organization:* (No Weight)

(a) Maintains and complies with written policies and documented procedures that govern core business processes of its operations related to the scope of the accreditation; (Mandatory)

(b) Maintains the ability to produce a master list of all such policies and procedures; (2)

(c) Reviews written policies and documented procedures no less than annually and revises as necessary; (3)

(d) Includes the following on the master list or on all written policies and documented procedures: (No Weight)

(i) Effective dates, review dates, including the date of the most recent revision; **and** (2)

(ii) Identification of approval authority. (2)

Interpretive Information/Commentary

- Written policies and/or documented procedures establish accountability for providing quality services to clients and consumers.

- Applicant organizations must define the terms "review date" and "approval date." URAC will use this information to determine that applicants have reviewed their policies and documented procedures [Core 3(c)].

- Policies provide direction and guide an organization's decision-making; whereas, procedures map out the steps for staff to follow to perform a particular function.

- The organization should monitor its internal operations for compliance with written policies and/or documented procedures, especially operations that relate to key processes within the organization.

- A document control sheet can be used to show the annual history of written policies and/or documented procedures. Hard-copy signatures are no longer required; however, the organization must be able to clearly demonstrate that policies have been approved.

Points to Remember

- "This standard applies to the applicant organization's written polices and documented procedures that apply to the functions within the scope of the accreditation, often collectively referenced as the 'program covered by the accreditation.'" It does not include the financial and other office services necessary to support general operations. Please see the "Scope of Standards" section below for more information.

- The organization should have a policy and procedure about policy and procedure development and review that describes the development and approval process for written policies and/or documented procedures to include document management and review.

- The master list of written policies and/or documented procedures should include all written policies and/or documented procedures related to key services of all related programs within the scope of the accreditation. (This will include departmental level written policies and/or documented procedures and may include some corporate level written policies and/or documented procedures).

- In cases where the scope of URAC's review under these standards encompasses more than one department or function within the organization, each department may maintain a separate master list of written policies and/or documented procedures.

- Written policies and/or documented procedures should be reviewed and revised as necessary, but no less than annually (Month Year to month Year). If the organization's written policies and/or documented procedures are more stringent (i.e., if the policies are reviewed on a semi-annual basis, then URAC will hold the organization to the stated policy and procedure.)

- Proof of written policies and/or documented procedures approval: individually signed policies and/or documented procedures, signed master list of policies and/or documented procedures, or signed committee minutes documenting approval. Note that electronic signatures are acceptable.

- The master list, or the written policies and/or documented procedures must include the effective date, the review date and the most recent revision date for each individual policy or procedure.

- If an organization misses three or more _non_-mandatory (i.e., numerically-weighted) standard elements across three or more _separate_ standards, Core 3(a) will be rated as "not met."
  - Example: Applicant misses Core 8(a), Core 10(a), and Core 20(b): Core 3(a) is rated as not met.
  - Example: Applicant misses Core 8(c), Core 8(d), and Core 8(e): Core 3(a) is not impacted.
  - Example: Applicant misses Core 8(c), Core 8(d), and Core 10(a): Core 3(a) is not impacted.

Scope of Standards

- "This standard applies to the key services and internal programs established by the applicant. For purposes of accreditation, the written policies and/or documented procedures that cover program services will be examined for compliance with these standards.

- The master list may include some corporate-level written policies and/or documented procedures addressing Information Management, Oversight of Delegated/Sub-Contracted Functions (if applicable), Staff Management, Regulatory Compliance, Quality Management, Marketing, and Customer Service.
- Written policies and/or documented procedures covering general personnel, accounting, office management, and other such support services for the organization are not required as evidence for meeting these standards."

Evidence for Meeting the Standard - Desktop Review Materials

- Required Documents:
    - Master list of written policies and/or documented procedures. The masterlist may be the table of contents of the policy manual or a screenshot from company intranet/shared drive.
    - A written policy and/or documented procedures regarding developing and maintaining policies and procedures. The policy and/or procedures must include the frequency of review (no less than annually) and identification of approval authority.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

    - Demonstration of access to policies and/or documented procedures by staff and a review of policies and procedures and the master list.

Bright Ideas

    - When establishing a master list of the written policies and/or documented procedures, develop a spreadsheet or table that includes the following categories:
        - Name and number of document;
        - Original effective date,
        - Last review Date,
        - Last revision date,
        - Approval authority,
        - Applicable standards and applicable regulations, and
        - Applicable lines of business.

    - Place written policies and/or documented procedures on an intranet making them "live" documents instantly updated, then hyperlink documentation to relevant standards, state and federal laws, and specific client requirements.
    - Establish a mechanism for updating intranet documents and notifying staff of changes.
    - In the annual policy and/or documented procedure review process, make sure that staff responsible for carrying out the procedure validate that the actual department process accurately reflects the description documented in written policies and/or documented procedures.
    - Establish a template for the documentation of written policies and/or documented procedures that are utilized by the entire organization (corporate and departmental) for consistency with policy and procedure development. On the template specify which lines of business are applicable to the policy and procedure.
    - Note: applicable URAC and other accreditation standards in written policies and/or documented procedures.

Related Standards

- ❍ CORE 17 - Quality Management Program
- ❍ CORE 21 - Quality Management Documentation
- ❍ CORE 28 - Staff Operational Tools and Support

Regulatory Compliance

CORE 4 - Regulatory Compliance

The *organization* implements a regulatory compliance program that: (No Weight)

(a) Tracks applicable laws and regulations in the jurisdictions where the *organization* conducts business; (Mandatory)

(b) Ensures the *organization's* compliance with applicable laws and regulations; **and** (Mandatory)

(c) Responds promptly to detected problems and takes corrective action as needed. (4)

Interpretive Information/Commentary

- It is URAC's goal to ensure that its programs fit within the context of existing regulatory structures. Since these structures vary, it is not always possible to develop standards that are consistent with existing legal requirements. The purpose of Standard Core 4 is to ensure that organizations understand and comply with regulatory requirements in the specific jurisdictions where they operate.

- Per the Department of Health and Human Services (DHHS)/Office of Inspector General (OIG) Draft OIG Compliance Program Guidance for Recipients of Public Health Service (PHS) Research Awards, some of the internal controls organizations can use to effectively monitor adherence to applicable statutes, regulations and program requirements include:
  - Designating a compliance officer.
  - Include a review and annual updates of the compliance program in the organization's training and education.
  - Periodically conducting internal monitoring and auditing pursuant to the organization's policy.
  - Enforce standards through well-publicized guidelines.

- A compliance program should address fraud, waste and abuse as appropriate to the organization.

- Organizations can demonstrate compliance with Core 4 by:
  - Maintaining copies of relevant laws and regulations;
  - Designating a staff person with responsibility for compliance and providing sufficient resources for the compliance program;
  - Providing copies of state licenses (where such licenses are required);
  - Documenting specific actions taken to meet regulatory requirements (such as regulatory filings or correspondence with regulators).

- During the accreditation review, URAC will interview staff to evaluate their familiarity with applicable laws and regulations in their jurisdictions.

Points to Remember

- While URAC may identify regulatory compliance issues relevant to the standard URAC is not conducting a comprehensive audit of your compliance with laws and regulations relevant to your organization. URAC is evaluating that the organization has a mechanism in place to identify and comply with regulatory requirements in a dynamic regulatory environment.
- Some applicant organizations may handle protected health information (PHI) covered under the Health Insurance Portability and Accountability Act (HIPAA). Those that do should address it as part of their regulatory compliance program. In particular the organization should ensure that it conducts risk assessments, identify and sign agreements with Business Associates, and ensure that they and their Business Associates implement reasonable technical, physical, and administrative safeguards for PHI/ePHI.
- <u>Update 10/24/2014</u>: Vendor services that include handling of PHI and IIHI, such as shredding, interpretation/ translation services, and IT functions (e.g., business continuity, information system data integrity, and information confidentiality, security, storage, maintenance, and destruction) are not considered delegation under Core 6-9; however, they are subject to applicable regulatory compliance requirements under Core 4. In summary:
  - Delegation standards (Core 6-9) are not applicable to vendor services such as shredding, interpretation/ translation services, and IT functions, etc. (these vendors are not performing the functions that are the focus of the accreditation).
  - Except for organizations operating in the Workers' Compensation industry, organizations must execute a Business Associate (BA) agreement as well as a vendor agreement that addresses the following elements: breach, breach remediation, transferring of data, workforce training requirements for the BA, and proper handling of PHI.
  - These agreements have regulatory compliance implications. Regulatory compliance is addressed throughout the Core and modular standards. Examples include Core 4, 15 and 16.
  - For the vendor agreement, the organization may incorporate by reference the BA's written policies and/or documented procedures, which may be amended periodically as needed.

- <u>Update 10/24/2014</u>: For vendor services (see bullet above), both Workers' Compensation and non-Workers' Compensation organizations must have written policies and/or documented procedures that detail (where applicable):
  - How the vendor storage receptacles are secured onsite;
  - How the vendor receptacles containing PHI/ IIHI are transferred to the vendor;
  - The location where destruction is performed (onsite/ offsite);
  - How health information is transported offsite for shredding and destruction and/or storage; and
  - How information is exchanged or shared between entities.

Scope of Standards

- This standard applies to all regulations that are applicable to the program standards inclusive of State, Local, and Federal requirements.
- If state or federal requirements conflict with URAC standards, an organization must follow the more stringent requirement.

Evidence for Meeting the Standard - Desktop Review Materials

- Required Documents:
  - Regulatory compliance program description or written policies and/or procedures.
  - A Business Associate Agreement template (if a Business Associate or Covered Entity under HIPAA) or vendor agreement template (if not subject to HIPAA). The agreement must include: how the vendor uses and secures PHI/IIHI, how the PHI/IIHI is transferred to the vendor, the location where PHI/IIHI is housed (onsite/offsite) or transported, how information is shared or exchanged (disclosed) between the organizations.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interviews with staff from all levels of the organization. Review of documentation related to compliance program (e.g. UM/UR licenses, documentation of regulatory compliance trainings, legal/regulatory tracking documentation, and documentation of compliance audits).
- Copies of Business Associate Agreements (or vendor agreements) with Business Associates (or vendors) that use, process, access, or handle PHI and ePHI that address: staff training, breach notification ,and mitigation.
- Meeting minutes that reflect discussion of regulatory issues.

Bright Ideas

- Establish a database of applicable state and federal regulations that is available on a shared drive on the intranet or via a shortcut on the desktop of a PC.
- The compliance department may distribute a monthly or quarterly newsletter that provides ongoing regulatory updates.
- Establish a standing agenda item for regular staff meetings that addresses state and regulatory updates.
- Implement a help desk for staff questions related to regulatory compliance; develop additional training programs based on frequently asked questions.

Related Standards

- CORE 17 - Quality Management Program

Inter-Departmental Coordination

CORE 5 - Inter-Departmental Coordination

The *organization* establishes and implements mechanisms to promote collaboration, coordination and communication across disciplines and departments within the *organization*, with emphasis on integrating administrative activities, quality improvement, and where present, clinical operations. (3)

Interpretive Information/Commentary

- In order to provide quality services, departments and disciplines within an organization must communicate and coordinate their activities.
- Examples of "mechanisms to promote coordination and communication across disciplines and departments within the organization" can include (but are not limited to) your choice of the following:
  - Periodic and documented meetings among department heads and/or with designated staff members to discuss coordination of functions;
  - Assignment of department representatives to serve as liaisons to other departments, including participation in internal committees;
  - Quality improvement projects that include the participation of multiple departments.

Points to Remember

- Meetings are a common example of interdepartmental Coordination. Some examples of interdepartmental meetings are quality meetings, executive meetings, departmental/ team meetings, and staff meetings. Other mechanisms include inter-departmental newsletters and departmental blogs and intranet pages that regularly update staff on the activities and priorities of each department and the organization. It is important that the documentation include both the names of the position title or department that is being represented as your reviewer is not familiar with the responsibilities of individuals in your organization.
- Note: The scope of Core 5 is broad; therefore, provide documentation illustrating the program's activities/communication with at least three of the units supporting the organization's health care-related function or program coming under accreditation. See "Scope of Standards" below.

Scope of Standards

- This standard applies to departments/operational units involved in providing services, and those units that support the program including: Information Management, Oversight of Delegated/Sub-Contracted Functions (if applicable), Staff Management, Regulatory Compliance, Quality Management, Marketing/Communications, and Customer Service.
- Business functions covered by the accreditation conducted through off-shoring or outsourcing outside of the United States (see definitions for these terms) are within the scope of this standard.

Evidence for Meeting the Standard - Desktop Review Materials

- Agenda, meeting minutes, and attendance roster for a recent inter-departmental meeting: please identify the attendees by name, credentials, and affiliation/department.

- Or newsletters, memos, or screenshots of interdepartmental communications documents such as blogs, intranet pages, or other collaborative forums or media.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Staff will be interviewed to discuss interdepartmental collaboration, coordination, and communication.
- Staff and Quality Management Committee meeting minutes will be reviewed for evidence of collaboration. This may include departmental quality reports and/or inter-departmental representation on the Committee.

Bright Ideas

- Promote collaboration through joint projects or initiatives including QIPs.
- Create internal forum for identification of issues and potential solutions such as an internal quality blog.
- Hold regular staff and interdepartmental meetings.
- Develop a tracking log/report of the types of issues communicated between departments and use this report to identify potential quality improvement projects.
- In the program description, addresses how front line staff, senior management, and the board convey information to each other. For large organizations, it may be helpful to develop a flow chart depicting these lines of communication.

Related Standards

- CORE 19 - Quality Management Program Requirements
- CORE 22 - Quality Improvement Projects
- CORE 23 - Quality Improvement Project Requirements
- CORE 24 - Quality Improvement Projects: Consumer Organizations
- CORE 38 - Consumer Safety Mechanism
- CORE 35 - Consumer Complaint Process

Oversight of Delegated Functions

CORE 6 - Delegation Review Criteria

The *organization* establishes and implements criteria and processes for an assessment prior to the *delegation* of functions. (3)

Interpretive Information/Commentary

- Core 6, 7, 8 and 9 (delegation standards) are not applicable if the applicant organization does not delegate part of the health care-related services that it provides to its clients covered by the accreditation. However, the applicant may choose to submit documentation to meet these standards if it has established processes and criteria for delegation anticipating potential delegation in the future.

- To the extent that contractors perform delegated functions and are accredited by URAC for those services they provide to the organization, the organization is exempt from standards Core 6, 7, and 9.

- Prior assessment of a contractor's capabilities helps to promote good working relationships and ensure quality services to consumers.

- Assessments required under Core 6 may not always be onsite; the URAC standards do not require that every potential contractor receive a site visit. The organization's criteria should specify which potential contractors would receive site visits. For example, the criteria might specify that contractors performing a particular function – credentialing, for instance – would receive a site visit. Or the criteria might specify that contractors that are expected to perform a certain volume of services require a site visit.

- **Scope of Delegation:** URAC's definition of delegation is as follows: **"The process by which an organization contracts with or otherwise arranges for another entity to perform functions and to assume responsibilities covered under these standards on behalf of the organization, while the organization retains final authority to provide oversight to the delegate."** Given that definition, delegation is a situation where the organization contracts for a function that is within the scope of accreditation, for which it gives to that delegated entity discretion (i.e., the delegated entity performs independently of the organization.)
    - For purposes of an application for accreditation, the organization is required to list which specific parts of the accredited function have been delegated.
    - **Please note that individual provider contracting in a Health Plan/Health Network organization is excluded.** The provider contracting that is out of scope for delegation is that which is done with individual clinical practitioners, facilities, and individual providers of specific services, such as home health care companies, outpatient testing, etc.
    - Contracting with provider networks, however, is in scope for the delegation standards such that network management and credentialing functions, for example, would require delegation oversight.

Points to Remember

- These standards are "not applicable" if the organization does not delegate any program functions or if the organization is delegating functions to an organization accredited by URAC for these activities. Note: Points for standards determined to be not applicable are not counted as part of the total possible score and therefore do not count against an organization's final accreditation score.
- The organization should have documentation of the assessment conducted of the potential delegate. This includes a review of the entity's written policies and/or documented procedures and verification that the prospective delegate has the capacity to perform the delegated functions.

  For example, in addition to review of policies and procedures, when delegating credentialing, a credentialing file review would be conducted to confirm the entity's ability to perform the delegated function.

- The organization must document how it conducts its assessment of business functions covered by the accreditation that may be conducted through outsourcing performed outside of the United States.

- If the organization believes that this delegation standard does not apply, enter a reason for this determination in the citation area of AccreditNet.

Scope of Standards

- This standard applies to delegation of services within the scope of the accreditation. (Please review the definition of the term "contractor" for more information.)
- Business functions covered by the accreditation conducted through off-shoring or outsourcing outside of the United States (see definitions for these terms) are within the scope of this standard. The applicant remains accountable for ongoing compliance with this standard.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures or delegation program description indicating the criteria used for approving delegates and the criteria used to determine the type of assessment to be conducted prior to delegating. (The documentation should address the circumstances under which a site visit would be conducted as well as any other criteria determining the type of assessment to be used.)

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Pre-delegation audit files will be reviewed to verify implementation of pre-delegation assessment procedures.

Bright Ideas

- Develop a potential delegate screening form/tool with specific criteria, including mandatory URAC standards. Include the method used to apply the criteria (review of written policies and/or documented procedures, case file review, etc.). After completing the tool, potential delegate's can be objectively compared regarding quality of service.

- Establish a delegation file (paper or electronic) that contains the following documents: documentation of pre-delegation assessment tool and relevant documentation, delegation contract and any contract addenda, documentation of ongoing performance assessments, reports, and audit results, review of URAC accreditation or vendor certification status where applicable, and any general correspondence related to performance.

Related Standards

- CORE 7 - Delegation Review
- CORE 8 - Delegation Contracts
- CORE 9 - Delegation Oversight

CORE 7 - Delegation Review

Prior to *delegating* functions to another entity, the *organization:* (No Weight)

    (a) Establishes and implements a process to conduct a review of the potential contractor's written policies and documented procedures and capacity to perform delegated functions; **and** (3)

    (b) Outlines and follows criteria and processes for approving *contractors*. (3)

Interpretive Information/Commentary

- Core 6, 7, 8, and 9 (delegation standards) are not applicable if the applicant does not delegate part of the health care-related services that it provides to its clients. However, the applicant may choose to submit documentation to meet these standards if it has established processes and criteria for delegation anticipating potential delegation in the future.

- To the extent that contractors perform delegated functions and are accredited by URAC for those services they provide to the organization, the organization shall be exempt from standards Core 6, 7 and 9.

- Prior assessment of a contractor's capabilities helps to promote good working relationships and ensure quality services to consumers.

- **Scope of Delegation:** URAC's definition of delegation is as follows: **"The process by which an organization contracts with or otherwise arranges for another entity to perform functions and to assume responsibilities covered under these standards on behalf of the organization, while the organization retains final authority to provide oversight to the delegate."** Given that definition, delegation is a situation where the organization contracts for a function that is within the scope of accreditation, for which it gives to that delegated entity discretion (i.e., the delegated entity performs independently of the organization.) **Please note that provider contracting in a Health Plan/Health Network organization is excluded.** For purposes of an application for accreditation, the organization is required to list which specific parts of the accredited function have been delegated.

Points to Remember

- These standards are "not applicable" if the organization does not delegate any program functions or if the organization is delegating functions to an organization accredited by URAC for these activities. Note: Points for standards determined to be not applicable are not counted as part of the total possible score and therefore do not count against an organization's final accreditation score.
- The organization should have documentation of the assessment conducted of the potential delegate. This includes a review of the entity's written policies and/or documented procedures and verification that the delegate has the capacity to perform the delegated functions.
- The organization must document how it conducts its assessment of business functions covered by the accreditation that may be conducted through outsourcing performed outside of the United States.

- The process and authority for delegation must be clearly outlined in a policy and/or procedure.
- If the organization believes that this delegation standard does not apply, enter a reason for this determination in the citation area of AccreditNet.

Scope of Standards

- This standard applies to delegation of services within the scope of the accreditation. (Please review the definition of the term "contractor" for more information.)
- Business functions covered by the accreditation conducted through off-shoring or outsourcing outside of the United States (see definitions for these terms) are within the scope of this standard. The applicant remains accountable for ongoing compliance with this standard.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures or delegation program description outlining the process for reviewing the relevant polices and procedures of the delegate as well as written policies and/or documented procedures or delegation program description detailing the process for approving delegation.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Pre-delegation audits and delegation contracts will be reviewed to verify implementation of pre-delegation assessment and approval procedures.

Bright Ideas

- Develop a job description for a staff liaison to monitor all related delegated entity activities; or add the responsibilities to an existing job description to include the responsibilities of pre-assessment and ongoing assessments of delegated entities.
- Add an agenda item to the Quality Improvement Committee meeting to include reports from delegated entities.
- Develop a delegate screening form/tool with specific criteria, including mandatory URAC standards. Include the method used to apply the criteria (review of written policies and/or documented procedures, case file review, etc.). After completing the tool, delegate's can be objectively compared regarding quality of service.
- Establish a delegation file (paper or electronic) that contains the following documents: documentation of pre-delegation assessment tool and relevant documentation, delegation contract and any contract addenda, documentation of ongoing performance assessments, reports, and audit results, review of URAC accreditation or vendor certification status where applicable, and any correspondence related to performance.

Related Standards

- CORE 8 - Delegation Contracts
- CORE 9 - Delegation Oversight
- CORE 6 - Delegation Review Criteria

CORE 8 - Delegation Contracts

The *organization* enters into *written agreements* with *contractor*s that: (No Weight)

   (a) Specify those responsibilities *delegated* to the *contractor* and those retained by the *organization*; (2)

   (b) Require that services be performed in accordance with the *organization's* requirements and URAC standards; (Mandatory)

   (c) Require notification to the *organization* of any material change in the *contractor*'s ability to perform *delegated* functions; (4)

   (d) Specify that the *organization* may conduct surveys of the *contractor*, as needed; (2)

   (e) Require that the *contractor* submit periodic reports to the *organization* regarding the performance of its *delegated* responsibilities; (3)

   (f) Specify recourse and/or sanctions if the *contractor* does not make corrections to identified problems within a specified period; (2)

   (g) Specify the circumstances under which activities may be further *delegated* by the *contractor*, including any requirements for obtaining permission from the *organization* before any further *delegation*; **and** (4)

   (h) Specify that, if the *contractor* further *delegates* organizational functions, those functions shall be subject to the terms of the *written agreement* between the *contractor* and the *organization* and in accordance with URAC standards. (Mandatory)

Interpretive Information/Commentary

- Core 6, 7, 8 and 9 (delegation standards) are not applicable if the applicant does not delegate part of the health care-related services that it provides to its clients. However, the applicant may choose to submit documentation to meet these standards if it has established processes and criteria for delegation anticipating potential delegation in the future.

- Core 8 applies to all delegated entities, both URAC-accredited and non-accredited companies. Clearly defined, written service requirements allow an organization to hold contractors accountable for delegated program functions and provides recourse, which may include canceling the contract, when contractor performance does not meet, agreed upon quality performance standards.

- To the extent that contractors perform delegated functions and are accredited by URAC for those services they provide to the organization, the organization shall be exempt from standards Core 6, 7 and 9. The organization should verify that the contractor's accreditation certificate is current and that it has a current written business agreement with the delegated entity.

    ○ For Core 8c, it is up to the organization to determine and clearly articulate what constitutes a material change; however, it needs to include a change in the ability of the delegated entity to perform the delegated work. Examples of this type of "material change" may include loss or replacement of the senior clinical staff person or prolonged interruption of services due to any cause (e.g., natural disaster, IT systems down, decrease in staffing, substantive change in delegated processes, etc.)

- In order to demonstrate that a delegated entity is URAC accredited, applicant organizations must provide a copy of the URAC online directory (www.urac.org) showing current accreditation for the delegated entity.

Points to Remember

- These standards are "not applicable" if the organization does not delegate any program functions or if the organization is delegating functions to an organization accredited by URAC for these activities. Note: Points for standards determined to be not applicable are not counted as part of the total possible score and therefore do not count against an organization's final accreditation score.
- Prior to URAC onsite review, discuss the vendors and delegation relationships the organization may have with department heads to identify any potential cases of delegation. Review your existing contracts to ensure that they comply with the standards.
- If a delegation contract does not address all of the elements in of the standard, URAC will accept a contract addendum.
- Ensure that sub-delegation is addressed in the written agreements for delegation; contract language addressing further delegation, or sub-delegation, must be included in the agreement which does not need to explicitly refer to URAC standards. If the organization's requirements mirror URAC standards, then those would suffice.
- Health Plan accreditation applicant organizations using an independent review organization (IRO) for internal peer clinical review and/or appeals are delegating those functions to the IRO. On the other hand, when a Health Plan applicant organization accesses an IRO for external reviews (i.e., state-mandated reviews), then this is not considered delegation, regardless of the existence of a contract between these entities for external review services.
- Some applicant organizations may handle protected health information (PHI) covered under the Health Insurance Portability and Accountability Act (HIPAA). Those that do should address it as part of their regulatory compliance program. In particular the organization should ensure that it conducts risk assessments, identify and sign agreements with Business Associates, and ensure that they and their Business Associates implement reasonable technical, physical, and administrative safeguards for PHI/ePHI.
- <u>Update 10/24/2014</u>: Vendor services that include handling of PHI and IIHI, such as shredding, interpretation/ translation services, and IT functions (e.g., business continuity, information system data integrity, and information confidentiality, security, storage, maintenance, and destruction) are not considered delegation under Core 6-9; however, they are subject to applicable regulatory compliance requirements under Core 4. Please see standard Core 4 for more information.

Scope of Standards

- This standard applies to delegation of services within the scope of the accreditation. (Please review the definition of the term "contractor" for more information.)
- If the parent company delegates services on behalf of the organization under review, this delegation is under the scope of the accreditation.
- Business functions covered by the accreditation conducted through off-shoring or outsourcing outside of the United States (see definitions for these terms) are within the scope of this standard. The applicant remains accountable for ongoing compliance with this standard.

Evidence for Meeting the Standard - Desktop Review Materials

- Templates of written agreements with delegates addressing each of the elements.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Review of signed written agreements with delegates. These agreements will be examined to verify inclusion of all elements of the standard. (Flagging the elements of the standard within the contracts will speed the review).

Bright Ideas

- Develop a template that includes all of the elements of Core 8. Review the delegated entity contracts with the organization's legal department.
- Work with the department heads to make a list of delegation contracts and vendor relationships.
- As part of the delegated oversight activities, establish a process to verify URAC accreditation and ongoing compliance of URAC accreditation status by accessing the URAC Online Directory at www.urac.org.
- For URAC accredited delegates, require the delegated entity to notify the organization of any change in the URAC accreditation status or less than Full Accreditation.

Related Standards

- CORE 6 - Delegation Review Criteria
- CORE 7 - Delegation Review
- CORE 9 - Delegation Oversight

CORE 9 - Delegation Oversight

The *organization* establishes and implements an oversight mechanism for delegated functions within the scope of accreditation that includes: (No Weight)

(a) A periodic review (no less than annually) of the *contractor*'s written policies and documented procedures and documentation of quality activities for related delegated functions; (2)

(b) A process to verify (no less than annually) the *contractor*'s compliance with contractual requirements and written policies and documented procedures; **and** (Mandatory)

(c) A mechanism to monitor financial incentives to ensure that quality of care or service is not compromised. (3)

Interpretive Information/Commentary

- Core 6, 7, 8, and 9 (delegation standards) are not applicable if the applicant does not delegate part of the health care-related services that it provides to its clients. However, the applicant may choose to submit documentation to meet these standards if it has established processes and criteria for delegation anticipating potential delegation in the future.

- To the extent that contractors perform delegated functions and are accredited by URAC for those services they provide to the organization, the organization shall be exempt from standards Core 6, 7 and 9.

- An oversight mechanism allows an organization to monitor services provided by a contractor and take corrective action as needed.

- Under Core 9(a), the organization should check to ensure that the contractor has a process to monitor the quality of services it provides to the organization (or the organization's clients and consumers). In cases where the contractor's performance does not meet quality expectations, the organization should ensure that the contractor has a process to improve quality. The quality management section of these standards may provide guidance for a contractor's QM program.

- Core 9(c) requires the organization to monitor the impact that financial incentives (if they are present) have on the performance of delegated activities. For example, if a health plan provides a bonus to a delegated utilization management organization based on turnaround time for medical reviews, then the health plan must have a process to monitor or audit the medical reviews to ensure that quality does not suffer. The health plan could implement this monitoring system by doing case audits, evaluating overall utilization patterns, checking for complaints regarding the review process, surveying patients or providers going through the review process, etc.

Points to Remember

- These standards are "not applicable" if the organization does not delegate any program functions or if the organization is delegating functions to an organization accredited by URAC for these activities. Note: Points for standards determined to be not applicable are not counted as part of the total possible score and therefore do not count against an organization's final accreditation score.

Scope of Standards

- This standard applies to delegation of services within the scope of the accreditation. (Please review the definition of the term "contractor" for more information.)
- Business functions covered by the accreditation conducted through off-shoring or outsourcing outside of the United States (see definitions for these terms) are within the scope of this standard. The applicant remains accountable for ongoing compliance with this standard.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures or delegation program description documenting contractor oversight mechanism. This should include a review of the delegate's financial incentive policies.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Delegation audits results will be examined to verify that the oversight mechanisms for delegated program functions have been implemented.
- Interview with staff responsible for delegation oversight..

Bright Ideas

- Many organizations submit delegated entity performance reports to their quality management committee, thus allowing committee evaluation and oversight of the full scope of services provided by their organization.
- The organization can assess complaints regarding the delegated processes related to the contractor's performance through the Quality Management Process (e.g. complaint, grievance, and appeal process, and surveys).
- Develop a delegate assessment form or tool using each URAC standard as individual criteria to show how the intent of each standard is met, either in the delegated entity's documentation or upon site visit (staff interview or file review).

Related Standards

- CORE 6 - Delegation Review Criteria
- CORE 7 - Delegation Review
- CORE 8 - Delegation Contracts
- CORE 17 - Quality Management Program

Marketing and Sales Communications

CORE 10 - Review of Marketing and Sales Materials

The *organization* follows marketing and sales practices that include: (No Weight)

(a) Mechanisms to clearly and accurately communicate information about services inclusive of delegated activities; (3)

(b) A formal process of inter-departmental review of marketing and sales materials before dissemination to safeguard against misrepresentations about the *organization's* services; (3)

(c) Monitoring of existing materials for accuracy; **and** (3)

(d) Responds promptly to detected problems and corrective action as needed. (4)

Interpretive Information/Commentary

- The intent of this standard is to ensure that services represented in **marketing and other general communication** materials are accurate. URAC requires written policies and/or documented procedures related to the development of marketing materials. These procedures are expected to include review of the marketing materials by the operational units that are responsible for conducting these services.

- Appropriate parties are expected to review marketing materials and document the review/approval. Examples of compliance with this standard include emails, sign-off documents, and meeting minutes.

- URAC expects companies to comply with the URAC marketing guidelines outlined in the document "Marketing and Press Release Guidelines for Accredited and In Process Companies," which is distributed with the accreditation application and certificate.

- During the onsite review, URAC will interview the person responsible for developing marketing materials for the lines of business within the scope of the accreditation.

- One suggestion on how to comply with the intent of Core 10(c) includes developing a policy for periodic review of existing materials such as provider directories, Web site materials, etc.

Points to Remember

- Examples of acceptable mechanisms include newsletters, website postings, brochures, individual mailings, requests for proposal (RFP) responses.

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- Acceptable mechanisms to meet include implementing written marketing program descriptions or policies and/or documented procedures that specify how marketing material is developed, approved, and reviewed for accuracy, and who has the authority to approve the materials for distribution. This documentation should include a statement of transparency or truth in advertising addressing delegation of services. Program documents must address processes for implementing corrective actions to identified problems.
- If the organization's program is not typically marketed directly to consumers, then the applicant should include marketing materials used to communicate with a prospective client.

Scope of Standards

- This standard addresses all marketing and sales materials as they apply to clients (business-to-business) as well as consumers. An organization must identify whether it markets to clients or consumers by citing this in its application for accreditation in Accreditnet for this standard. It needs to be perfectly clear if an organization does not market to one or the other.
- Marketing materials include reponses to RFP by clients.
- On the rare occasion that an organization does not market to prospective clients (for example, a CVO department within a health plan with no external clients), then this must be addressed in the application.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures or marketing/communications program description addressing the development, approval, review, and correction of information that is directed to prospective and current consumers and clients.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Review of marketing/communication materials and the approval and review of these materials.
- Interviews with marketing and other staff regarding the types of information shared with clients and/or consumers and the development, review, approval, and correction of these materials.

Bright Ideas

- Develop a database of all marketing materials, initial date of distribution and date of last revision/review. Include the revision date and document identifier in the footer of all printed materials.
- Establish an interdepartmental team to develop a process for an annual review (audit) of all marketing materials, to include both paper and electronic marketing media.
- As part of the approval procedures, include a clinical and legal review of all marketing and correspondence/communication materials.
- Submit periodic reports to the quality management committee on oversight of marketing and sales materials, including any corrective actions taken.

Related Standards

- CORE 4 - Regulatory Compliance
- CORE 21 - Quality Management Documentation

Business Relationships

CORE 11 - Written Business Agreements

The *organization* maintains signed *written agreements* with all *clients* describing the scope of the business arrangement. (2)

Interpretive Information/Commentary

- Clearly defined, written service requirements allow an organization to measure and improve its service performance.
- In general, organizations need to clearly define their roles and responsibilities and communicate them to the purchaser, including their role regarding the administrative aspects of the program they offer. Some of the various administrative areas to address include, <u>as applicable</u>:
    - The relationship of the organization's program with the purchaser client;
    - Criteria for eligibility for the program;
    - Procedures for opting-in, opting-out or dis-enrolling from the program as applicable to the program model;
    - Instructions for contacting the program for urgent and non-urgent situations.
    - A description of the potential health benefits of receiving program services;
    - The existence of restrictions, limitations or incentives in the program that may affect the participating consumer.

- <u>For wellness programs</u>: Organizations applying for wellness accreditation must cite any specific contract language restricting the organization from addressing the administrative elements listed above.
- <u>Update 7/6/2015</u>: For Health Plan with Health Insurance Marketplace applicants who sell health coverage directly to consumers, the consumer is the client and as such, applicant organizations would submit a template contract for desktop review. An "Explanation of Coverage" (EOC) is not a "written agreement" per the definition of the term (see the Glossary located in the front of this Guide).

Points to Remember

- The written agreement must describe the range of services to be provided by the organization as well as any client responsibilities.
- Core 11 applies to written agreements with a business or individual that purchases services from the organization.
- The standard does not specify the exact type of agreement. A contract and any attachments or addenda is an example of an agreement meeting the intent of the standard.
- Sample template agreements or contracts with clients may be submitted with the application for accreditation. It is not necessary to include any attachments to the template agreement that contain financial information.
- Onsite review will include examination of signed agreements with clients along with referenced attachments.
- Contracts must reflect the current name of the organization.

- Note: If the organization is seeking initial accreditation and is just beginning to implement written agreements with clients, then at least one agreement must be signed and available for review during the accreditation onsite visit. An action plan, including timeline for implementation, covering the remainder of the organization's clients would need to be provided no later than the onsite visit.

Scope of Standards

- This standard applies to written agreements with a business or individual that purchases services from the organization. Please see the definition of terms "written agreements" and "clients.

Evidence for Meeting the Standard - Desktop Review Materials

- Contract templates or samples of written agreements with clients that address the scope of the business arrangement, including the services to be provided.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Signed business agreements with clients will be examined to verify implementation of written agreements and that they address the scope of the business arrangement, including the program services to be provided.

Bright Ideas

- Develop a system for detecting expiring contracts and methods for review and renewal.
- Implement written policies and/or documented procedures to establish new contract templates and examine new client contracts using an interdepartmental review team.

Related Standards

- CORE 10 - Review of Marketing and Sales Materials
- CORE 34 - Access to Services

CORE 12 - Client Satisfaction

The *organization* implements a mechanism to collect or obtain information about *client* satisfaction with services provided by the *organization.* (3)

Interpretive Information/Commentary

- Examples of mechanisms to collect or obtain information about client satisfaction include (but are not limited to) surveys, client meetings, complaints/grievances, etc.

Points to Remember

- This standard addresses business-to-business services. Providers and consumer Satisfaction are generally addressed elsewhere. Unless your organization contracts directly with providers to provide services this would not apply to provider satisfaction. Credit for provider satisfaction can be given under Core 20(e).
- During the accreditation review, URAC will look for evidence in the applicant's quality management committee minutes (see Core 20(d)) that the quality management committee has received and discussed information related to client satisfaction with program services.
- Note: For client satisfaction information related to the program, the relevant "quality management" committee can be composed of at least two (2) individuals that come from within the program department. If there are additional levels of committees, then client satisfaction information related to the program is reported up through the organization's committee structure as applicable.

Scope of Standards

- This standard refers to client satisfaction with the organization's services covered by the accreditation. Consumer satisfaction is addressed under Core 39.
- In cases where a consumer is the client, such as when a health plan sells healthcare coverage directly to consumers, this standard is "non-applicable" and Core 39, which addresses consumer satisfaction, applies instead.

Evidence for Meeting the Standard - Desktop Review Materials

- QM program description or written policies and/or documented procedures addressing client (client, not consumer) satisfaction.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Review of the QM minutes and meeting materials relevant to this element.

Bright Ideas

- Establish a way for clients to provide feedback on services and programs via the organization's Web site.

Related Standards

- CORE 21 - Quality Management Documentation

Information Management

CORE 13 - Information Management

The *organization* implements information system(s) (*electronic* and paper) to collect, maintain and analyze information necessary for organizational management that: (No Weight)

    (a) Provides for *data integrity*; (Mandatory)

    (b) Includes a plan for storage, maintenance and destruction; **and** (2)

    (c) Includes a plan for *interoperability*: (No Weight)

        (i) Between internal information systems; **and** (Leading Indicator)

        (ii) With external entity information systems. (Leading Indicator)

Interpretive Information/Commentary

- Proactive information systems management helps to maintain confidentiality and consistent information flow, supporting an organization's ability to provide appropriate and timely services.
- In this context, "data integrity" means data accuracy and trace-ability. For example, when an organization pulls up a consumer's records, what steps has it taken to ensure that it has pulled the correct record and how accurate is the information in the record? Examples of "providing for data integrity" include (but are not limited to):
  - Monitoring data entry personnel for accuracy;
  - Cross-checking databases for consistency;
  - Using unique identifiers for consumer data; and
  - Prevention of and checking for duplicate entries.

- Specific methods to meet Core 13(a)-(b) will vary depending on whether you are dealing with an electronic or paper environment.

- Update 8/3/2015 for standard element (b): URAC will confirm that applicant organization have a plan for storage, maintenance and destruction of the information that they handle.
  - For organizations handling protected health information (ePHI) (i.e., individually identifiable health information) on electronic media, URAC will look to see what provisions, including encryption* or its comparable equivalent, are used to protect this type of data when it comes to storage, maintenance and destruction.
  - *Definition: "encryption" is the conversion of electronic data into another form, called ciphertext, which cannot be easily understood by anyone except authorized parties.
  - The plan must address ephemeral messaging* solutions – in particular, organizations using cloud or social media technology where ePHI and/or ePII may be kept.
  - *Definition: "ephemeral messaging" is secure messaging that never creates electronic stored information, messages only exist in volatile memory streaming from device to cloud to device and leaves no data trace on devices or servers. Data cannot be stored or shared and disappears once read by the recipient. The word "ephemeral" describes something that only lasts for a short period of time.
  - Please note that password protection, though helpful, is not a comparable substitute for encryption.
  - Without a plan for storage, maintenance and destruction, the applicant will not meet the intent of Core 13(b) or Core 15(b), the latter of which is mandatory.

- A standard element designated as a "leading indicator" [L] is *optional* for applicant organizations to meet and if fully met and a full accreditation is achieved, the leading indicator will be listed on the organization's Accreditation Summary Report (ASR).
- URAC will examine the organization's plan for establishing interoperability between its own internal automated information systems and external information systems. URAC will not verify implementation of this plan for this version of the standards.

Points to Remember

- Data integrity addresses both controls to prevent inappropriate editing of data and corruption of data. Technical and administrative controls on access and data quality checks to identify data duplication and/or corruption. Data integrity controls are often associated with addressing the "garbage in, garbage out" problem.
- Data integrity can be addressed in various corporate-wide written policies and/or documented procedures, specific departmental written policies and/or documented procedures, or both. Another option would be to provide key components of an information systems management program description or plan, including the sections addressing high-level procedures in these areas.
- A plan for storage, maintenance and destruction would include where information would be stored, how it could be retrieved, who is responsible for stored information, who has access or approves access, how long information would be maintained before it is destroyed (if it is ever to be destroyed), and how it would be destroyed.
- If the organization has program staff that telecommutes, establish documentation that indicates which positions telecommute and what measures are in place to maintain data integrity and confidentiality. How do you provide for storage, maintenance and destruction of data for remote users.

- Include documentation of written policies and/or documented procedures related to destruction of data for discarded or unused terminals, personal computers and portable media devices.
- Leading indicators [L] are non-weighted, optional elements highlighting effective practices not yet widely adopted in health care. They may not be designated as "not applicable" since they are optional. Leading indicators are not reported to the Accreditation or Executive Committees and are not considered when making an accreditation level determination. For more information, please see the scoring information included in the introductory section of this guide.

- Integrated document distribution programs such as "RightFax" do not meet the intent of Core 13 (c) since the information contained in the documents that have been exchanged cannot be used (versus displayed) by the other systems.

Scope of Standards

- This standard applies to all information systems (electronic and paper) supporting the program covered by the accreditation.
- Delegation: Standard Core 13 applies to delegated contractors (i.e., business entities, not contracted individuals) that handle consumer or client information.
- Business functions covered by the accreditation conducted through off-shoring or outsourcing outside of the United States (see definitions for these terms) are within the scope of this standard.

Evidence for Meeting the Standard - Desktop Review Materials

- Data Integrity: Written policies and/or procedures identifying your strategies for maintaining data integrity through database checks and audits, assigning unique identifiers where necessary, and utilizing technical and access controls to protect and maintain data integrity.
- Data Management: Witten policies and/or documented procedures addressing the "data lifecycle." The policy should specifically address the storage, editing, and eventual destruction of both paper and electronic information (including PHI/ePHI). If you rely on a vendor for the storage or destruction of your data please include any policies and procedures, business associate agreements, or vendor agreements governing these activities. Witten policies and/or documented procedures addressing encryption of PHI/ePHI including portable media. If applicable, written policies and/or documented procedures addressing telecommuters.
- Interoperability: policies and/or documented procedures, IT program descriptions or plans addressing the use of common software platforms, database language, and/or network architecture to allow for the exchange and use of data between internal and external information systems (interoperability). Diagrams of your IT infrastructure showing the various information systems and explaining the mechanism for interoperability are often helpful.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview with operations management and staff (including IT staff) regarding their role in maintaining data integrity and information. Your Security officer and the IT Staff that support the key software applications use by your staff may be necessary to answer some questions.
- Tour and observation of equipment and data security, storage, maintenance, and destruction located at the organization's site.
- Interviews with staff about privacy and security practices relevant to their position.

- Discussion with operations management regarding information systems equipment and capabilities, including services provided by a contractor.

Bright Ideas

- Conduct routine data integrity audits for accuracy of data entry as part of your quality management program and use dropdowns, checkboxes, and radio buttons in preference to free text wherever possible.
- Include in the audit tool for pre-assessment evaluation of delegated entities (refer to Core 7) and ongoing compliance audits (refer to Core 9) elements that demonstrate the delegated entity's information systems are capable of maintaining data integrity and interoperability with your information systems.

Related Standards

- CORE 14 - Business Continuity
- CORE 15 - Information Confidentiality and Security
- CORE 27 - Staff Training Program

CORE 14 - Business Continuity

The *organization* implements a business continuity plan for program operations, including information system(s) (*electronic* and paper) that: (No Weight)

(a) Identifies which systems and processes must be maintained and the effect an outage would have on the *organization's* program; (3)

(b) Identifies how business continuity is maintained given various lengths of time information systems are not functioning or accessible; (3)

(c) Is tested at least every two years; **and** (3)

(d) Responds promptly to detected problems and takes corrective action as needed. (3)

Interpretive Information/Commentary

- Applicants need to comply with state and federal regulations regarding business continuity. Meeting regulations will contribute to meeting the intent of the standard.

- Specific methods to meet Core 14(a)-(b) will vary depending on whether you are dealing with an electronic or paper environment.

- Element (c): Business continuity testing is company-specific. The organization determines how comprehensive its business continuity testing should be, documenting the rationale – including best practices and constraints, to support the level of testing it selects.

- This standard refers to recovery of key data (electronic and paper), not the recovery of physical facilities; however, applicant organizations need to address program functioning and infrastructure as it is affected by disasters, which would include when a facility is compromised.

- It is not the intent of the standard to require organizations to make all documents electronic, but rather in the event of a disruption in business operations , key documentation needs to be maintained so the organization can resume business without substantial problems. For example, this standard should not be interpreted by organizations that credential providers to be a requirement that each provider credential be collected and maintained electronically.

Points to Remember

- Business continuity can be addressed in various corporate-wide written policies and/or documented procedures, specific departmental written policies and/or documented procedures, or both. The scope of the standard includes electronic and paper information systems, communications systems, and other systems as needed to maintain critical functions related to the accreditation.
- If the organization has program staff that telecommutes, written policies and/or documented procedures must indicate what measures are in place related to business continuity where it relates to telecommuters.

- Business continuity testing should occur at least once by the date of the onsite visit or initial applicants.
- The intent of the standard is for an organization to test its systems periodically. Submitting only documentation of an unplanned event and discussion/review of the plan is not sufficient to meet the standard.
- The organization should submit documentation that the business continuity plan has been tested at least every two years and the test results should include documentation of any corrective actions taken in response to areas identified for improvement.

Scope of Standards

- The standard addresses business continuity for the functions covered by the accreditation.
- This standard includes information systems that are electronic, paper-based, or a combination of both.

Evidence for Meeting the Standard - Desktop Review Materials

- Business continuity-related written policies and/or documented procedures, and/or key sections of a program description or plan addressing business continuity systems and processes, including formal testing at a minimum every two years and a response plan for identified improvement opportunities.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Review of a comprehensive set of business continuity plan and documentation of testing.
- Interview with operations management and staff regarding their role in business continuity planning.
- Tour and observation of equipment and data security, storage, and maintenance located at the organization's site.
- Discussion with operations management regarding off-site information systems equipment and capabilities, including services provided by a contractor.
- Documentation of date of last business continuity plan test and related documentation/action plan developed after test.

Bright Ideas

- Incorporate results of business continuity testing and lessons learned into the quality management program.

Related Standards

- CORE 13 - Information Management
- CORE 15 - Information Confidentiality and Security
- CORE 27 - Staff Training Program

CORE 15 - Information Confidentiality and Security

The *organization* provides for data confidentiality and security of its information system(s) (*electronic* and paper) by implementing written policies and/or documented procedures that address: (No Weight)

> (a) Assessment of the potential risks and vulnerabilities to the confidentiality, integrity and availability of information systems; (3)

> (b) Prevention of confidentiality and security breaches; **and** (Mandatory)

> (c) Detection, containment and correction of confidentiality and security violations. (Mandatory)

Interpretive Information/Commentary

- Proactive information systems management helps to maintain confidentiality and consistent information flow, supporting an organization's ability to provide appropriate and timely services.
- Update 8/3/2015 for standard element (a): for organizations handling protected health information (ePHI) (i.e., individually identifiable health information) on electronic media, the risk assessment must address:
  - Encryption, and if it is not used, must include an explanation as to why it is not used and the alternate means of securing PHI.
  - Definition: "encryption" is the conversion of electronic data into another form, called ciphertext, which cannot be easily understood by anyone except authorized parties.
  - Ephemeral messaging* solutions for organizations using cloud or social media technology where ePHI and/or ePII may be kept.
  - *Definition: "ephemeral messaging" is secure messaging that never creates electronic stored information, messages only exist in volatile memory streaming from device to cloud to device and leaves no data trace on devices or servers. Data cannot be stored or shared and disappears once read by the recipient. The word "ephemeral" describes something that only lasts for a short period of time.

- Update 8/3/2015 for standard element (b): URAC is looking to confirm that any applicant organization handling PHI and PII has a plan for storage, maintenance and destruction [Core 13 (b)], and has conducted a risk assessment [Core 15(a)].
  - If either of these standard elements are not met, Core 15(b) is not met.
  - Given government requirements* and that the industry standard for protecting ePHI and preventing confidentiality and security breaches is encryption**, applicant organizations must implement encryption for all devices, including storage devices, handling ePHI.
  - *Reference: HIPAA Security Rule:
    - Encryption and Decryption - 164.312(a)(2)(iv): Implement a method to encrypt and decrypt electronic protected health information.
    - Encryption - 164.312(e)(2)(ii): Implement a mechanism to encrypt electronic protected health information whenever deemed appropriate.
  - **Reference: National Institute of Standards and Technology (NIST): An Introductory Resource Guide for Implementing the Health Insurance Portability and Accountability (HIPAA) Security Rule; NIST Special Publication 800-66 Revision 2; via link: http://csrc.nist.gov/publications/nistpubs/800-66-Rev1/SP-800-66-Revision1.pdf
  - If encryption has not been implemented, a comparable alternative has been implemented.
  - Please note that password protection, though helpful, is not a comparable substitute for encryption.
  - For organizations using cloud or social media technology where ePHI and/or ePII may be kept, URAC will look to see what ephemeral messaging* solution(s) have been employed by the applicant organization.
  - *Definition: "ephemeral messaging" is secure messaging that never creates electronic stored information, messages only exist in volatile memory streaming from device to cloud to device and leaves no data trace on devices or servers. Data cannot be stored or shared and disappears once read by the recipient. The word "ephemeral" describes something that only lasts for a short period of time.
  - *Definition: "ephemeral messaging" is secure messaging that never creates electronic stored information, messages only exist in volatile memory streaming from device to cloud to device and leaves no data trace on devices or servers. Data cannot be stored or shared and disappears once read by the recipient.

- Specific methods to meet Core 15(a)-(c) will vary depending on an electronic or paper environment.

Points to Remember

- Some applicant organizations may handle protected health information (PHI) covered under the Health Insurance Portability and Accountability Act (HIPAA). Those that do should consider the implications of this regulation on their information systems as they seek to comply with the URAC standards. Documents used to evaluate program information systems for compliance with HIPAA may be referenced as applicable.
- Confidentiality and security can be addressed in various corporate-wide written policies and/or documented procedures, specific departmental written policies and/or documented procedures, or both. Provide key components of an information systems management program description or plan, including the sections addressing high-level procedures in these areas.

- The organization should designate an individual responsible for corporate compliance with information confidentiality and security.
- Information confidentiality and security written policies and/or documented procedures apply to telecommuters. If the organization has program staff that telecommutes, written policies and/or documented procedures must indicate what systems are in place to ensure confidentiality and security of data and information.
- Data confidentiality and security measures include paper documents and the transmission of documents by facsimile. Be sure that fax cover sheets contain a confidentiality statement/disclaimer and information to allow them to contact you. Also ensure that the facsimile machine is in a secure area with access limited to only authorized staff.

Scope of Standards

- This standard addresses data confidentiality, security and integrity of the electronic and paper information systems supporting the function covered by the accreditation. This includes electronic, which includes Web-based systems and portable media.
- This standard applies to the confidentiality and security of personal health information (PHI) as well as individually identifiable health information (IIHI).
- Business functions covered by the accreditation conducted through off-shoring or outsourcing outside of the United States (see definitions for these terms) are within the scope of this standard. The applicant remains accountable for ongoing compliance with information confidentiality and security.

Evidence for Meeting the Standard - Desktop Review Materials

- Risk assessment: Written policies and/or documented procedures detailing your risk assessment practices. The "Risk Analysis" required by HIPAA has the same meaning and can be used as evidence.
- Breach Prevention: Written policies and/or documented procedures detailing your technical, physical, and administrative safeguards to prevent a breach.
- Detection: Written policies and/or documented procedures addressing your process to monitor for security threats and breaches, containment of breaches and vulnerabilities once identified, and process to prevent recurrence.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Review of the breech/incident log and risk assessment.
- Interview with operations management and staff regarding their role in maintaining information systems.
- Tour and observation of equipment and data security, storage, maintenance, and destruction located at the organization's site; off-site information system equipment and capabilities, including services provided by a contractor, will be verified with operations management and discussed in terms of its effects (if any) on program services.
- Interview of staff and management personnel to verify organizational confidentiality and security practices.

Bright Ideas

- Set up the facsimile machine to go into memory mode after regular business hours so incoming faxes do not remain on the facsimile machine after-hours.
- Fax coversheets with confidentiality notices and contact information help protect the confidentiality of faxed information.
- Include compliance with all of the elements of Core 15 in the audit tool used to evaluate prospective delegated entities and ongoing compliance audits.

Related Standards

- CORE 27 - Staff Training Program

CORE 16 - Confidentiality of Individually-Identifiable Health Information

The *organization* implements written policies and/or documented procedures to protect the confidentiality of *individually-identifiable health information* that: (No Weight)

(a) Identifies how *individually-identifiable health information* will be used; (Mandatory)

(b) Specifies that *individually-identifiable health information* is used only for purposes necessary for conducting the business of the organization, including evaluation activities; (Mandatory)

(c) Addresses who will have access to *individually-identifiable health information* collected by the *organization*; (Mandatory)

(d) Addresses oral, written or *electronic* communication and records that are transmitted or stored; (Mandatory)

(e) Address the responsibility of *organization* employees, committee members and board members to preserve the confidentiality of *individually-identifiable health information*; **and** (Mandatory)

(f) Requires employees, committee members and board members of the *organization* to sign a statement that they understand their responsibility to preserve confidentiality. (Mandatory)

Interpretive Information/Commentary

- Electronic systems include all forms of wireless communication, Internet, fax, portable electronic media, etc.

Points to Remember

- State laws relating to use of individually identifiable health information may be more restrictive than federal laws. All personnel should receive training on both state and federal laws related to the use and disclosure of individually identifiable health information.
- Identify all staff that should have access to individually-identifiable health information (IIHI) to perform their jobs. (Access to IIHI should be limited to only those personnel who need access to this information to perform job-related tasks.)
- Policies should specify acceptable uses of IIHI within the organization, not only that which is unacceptable.
- Include in the written policies and/or documented procedures guidelines for personnel who may have access to either electronic or paper documents that contain individually-identifiable health information.
- If an organization is a covered entity under HIPAA regulations, the organization should have a notice of privacy practices available for consumers, clients, and providers.
- The organization should have a corporate compliance officer or privacy official who is responsible for training and ongoing compliance with confidentiality and privacy rules.

- Even if board or committee members do not routinely access IIHI, the standard requires both committee members and board members to sign a statement that they understand their responsibility to preserve confidentiality of individually-identifiable health information. Confidentiality statements with a primary focus on trade secrets or protection of company-specific proprietary information do not meet the intent of the standard. If the organization does not have a board of directors, provide a citation in AccreditNet and identify the person(s) who comprise the organization's oversight authority.

Scope of Standards

- The scope of the standard is inclusive of the state privacy laws and the HIPAA privacy laws. For more information regarding HIPAA, access the following website: www.hhs.gov/ocr/hipaa.

Evidence for Meeting the Standard - Desktop Review Materials

- Use: Written policies and/or documented procedures addressing the appropriate use of IIHI only for purposes necessary for conducting the business of the organization, including evaluation activities.
- Access: Written policies and/or documented procedures related to access to IIHI including the principle of minimum necessary.
- Training: Written policies and/or documented procedures requiring staff training related to privacy regulations that address the written, oral, and electronic storage and transmission of IIHI.
- Individual responsibility: Written policies and/or documented procedures addressing individual responsibility to protect IIHI and requirements that all staff, board, and committee members sign an attestation that they understand their responsibility.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview with compliance or privacy official and manager of information systems security.
- Signed statements by all staff, committee members, and board members that they understand their responsibility to preserve the confidentiality of individually identifiable health information.
- Documentation of training related to the confidentiality of individually- identifiable health information that addresses paper, electronic, verbal transmission and storage.
- Interview with all levels of staff to verify understanding of their responsibility to preserve confidentiality.

Bright Ideas

- Provide a "fact sheet" that is a quick reference guide to written policies and/or documented procedures regarding the access and use of individually-identifiable health information; this may be available via paper, online, or via shared drive on the intranet.
- Provide training scenarios related to the use and disclosure of individually identifiable health information for orientation and provide annual training updates.
- Periodically distribute information such as "tip of the week" regarding confidentiality and privacy laws.

Related Standards

- CORE 4 - Regulatory Compliance
- CORE 13 - Information Management
- CORE 15 - Information Confidentiality and Security
- CORE 35 - Consumer Complaint Process

Quality Management

CORE 17 - Quality Management Program

The *organization* maintains a *quality management program* that promotes objective and systematic measurement, monitoring and evaluation of services and implements quality improvement activities based upon the findings. (Mandatory)

Interpretive Information/Commentary

- A viable quality management (QM) program has the requisite structures and processes in place to ensure quality services to clients and consumers.

- URAC recognizes that quality management activities will vary by organization. The standards provide flexibility for an organization to implement its own quality management program. The intent of this section is to provide the framework for a quality management program within which an organization can focus on its unique needs.

Points to Remember

- The QM program description addresses the needs of internal and external "customers," including the organization's various internal departments, clients and consumers.
- Organizations monitor clinical and non-clinical services as applicable to their books of business.

Scope of Standards

- This standard applies to the quality management program that oversees the program coming under accreditation. The program may be contained within the requisite department or it may be organization-wide.

Evidence for Meeting the Standard - Desktop Review Materials

- Program description and plan or written policies and/or documented procedures addressing QM oversight of the program.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Committee minutes and QM program documentation for the period under review. Initial applicants can provide minutes for meetings occurring after the submittal date for the application for accreditation. Minutes are reviewed to verify program implementation and should be flagged to refer to those areas identified in the onsite agenda such as annual review and approval of the QM plan, approval of QIPs, and reporting of quality measures.
- Interviews with staff responsible for QM program.

Bright Ideas

- Work with your IT staff to create reports addressing your quality goals.

Related Standards

- CORE 18 - Quality Management Program Resources
- CORE 19 - Quality Management Program Requirements
- CORE 20 - Quality Management Committee
- CORE 38 - Consumer Safety Mechanism

CORE 18 - Quality Management Program Resources

The *organization* employs *staff* and/or provides the resources necessary to support the day-to-day operations of the *quality management program.* (3)

Interpretive Information/Commentary

- A viable quality management (QM) program has the requisite structures and processes in place to be able to evaluate and ensure quality services to clients and consumers.

- URAC recognizes that actual quality management activities will vary by organization, and URAC wishes to provide flexibility for an organization to implement its own quality management program. The intent of this section is to provide the framework for a quality management program within which an organization can focus on its unique needs.

- Core 18 does not imply that a specific quality management department must be created.

Points to Remember

- For smaller organizations, QM activity may be a percentage of a staff person's overall job requirements. This percentage must be noted in job descriptions.
- Temporary consultants cannot fulfill the role of ""QM staff"" for purposes of this application for accreditation; however, it is acceptable for all staff to have a role in promoting quality within their organization instead of limiting that role to certain staff. When that is the case, URAC will verify staff's role through job descriptions and evaluations.

Scope of Standards

- This standard applies to the quality management program that oversees the program coming under accreditation. The program may be contained within the requisite department or it may be organization-wide.

Evidence for Meeting the Standard - Desktop Review Materials

- Program description and plan or written policies and/or documented procedures addressing QM oversight of the program.
- Or Job descriptions for staff with QM responsibilities including oversight of the program. For programs with less than one FTE dedicated to QM, the job description must indicate what percentage of person's overall responsibilities are dedicated to QM. If all program staff are responsible for quality, then their scope of responsibilities pertaining to this area needs to be made clear in the job description and QM documentation.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Committee minutes and QM program documentation for the period under review. Initial applicants can provide minutes for meetings occurring after the submittal date for the application for accreditation. Minutes are reviewed to verify program implementation and should be flagged to refer to those areas identified in the onsite agenda such as annual review and approval of the QM plan, approval of QIPs, and reporting of quality measures.

- Interview(s) with staff responsible for QM activities.
- Review of the QM program documents including the annual evaluation to confirm that the resources of the QM program were evaluated and addressed.

Bright Ideas

- In the annual evaluation of the quality management program, include a section that covers "evaluation of resources" that addresses issues including computer resources, internal staffing, external consultants, independent survey firms, and financial resources.

Related Standards

- CORE 17 - Quality Management Program
- CORE 19 - Quality Management Program Requirements
- CORE 20 - Quality Management Committee
- CORE 38 - Consumer Safety Mechanism

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CORE 19 - Quality Management Program Requirements

The *organization* has a written description for its *quality management program* that: (No Weight)

(a) Is approved by the *organization's* appropriate oversight authority; (2)

(b) Defines the scope, objectives, activities, and structure of the *quality management program*; (2)

(c) Is reviewed and updated by the Quality Management Committee at least annually; (2)

(d) Defines the roles and responsibilities of the Quality Management Committee; **and** (2)

(e) Designates a member of senior management with the authority and responsibility for the overall operation of the *quality management program* and who serves on the Quality Management Committee. (3)

Interpretive Information/Commentary

- A well-articulated quality management (QM) program, approved by organizational leadership, helps to assure ongoing support for the program.

Update 1/12/2015

- The appropriate oversight authority may be the board of directors, or an executive committee that may include board members and that has the authority to make decisions and allocate resources for the QM program.
- For smaller organizations not governed by a board or committee, company leadership would then approve QM program documents.
- In small organizations the executive team or the board of directors can act as both the oversight authority and the QMC.
  - Include in the quality management program documents the definition of the organization's oversight authority.

- In large, complex organizations (such as corporations or universities) where the board is far removed from the program seeking accreditation, the oversight authority can be composed of executive team members and program management representatives. The QM program documents then must include the definition of the organization's oversight authority for the quality management program. Membership in the oversight body must be stated as part of this definition. Functions required of the oversight body must be described. URAC will review minutes of the meetings of the oversight body for compliance with QM program standards.

End of 1/12/2015 update

- In any case, the oversight authority may delegate responsibility for approving the quality management plan to another group within the organization. URAC will look for documentation of this delegation.

- There are numerous strategies for implementing quality within the organization. For instance, resources allocated do not have to be a single person designated with responsibility for the QM program. This responsibility may be dispersed throughout the organization as evidenced through job descriptions, the quality management program description, meeting minutes and quality improvement project documentation.
- Core 19 is not intended to imply that a specific quality management department be created, rather that quality management is integrated into organizational processes.

Points to Remember

- The vesting of authority in the QMC can be documented in a committee charter, management memo or directive from the oversight authority, or documented in an approval of the QM plan.
- Standard Core 19 applies to delegated contractors (business entities, not contracted individuals) including those that handle time-sensitive consumer clinical information or that provide clinical care to consumers.

Scope of Standards

- This standard applies to the quality management program that oversees the program. The program may be contained within the program department or it may be organization-wide.

Evidence for Meeting the Standard - Desktop Review Materials

- Program description/plan or written policies and/or documented procedures addressing QM oversight, the scope, structure (including the designated member of senior management with responsibility for QM), objectives, activities, and roles and responsibilities of the QM Committee and staff, documentation of annual review and approve.
- And any job descriptions, charters, or management directives or memos that confer authority or responsibilities not explicitly addressed in the program description/plan or written policies and/or documented procedures.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Committee minutes and QM program documentation for the period under review. Initial applicants can provide minutes for meetings occurring after the submittal date for the application for accreditation. Minutes are reviewed to verify program implementation and should be flagged to refer to those areas identified in the onsite agenda such as annual review and approval of the QM plan, approval of QIPs, and reporting of quality measures.
- Interview with program management to discuss the structure of the QM program as it effects the organization's program.

Bright Ideas

- Many organizations use the following format to establish program documentation: (1) program description– focuses on the program structure, including staff, committee, and board, and relevant accountabilities, (2) annual program plan – often a table that includes dates for special projects as well as recurring activities, and (3) annual program evaluation documenting the outcome of the previous years plan.

- In the annual evaluation of the quality management program, include a section that covers "evaluation of resources" that addresses program resources.
- Include the annual review of the QI program or work plan as an agenda item for departmental staff meetings so that staff are aware of the QM activities of the organization.
- Solicit ideas or input from departmental staff for quality improvement projects to be presented to the QMC as part of the quality management program.
- Use your QM program to conduct ongoing oversight of delegated activities.

Related Standards

- CORE 17 - Quality Management Program
- CORE 18 - Quality Management Program Resources
- CORE 33 - Financial Incentive Policy
- CORE 38 - Consumer Safety Mechanism

CORE 20 - Quality Management Committee

The *organization* has a quality management committee that: (No Weight)

    (a) Is granted authority for quality management by the *organization's* oversight authority; (3)

    (b) Provides ongoing reporting to the *organization's* oversight authority; (3)

    (c) Meets at least quarterly; (3)

    (d) Maintains approved records of all committee meetings; (2)

    (e) If applicable, includes at least one participating provider or receives input from participating providers; (4)

    (f) Provides guidance to *staff* on quality management priorities and projects; (3)

    (g) Approves the *quality improvement projects* to undertake; (3)

    (h) Monitors progress in meeting quality improvement goals; **and** (3)

    (i) Evaluates the effectiveness of the *quality management program* at least annually. (3)

Interpretive Information/Commentary

- The committee specified in these standards may be named something other than "quality management committee" as long as it meets the requirements of the standard.

- For discussion on the term "oversight authority," please refer to Core 19.

- Core 20(b): In order to meet this standard element, the quality management committee must report to the organization's oversight authority at least once a year.

- Core 20(d): "Record of all committee meetings" should include reports, decisions, action items, meeting minutes, and attendees.

- Core 20(d): Organizations may demonstrate that records and minutes are approved through signatures by a competent authority (such as a committee chairman).

- Core 20(d): During the accreditation review, URAC will focus on committee minutes and records from the previous three years. URAC recommends that organizations consult the regulatory compliance staff for state or federal timeframes for retention of records.

- Core 20(e) may not apply to all organizations, but does apply to organizations that maintain a network of participating providers.

- With respect to Core 20(f) and (g), URAC expects the quality management committee to focus on projects that relate to key processes and performance measures, including those related to the functions covered by the accreditation.

Points to Remember

- The Committee must have at least two members and should represent all of the organization's functional areas.
- The QMC meeting minutes should reflect approval of previous meeting minutes and records by the committee.

Scope of Standards

- This standard applies to a committee that oversees the organization's QM program. The committee may be contained within the program department or it may be organization-wide.

Evidence for Meeting the Standard - Desktop Review Materials

- Program description/plan/charter or written policies and/or documented procedures addressing QMC, its meeting cycles, meeting records, and roles and responsibilities including the communications of quality activities with oversight bodies and staff, and the approval and monitoring of QIPs and quality measures.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Committee minutes and QM program documentation for the period under review. Initial applicants can provide minutes for meetings occurring after the submittal date for the application for accreditation. Minutes are reviewed to verify program implementation and should be flagged to refer to those areas identified in the onsite agenda such as annual review and approval of the QM plan, approval of QIPs, and reporting of quality measures.
- QM committee minutes/agenda/attendance roster (include name, credentials, and affiliation) that demonstrates committee discussion, guidance, and approval of quality improvement projects, and progress toward quality improvement goals, and effectiveness of the overall QM program.

Bright Ideas

- Construct a 5 year strategic analysis and quality management plan to assist in year to year goal setting with an eye to corporate mission, growth and other long-term strategic planning initiatives. Development of a five year, long term strategic quality management plan also ensures oversight authority (Board of Directors) involvement and oversight.
- Establish a meeting calendar for the year and distribute the meeting dates and time for the year to committee participants.
- Post and update QIPs prominently (physically and electronically) so that staff are aware of Quality priorities.

Related Standards

- CORE 4 - Regulatory Compliance
- CORE 17 - Quality Management Program
- CORE 18 - Quality Management Program Resources
- CORE 19 - Quality Management Program Requirements

- CORE 21 - Quality Management Documentation
- CORE 22 - Quality Improvement Projects
- CORE 23 - Quality Improvement Project Requirements
- CORE 24 - Quality Improvement Projects: Consumer Organizations
- CORE 38 - Consumer Safety Mechanism

CORE 21 - Quality Management Documentation

The *organization*, as part of its *quality management program*, provides written documentation of: (No Weight)

(a) Objectives and approaches utilized in the quality management activities; (3)

(b) Identification and tracking and trending of *performance measures* relevant to the scope of the accreditation including, but not limited to: (Mandatory)

(i) Access to services; (3)

(ii) Complaints; **and** (3)

(iii) Satisfaction; (3)

(c) *Measures* that are quantifiable and used to establish acceptable levels of performance; (Mandatory)

(d) Measuring baseline level of performance; (Mandatory)

(e) Re-measuring level of performance at least annually; (Mandatory)

(f) The implementation of action plans to improve or correct identified problems or meet acceptable levels of performance on measures; (Mandatory)

(g) The mechanisms to communicate the results of such activities to relevant *staff*; **and** (3)

(h) The mechanism to communicate the results of such activities to the quality management committee. (3)

Interpretive Information/Commentary

- Successful quality management programs communicate activities to staff and organizational leadership.
- In order to proactively manage problems, organizations need to track and trend data related to consumer and client services.
- The intent of this standard is integral to the organization understanding the quality management process and the monitoring of compliance with the URAC Standards for which the organization is accredited. This standard provides guidance to the organization on how to establish performance measures on activities within the program, the monitoring of these measures, and efforts to improve when these measures are not met.

- URAC will focus on an organization's ability to demonstrate efforts to improve services when performance goals are not met. Organizations can still meet the intent of this standard even when measures are not met as long as they can show that they are taking action to improve. The process is as follows:
  - Identify performance measures for the program's operations;
  - Track and trend performance against these measures; and
  - If performance measures are not met, then develop an action plan to meet them.

- For example: A new client requires that the program's telephone abandonment rate must average 5% or less per month and the organization meets this goal from July through December 2007. In January 2008, the organization accepts several new clients and the abandonment rate climbs to an average of 10% in January and February. The organization develops an action plan to address the abandonment rate that includes hiring new staff and the abandonment rate decreases to an average of 5% by April 2008.
- The organization may decide to develop a QIP based on this process.

Points to Remember

- While your quality measures may serve as an impetuous for a QIP the two are separate activities of the QMC. Your measures will guide you in implementing a quality plan that addresses the challenges you face and allow you to monitor the quality of your services. The QIP will provide structure for you to implement a series of interventions to improve identified opportunities for improvement.
- Documentation of monitoring and evaluation must include the activities of the requisite program department or operational units including quality management.

Scope of Standards

- This standard applies to the quality management program that oversees the organization's program coming under accreditation. The quality management program may be contained within the program department or it may be organization-wide.
- Identification and analysis of performance measures (i.e., key indicators) must include those related to the program coming under accreditation and address issues related to both clients and consumers as appropriate.

Evidence for Meeting the Standard - Desktop Review Materials

- Program description/plan/charter or written policies and/or documented procedures addressing QMC goals and measures (including access, complaints, and satisfaction) and measurement (at least annually) of performance against goals and baselines.
- Documentation of reporting to the QMC and relevant staff.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Summary reports demonstrating ongoing monitoring and tracking/trending of data (related to performance measures) and printouts of the data analyzed for the reports.
- QMC minutes showing the reporting of quality measures.
- Interview QM staff about QM opp and all staff.

Bright Ideas

- Work with Your IT staff to develop reports that monitor your identified quality measures over time.
- Include as a standing agenda item for the QI Committee meetings, reports regarding the identified performance measures, and selected program metrics.
- Create a "Quality Newsletter" to communicate with staff about the QM program, QI projects, and customer satisfaction.

Related Standards

- CORE 4 - Regulatory Compliance
- CORE 22 - Quality Improvement Projects
- CORE 23 - Quality Improvement Project Requirements
- CORE 24 - Quality Improvement Projects: Consumer Organizations
- CORE 38 - Consumer Safety Mechanism

CORE 22 - Quality Improvement Projects

At any given time, the *organization* maintains no less than two *quality improvement projects* that address opportunities for *error* reduction or performance improvement related to the services covered by the accreditation. (Mandatory)

Interpretive Information/Commentary

- Core 22 requires the applicant organization to maintain at least two quality improvement projects (QIP) per accreditation program.

- A single QIP can be submitted for two accreditations if it addresses the functions covered by both accreditations.

- Quality improvement projects (QIP) promote continuous quality improvement, supporting organizational efforts to maintain and refine consumer and client services.

Points to Remember

- Your QIP can addresses all or part of the program under the accreditation, but the project must address at least a portion of the program under review. For example, you could not submit a QIP addressing only an excluded line of business or program.
- The following resources may be helpful in identifying patient safety/error reduction quality improvement projects:
    - The Leapfrog Group, www.leapfroggroup.org
    - Agency for Healthcare Research and Quality, www.ahrq.gov
    - Pennsylvania Patient Safety Reporting System, (PA-PSRS), www.psa.state.pa.us
    - Institute of Medicine (www.iom.edu)
    - National Patient Safety Foundation (NPSF) (www.npsf.org)
    - NQF – National Quality Forum (www.qualityforum.org)
    - NTOCC – National Transitions of Care Coalition (www.ntocc.org)

- Note: In order for a quality management project to count as one of the two projects required by the standards, the organization must show that it has started to implement the improvement strategy at least by the time of the onsite review. If the project was completed within the past twelve months – back from the date that URAC receives the organization's application for accreditation or reaccreditation – then the project will count towards one of the required two.
- Organizations may have several improvement projects in progress at any given time. The intent of the standard is for organizations to submit two projects to URAC that meet all elements of the relevant Core standards.

Scope of Standards

- The two quality improvement projects must address program-related issues and the documentation for those projects must include the elements in related standards.

Evidence for Meeting the Standard - Desktop Review Materials

- Program description/plan/charter or written policies and/or documented procedures identifying the number of QIPs that you will maintain.
- Write-ups of your two existing QIPs.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Documentation of QIP performance improvement interventions.
- QI staff presentation providing an update on the QIPs.
- Interview with management to discuss the QIPs.

Bright Ideas

- Use the URAC provided QIP form or develop a "quality improvement project form" that addresses URAC standards' requirements and other information needed by the organization in order to manage each project. Ensure that you document all interventions and re-measurements.
- Use quality measures such as access, satisfaction, and complaints for opportunities for quality improvement.

Related Standards

- CORE 23 - Quality Improvement Project Requirements
- CORE 24 - Quality Improvement Projects: Consumer Organizations
- CORE 34 - Access to Services
- CORE 38 - Consumer Safety Mechanism

CORE 23 - Quality Improvement Project Requirements

For each *quality improvement project*, the *organization* will: (No Weight)

  (a) Establish measurable goals for quality improvement; (3)

  (b) Design and implement strategies to improve performance; (3)

  (c) Establish projected time frames for meeting goals for quality improvement; (3)

  (d) Re-measure level of performance at least annually; (3)

  (e) Document changes or improvements relative to the baseline measurement; **and** (3)

  (f) Conduct an analysis if the performance goals are not met. (3)

Interpretive Information/Commentary

- Measurable goals and outcomes allow an organization to verify improvement.

- Measures for quality improvement projects will vary by the type of project. Examples include immunization rates, consumer satisfaction levels, turn-around times for cases, response times for telephone calls, etc. The key is to establish a measurable baseline performance and then estimate how long it will take to get there.

- Improvement strategies will vary by the type of project. The strategy should have a reasonable expectation of producing the desired improvement.

- Incremental performance measurement periods are defined by the organization, but the minimum requirement for re-measurement is at least annually per Core 23(d).

- Documentation of QIPs should include the following either on a QIP form or in the quality management meeting minutes:

  ○ Project start date;

  ○ Identified quantifiable baseline measure(s) for the indicator and relevance to the clients and/or consumers served;

  ○ Quantifiable goals associated with the measure;

  ○ Improvement strategies and dates these were implemented;

  ○ Periodic progress measurements and documented discussions;

  ○ Any changes in improvement strategy and brief description of changes; and

  ○ Project end date.

- URAC recognizes HEDIS® studies as meeting the intent of URAC's Quality Management (QM) standards requiring Quality Improvement Projects (QIPs). The Healthcare Effectiveness Data and Information Set (HEDIS)® is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans.

- Quality improvement projects may be clinical or non-clinical. Access to certain types of information, such as claims data, may determine an organization's ability to conduct clinical studies. Clinical performance improvement projects can cover such topics as prevention, care of acute or chronic conditions, high-volume or high-risk services, or coordination and transitions of care (see Core 36).

- Non-clinical performance improvement projects may focus on such areas as availability, accessibility, and cultural competency of services, interpersonal aspects of care (e.g., quality of provider patient encounters, or appeals, grievances, and other complaints.)

- Note: In order for a quality management project to count as one of the two projects required by the standards, the organization must show that it has started to implement the improvement strategy at least by the time of the onsite review. If the project was completed within the past twelve months – back from the date that URAC receives the organization's application for accreditation or reaccreditation – then the project may count towards the two that are required.

- A single QIP issue area can be addressed in multiple accreditation programs. For example, if the organization is accredited for two modules, the organization must have two QIPs for each module; however, a QIP may be used for both modules if an identified issue relates to the functions of both programs.

- If an organization interacts with consumers, then one of the projects must focus on consumer safety for the population served. If you're not sure that your organization falls into that category, then please see the introductory documents found at the beginning of this guide for more information.

Points to Remember

- Each QIP must contain quantifiable/measurable outcomes relative to the baseline measurement. Measurable means numerical measurements—not a y/n and not "an improvement." The measurements (baseline, goal, re-measurement) must be in the same unit of measure (i.e., percentages, ratios, or whole numbers).
- "Strategies" refer to interventions used to impact the desired changes.
- Baseline measurement is required for a QIP as the organization cannot know that you have an opportunity for improvement without initial measurement. This will prevent you from expending resources to develop a QIP when no problem exists.
- Each QIP must include established time frames for meeting quality improvement goals. The designation of "ongoing" does not qualify as a projected time frame; it must be a specific date. The dates and measurements can be revised over time. If you wish to have a goal to maintain a quantifiable measured improvement—for example, "10% for three consecutive quarters"—you may have such a goal; however, you must have a projected date for meeting the steady state goal (e.g. 18 months or mm/dd/yyyy).

- URAC requires that organizations document an analysis of any barriers affecting the progress of the QIP.
- Refer to the "Quality Improvement Project Description Form" provided with the application materials for a sample that you can use and modify as needed. You may also use your own project form, just be sure that it addresses the elements of the relevant standards.

Scope of Standards

- The two quality improvement projects must address program-related issues and the documentation for those projects must include the elements in this standards.

Evidence for Meeting the Standard - Desktop Review Materials

- QI project descriptions for two (2) different projects coming under the scope of the accreditation.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Documentation of QIPs.
- QI staff presentation providing an update on the QIPs.
- QI meeting minutes reflecting monitoring of the QIPs.
- Interview with program management to discuss QIPs.

Bright Ideas

- Pre-populate quality management meeting agendas for the next year with project reporting. Document the committee's comments on project progress and any recommended changes in project implementation in committee meeting minutes. Be sure to record the rationale behind any recommendations.
- Use the URAC provided QIP form or develop a "quality improvement project form" that addresses URAC standards' requirements and other information needed by the organization in order to manage each project. Ensure that you document all interventions and re-measurements.
- Survey the staff to identify any patient safety issue/s that the staff sees as a priority then take establish a baseline measurement to identify opportunity for improvement.
- Post QI project information and progress in a highly visible place (physical or electronic) for all management staff to follow. Include staff in discussions of barrier analysis (QIP idea box).
- Develop a power point presentation that addresses all of the requirements to present at the onsite visit and other meetings focused on quality initiatives.

Related Standards

- CORE 22 - Quality Improvement Projects
- CORE 24 - Quality Improvement Projects: Consumer Organizations

CORE 24 - Quality Improvement Projects: Consumer Organizations

For an *organization* that interacts with *consumers*: (No Weight)

(a) At least one of the two *quality improvement projects* must address consumer safety for the population served; **and** (Mandatory)

(b) If the *quality improvement project* is clinical in nature, then the *organization* demonstrates the involvement of a senior clinical *staff* person in judgments about the use of clinical quality *measures* and clinical aspects of performance. (Mandatory)

Interpretive Information/Commentary

- A single QIP issue area can be addressed in multiple accreditation programs. For example, if the organization is accredited for Disease Management and Case Management, the organization must have four QIPs, but the QIPs for Disease Management and Case Management can be the same two issue areas.

- Theoretically, a single quality improvement project can meet the requirements of both (a) and (b) if it focuses on consumers safety AND relates to performance measures AND involves a senior clinical staff person, if clinical in nature.

- Quality improvement projects may be clinical or non-clinical. Access to certain types of information, such as claims data, may determine an organization's ability to conduct clinical studies.

- Clinical performance improvement projects may include: Prevention or care of acute or chronic conditions, high-volume or high-risk services, or continuity and coordination of care.

- Non-clinical performance improvement projects may focus on such areas as: availability, accessibility, and cultural competency of services, interpersonal aspects of care (e.g., quality of provider patient encounters, or appeals, grievances, and other complaints.

- Note: In order for a quality management project to count as one of the two projects required by the standards, the organization must show that it has started to implement the improvement strategy at least by the time of the onsite review. If the project was completed within the past twelve months – back from the date that URAC receives the organization's application for accreditation or reaccreditation – then the project may count towards the two that are required.

- For detailed examples of QIP's for each program refer to the document "Consumer Safety Quality Improvement Projects (QIPs): Technical Specifications" located in the online resource center of AccreditNet.

Points to Remember

- Your QIP can addresses all or part of the program under the accreditation, but the project must address at least a portion of the program under review. For example, you could not submit a QIP addressing only an excluded line of business or program.

- The following resources may be helpful in identifying patient safety/error reduction quality improvement projects:
    - The Leapfrog Group, www.leapfroggroup.org
    - Agency for Healthcare Research and Quality, www.ahrq.gov
    - Pennsylvania Patient Safety Reporting System, (PA-PSRS) www.psa.state.pa.us
    - Institute of Medicine (www.iom.edu)
    - National Patient Safety Foundation (NPSF) (www.npsf.org)
    - NQF – National Quality Forum (www.qualityforum.org)
    - NTOCC – National Transitions of Care Coalition (www.ntocc.org)

Scope of Standards

- For organizations that interact with consumers, at least one QIP must relate to patient safety.

Evidence for Meeting the Standard - Desktop Review Materials

- QI project descriptions for your consumer safety QIP and documentation of clinical staff involvement in clinical QIPs.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Documentation of QIP performance improvement interventions.
- QI staff presentation providing an update on the QIPs.
- QI meeting minutes reflecting monitoring of the QIPs.
- Interview with program management to discuss QIPs.

Bright Ideas

- Include a field in your QIP form for the name of the clinical staff person assigned to your clinical QIPs (or use the URAC form).
- Include a field in your QIP form to address the impact on consumer safety (or use the URAC form).

Related Standards

- CORE 22 - Quality Improvement Projects
- CORE 23 - Quality Improvement Project Requirements

Staff Qualifications

CORE 25 - Job Descriptions

The *organization* has written job descriptions for *staff* that address requirements pertinent to the scope of the positions' roles and responsibilities: (No Weight)

    (a) Required education, training, and/or professional experience; (2)

    (b) Expected *professional competencies*; (2)

    (c) Appropriate *licensure*/*certification* requirements; **and** (2)

    (d) Current scope of roles and responsibilities. (2)

Interpretive Information/Commentary

- The applicant organization has job descriptions that reflect staff's current role and responsibilities.

- Written job descriptions and verification of licensure requirements will help to ensure that staff, both clinical and non-clinical, is qualified to provide program services.

- Specific requirements as mentioned in Core 25(a) will vary by organization and health profession.

- Organizations may specify which credentials they verify for health professionals in light of their services and the types of health professionals utilized.

- Please note the definition of <u>staff</u>: The organization's employees, including full-time employees, part-time employees, and consultants. See also the bullet point below under "Points to Remember" addressing consultants.

Points to Remember

- Professional competencies refer to an individual's ability to perform assigned professional responsibilities.
- When examining licensure or certification requirements for a particular position, it may be helpful to check the state or jurisdiction's practice act for scope of practice and other information.
- Periodically verify that a job position's written scope of role and responsibilities accurately reflects the job being performed.

Scope of Standards

- This standard applies to staff involved in providing program services, including those with direct supervisory roles within the program (e.g., Director, Manager, Team Leader, etc.)

- It is not URAC's intent to require job descriptions for consultants. To do so would imply employment and require an organization to abide by employment regulations, which would not be appropriate for individual consultants. Therefore, in lieu of a written job description, the organization may provide a copy of the written agreement or contract that describes the requirements and accountabilities of the consultant's position.

Evidence for Meeting the Standard - Desktop Review Materials

- A job description, template job description, or sample contract for individuals involved in the day-to-day operations of the program(s) under review or performing key functions covered by the accreditation.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Staff listing/directory: For random selection of staff files.
- Review of current job descriptions and consultant contracts.

Bright Ideas

- Provide a job description upon hire and have employee verify/attest to understanding of job requirements.
- Ensure that employees receive updates or revisions to job descriptions.
- Review the job description with the employee at the time of the annual performance review.
- Establish a template for all job descriptions to include at minimum the following categories: Job title, reporting accountability; role and key responsibilities; job requirements to include: professional competencies, educational requirements and required qualifications; and appropriate licensure and certification requirements.
- Where applicable, include in the job description educational requirements for ongoing professional training, i.e., individual must attend "x" number of continuing education sessions each calendar year.

Related Standards

- CORE 29 - Staff Assessment Program
- CORE 31 - Senior Clinical Staff Requirements
- CORE 32 - Senior Clinical Staff Responsibilities

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CORE 26 - Staff Qualifications

Staff meets qualifications as required in written job descriptions. (3)

Interpretive Information/Commentary

- Written job descriptions and verification of licensure requirements will help to ensure that staff, both clinical and non-clinical, is qualified to provide program services.

Points to Remember

- All staff members must meet the qualifications as outlined in the written job descriptions. If one staff member does not meet the qualifications as stated in the written job description, the organization will not be in compliance with this standard.

Scope of Standards

- This standard applies to staff involved in providing program services, including those with direct supervisory roles within the program (e.g., Director, Manager, Team Leader, etc.)

Evidence for Meeting the Standard - Desktop Review Materials

- Compliance will be assessed onsite. For the desktop review credit is assigned based on evidence of URAC compliant job descriptions submitted under other standards.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Staff listing/directory: For random selection of staff files.
- Staff files will be examined for credentials and qualifications.
- Copies of current job descriptions will be compared to evidence of qualifications of selected staff files

Bright Ideas

- At the time of the annual performance review, ask personnel to provide an updated resume or CV for the personnel file.
- Also review the job description with the employee at the time of the annual performance review.
- Establish a template for all job descriptions to include at minimum the following categories: job title, reporting accountability; role and key responsibilities; job requirements to include: professional competencies, educational requirements and required qualifications; and appropriate licensure and certification requirements.
- Where applicable, include in the job description educational requirements for ongoing professional training, i.e. individual must attend "x" number of continuing education sessions each calendar year.
- Develop a checklist or spreadsheet for each employee personnel file to assure these documents are in the personnel file and are current.

Related Standards

- CORE 25 - Job Descriptions
- CORE 29 - Staff Assessment Program
- CORE 31 - Senior Clinical Staff Requirements
- CORE 32 - Senior Clinical Staff Responsibilities

Staff Management

CORE 27 - Staff Training Program

The *organization* has an ongoing training program that includes: (No Weight)

(a) Initial orientation and/or training for all *staff* before assuming assigned roles and responsibilities; (2)

(b) Training in current URAC standards as appropriate to job functions; (2)

(c) Conflict of interest; (4)

(d) Confidentiality; (Mandatory)

(e) Documentation of all training provided for *staff*; **and** (2)

(f) Ongoing training, at a minimum annually, to maintain *professional competency*. (2)

Interpretive Information/Commentary

- Orientation and ongoing training programs help to ensure that staff are kept up-to-date and have the knowledge and resources to provide quality program services.
- Regarding Core 27(b): Staff need only be trained in those URAC standards that apply directly to their job and not all standards and regulations that affect the organization.
- Update 7/27/2015 regarding element (b): Organizations using email to train staff will need to address this training methodology in their policy and procedure covering staff education on URAC standards. This documentation will need to cover how the training will be documented, such as using the return receipt email feature, and it clarifies that staff receiving the training emails are:
  - Responsible for knowing the content;
  - Implement changes to policy and procedure as indicated and appropriate; **and**
  - Ask questions for further clarification as needed.

- As specified in standard element (f), annual (i.e., "ongoing") training is only required for maintaining professional competency; no other aspect of this "Staff Training Program" standard requires annual training.
- Training may vary by profession and the type of organization. Examples of training include:
  - Obtaining continuing education credits in a relevant field
  - Attendance at meetings or conferences related to job functions
  - In-house on performance of job functions.
  - Ongoing training should be documented in personnel files.

- <u>For Case Management Accreditation (07/01/2013):</u>
  - Core 27 (f): The organization encourages professional development among case managers by providing them with the opportunity to:
    - Gain the experience as a case manager needed to apply for professional certification;
    - Pursue continuing education to remain current and attain expertise in the practice of case management; and
    - Become a member in or attend meetings of relevant professional organizations.

Points to Remember

- In-house training may be documented by sign in sheets, online courses, or attestations.
- Staff located remotely or off-site (e.g., telecommuters, peer reviewers, etc.) who are unable to participate in the training provided at the organization's site may attend electronically as long as attendance is documented.
- Training on the current version of the URAC standards means the version under which you are applying for accreditation. This means that applicants seeking reaccreditation will need to retrain the staff on the new version of the standards if the version has changed since the last accreditation.
- Ensure that your URAC training module includes the current version of the standards.
- URAC requires conflict of interest training that pertains to employment, familial, personal, financial, and the organization's code of conduct. If the organization requires employees to sign a conflict of interest statement the statement should be relevant to the types of conflict likely to be encountered by your staff.
- Confidentiality training should be relevant to the information process or encountered by the staff (i.e. HIPAA).
- Checklists and/or online tools may be used to meet documentation requirement.
- Options for orientation include the use of a preceptor and a checklist for documenting successful understanding of materials and performance of job functions. Checklists should include all topics covered in this standard.

Scope of Standards

- This standard applies to department staff members, including full-time and part-time employees that the organization has individually contracted with to provide program services.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures addressing training in all elements of the standard and mechanism for documentation of all training.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Orientation and training materials and staff attendance/completion documentation.
- Discussion with staff regarding orientation and ongoing training programs

Bright Ideas

- Create a program description that includes information that you would want a new employee to know about the organization. The mission and history of the organization, how the program is structured, who are the consumers served by the organization, and how oversight is conducted can all be a useful in the onboarding process.
- Make your training material modular by organizing it around job functions and not job titles. This prevents duplication (since often different jobs have overlapping functions) and simplifies material content maintenance.
- As part of the orientation and annual performance review require staff to review the conflict of interest and confidentiality policies and procedures and sign documents as appropriate.
- Send e-mails that contain a "training tip" for the day or week related to regulatory compliance (e.g., ongoing HIPAA training, updates on state regulatory requirements, new URAC standards, etc.)
- Develop a training participation sheet to be completed for each training session that is provided by the organization. The sign in sheet should include the name of the training session, the date of the training, and the participants' names and titles.
- Have each participant complete a program evaluation for each training session; maintain a copy of the training program evaluations in the departmental personnel files.
- Develop a training calendar for each year that lists the available training programs for the staff.
- Develop a database or purchase software to track ongoing education/training activities for each staff member.
- Conduct an educational needs assessment to identify continuing education priorities.
- Add standing agenda items to staff meeting agendas to include updates on policies and procedures and regulatory requirements.

Related Standards

- CORE 4 - Regulatory Compliance
- CORE 28 - Staff Operational Tools and Support
- CORE 35 - Consumer Complaint Process
- CORE 38 - Consumer Safety Mechanism

CORE 28 - Staff Operational Tools and Support

The *organization* provides *staff* with: (No Weight)

> (a) Written policies and/or documented procedures appropriate to their jobs; (2)

> (b) *Clinical decision support tools* as appropriate; **and** (2)

> (c) Regulatory requirements as related to their job function. (2)

Interpretive Information/Commentary

- Examples of a "documented process" referenced in standard element (a) include: Formal written policies and/or documented procedures, process flowcharts, escalation matrix, guidelines, etc.
- Where regulatory requirements are embedded in written policies and/or documented procedures and/or other documentation and the document identifies the regulatory requirement that it supports meeting, then this meets the intent of standard element (c) to provide staff with regulatory requirements related to their job function.
- Pursuant to the definition of "clinical decision support tools," these tools include protocols, guidelines, or algorithms that assist in the clinical decision-making process.
- For Case Management Accreditation (07/01/2013):
  - Core 28 (a): Includes seeking resources for resolution of legal questions
  - Core 28 (b): The organization provides case managers and others involved in the case management process with data collection tools and care plan templates designed to provide the data needed to determine if performance measures are being met for the purpose of program performance improvement.

Points to Remember

- Staff need to have access to policies and procedures for reference. Create a policy booklet or manual; this can be electronic or paper.
- Clinical decision support tools may be included as part of the clinical information system. Often this includes clinical guidelines and reference materials approved by the organization's senior clinical staff.
- List of regulatory requirements can include links to trainings and websites approved by the organization.
- If state or federal requirements conflict with URAC standards, an organization would follow the more stringent requirement.

Scope of Standards

- This standard applies to program written policies and/or documented procedures and related clinical decision support tools as appropriate for the organization's programs coming under accreditation.
- Clinical decision support tools is not applicable to those accreditations that do not use clinical decision support criteria such as Credentials Verification Organization (CVO) accreditation.

Evidence for Meeting the Standard - Desktop Review Materials

- Policies: Master list of written policies and/or documented procedures or a screenshot of the electronic policy booklet or manual.
- Clinical: Written policies and/or documented procedures or program description indicating the clinical decision support tools used and how they can be accessed.
- Regulations: Written policies and/or documented procedures related to training on regulatory requirements, including regulatory reference materials and training materials.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Staff interviews will verify access to written policies and/or documented procedures, clinical decision support tools, and documented regulatory requirements as appropriate.
- Interview program management and compliance officer to discuss training on regulatory requirements.

Bright Ideas

- Add standing agenda items to staff meeting agendas to include updates on state or federal regulatory requirements and any resulting policy/procedure changes.
- Provide links to compliance policies and procedures to allow a ready reference for staff.
- Put the applicable written policies and/or documented procedures on a shared drive of the intranet or set up a short-cut (on the desktop of the individual staff member's PC) to access the written policies and/or documented procedures.
- Create a compliance hotline or inbox.
- Linking appropriate use of clinical decision support tools and quality management activities with setting staff performance goals is a good way to assess how well staff understand and utilize the organization's clinical decision support tools.

Related Standards

- CORE 3 - Policy and Procedure Maintenance, Review and Approval
- CORE 4 - Regulatory Compliance

CORE 29 - Staff Assessment Program

The *organization* maintains a formal assessment program for individual *staff* members, which includes: (No Weight)

(a) An annual performance appraisal; **and** (2)

(b) A review of relevant documentation produced by that individual staff member. (3)

Interpretive Information/Commentary

- Using a formal assessment program, staff can be held accountable for appropriate implementation of documented program operations and tools.
- For Case Management Accreditation (07/01/2013):
  - Core 29 (b): The organization conducts reviews of the case management process through case review to promote achievement of case management goals as established in consumer-specific case management plans. These case reviews, conducted by the case management program director of other supervisor (or equivalent deignate) in collaboration with the case manager, include
    - Evaluate if goals are appropriate considering the circumstances surrounding the case and if not, revise them;
    - Determine if goals are being met and if not, examine why to establish next actions to move towards goal; and
    - In collaboration with the case manager, case review findings are used to assess the case manager's learning needs and to evaluate the case manager's performance, making it one of the sources of informaiton used to complete the annual performance appraisal.

Points to Remember

- Includes a review of work produced by the employee (e.g., via quality audits, inter-rater evaluations, case review, etc.).
- Individual performance reviews must show evidence that relevant documentation produced by the individual staff member was evaluated during the review period.
- The senior clinical staff person (if an employee) is required to receive at least an annual performance evaluation.
- Note: Accreditation reviewers need to see annual performance appraisals for each year of the accreditation cycle. For initial applicants, have the most recent staff evaluation (within the last year) available. They should be signed and dated. The reviewers are verifying that an evaluation has occurred annually and not the content of the evaluation.

Scope of Standards

- This standard applies to staff performing program functions.
- It is not URAC's intent to require performance evaluations for consultants. To do so would imply employment and require an organization to abide by employment regulations, which would not be appropriate for individual consultants.

Evidence for Meeting the Standard - Desktop Review Materials

○ Written policies and/or documented procedures addressing annual staff assessment.
○ Or a template of the annual performance appraisal including an area to review documentation produced by the staff under review. Examination of completed evaluations will be done as part of the onsite survey of staff files.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

○ Staff files will be examined to confirm annual evaluations that include an evaluation of relevant documentation produced by the staff member.

Bright Ideas

○ Establish performance metrics and goals, include them in the job description, and review them with the staff periodically and as part of the performance review.
○ The annual performance appraisal is a good time to review the current status of licensure and/or certifications; review the status of annual and ongoing continuing education for professional competency, and sign appropriate attestation documents.

Related Standards

○ CORE 27 - Staff Training Program

Clinical Staff Credentialing and Oversight Role

CORE 30 - Clinical Staff Credentialing

The *organization* implements a written policy and/or documented procedure to: (No Weight)

(a) *Primary source* verify the current *licensure* or *certification* of *staff* whose job description requires *licensure* or *certification* upon hire, and thereafter no less than every three (3) years; (Mandatory)

(b) Require *staff* to notify the *organization* in a timely manner of an adverse change in *licensure* or *certification* status; (Mandatory)

(c) Implement corrective action in response to adverse changes in *licensure* or *certification* status; **and** (Mandatory)

(d) *Primary source* verify current *licensure* and *certification* upon hire, and thereafter no later than scheduled expiration. (Leading Indicator)

Interpretive Information/Commentary

- If an organization is unable to secure a copy of a Web site primary source verification, then it would document the verification by identifying the person conducting the verification, name the primary source (the name/title of the Web site/written primary source documentation that was observed or name and title of who was spoken to for a verbal verification), the date of the verification, the date the license/certification expires, and if there are any restrictions on the license/certification.
  - Primary source verification needs to be done upon hire, and thereafter no less than every three (3) years.

- The intent of Core 30 (b) is to establish the time frame within which staff must notify the organization of adverse licensure or certification changes. The time frame will depend in part on the relevance of the licensure or certification to the type of services provided. For example, a case manager's certification in case management has lapsed, but that individual is still a nurse and as such, reporting on the certification may not need to be as immediate as if the nurse's licensure had lapsed.
- Update 3/3/2015 for element (d): When conducting primary source verification using the issuing source's Internet website, a screenshot of the credentialing information is required to document the verification. Quality oversight of credentials verification staff is an important quality control, but does not eliminate the need to retain a copy of the screenshot in the hard copy or electronic credentialing file.

Points to Remember

- Licenses, certifications, and/or registrations held by staff that are required by job descriptions (e.g., physician board certifications, case management certifications, pharmacist and pharmacy technicians, etc.) must be verified upon hire and thereafter at least every three years.

- All license and certification verification must be done using primary sources (entities issuing the license).
- Verify licensure status online via state board web sites. To meet the standard, license or certification must identify the issuing state or entity, type of licensure and expiration date (or evidence that the certification is the type that does not expire.)
- When examining licensure or certification requirements for a particular position, it may be helpful to check the state or jurisdiction's Practice Act for scope of practice and other information.
- The organization must have a written policy and/or documented procedure in place for a licensed individual to report any changes in licensure and/or certification status. This notification requirement must include the time frame for staff to notify your organization. When establishing a time frame for timely notification, an organization must consider the risk management issues for the functions covered by the accreditation program. An example would be to consider what time period is appropriate for licensed/certified personnel to report a loss of, or sanctions to, licensure/certification.
- Policies must describe possible corrective actions that may be taken in response to adverse licensure or certification status.
- Written policies and/or documented procedures for verifying credentials may originate at the department level, the organization's personnel written policies and/or documented procedures, or the organization's credentialing program documentation.
- Leading indicators [L] are non-weighted, optional elements highlighting effective practices not yet widely adopted in health care. They may not be designated as "not applicable" since they are optional. Leading indicators are not reported to the Accreditation or Executive Committees and are not considered when making an accreditation level determination. For more information, please see the scoring information included in the introductory section of this guide.

Scope of Standards

- This standard applies to staff involved in providing program services, including those with direct supervisory roles within the program (e.g., Director, Manager, Team Leader, medical/clinical directors, etc.).

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures for verifying initial credentials, re-verification at least every three years, staff notification of adverse changes in licensure/certification status, and the corrective action for loss of certification or license.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Staff listing/directory: For random selection of staff files.
- Staff files will be examined for primary source verification of certifications and licenses.
- Staff files will be examined to determine if verification of credentials occur upon hire and at least every three years.
- The threshold for compliance with this mandatory standard is 100% of files audited (e.g., if a job description requires current licensure or certification, applicants must be able to demonstrate that each person has a current license or certification).

Bright Ideas

- Develop an electronic database/tracking method for documentation of licensure, certification, and continuing professional education.
- For professional staff, develop an attestation regarding licensure status for staff to review and sign on an annual basis.
- Develop a checklist or spreadsheet for each staff file to assure that Professional licensure and/or certifications are in the staff file and are updated annually.
- Prior to URAC onsite review, perform a pre-audit of staff credentialing files to ensure compliance with job descriptions.

Related Standards

- CORE 29 - Staff Assessment Program
- CORE 31 - Senior Clinical Staff Requirements
- CORE 32 - Senior Clinical Staff Responsibilities

CORE 31 - Senior Clinical Staff Requirements

The *organization* designates at least one senior clinical *staff* person who has: (No Weight)

(a) Current, unrestricted clinical *license(s)* (or if the *license* is restricted, the *organization* has a process to ensure job functions do not violate the restrictions imposed by the state licensure board); (Mandatory)

(b) Qualifications to perform clinical oversight for the services provided; (Mandatory)

(c) Post-graduate experience in direct patient care; **and** (Mandatory)

(d) *Board certification* (if the senior clinical *staff* person is an M.D. or D.O.). (3)

Interpretive Information/Commentary

- A clinically qualified and experienced staff person in a leadership position is the most appropriate person to oversee the clinical aspects of an organization's program.

- The senior clinical staff person, who may or may not also serve as a clinical decision-maker, needs to ensure that the organization has access to and utilizes qualified individuals with clinical experience for those areas covered by the organization's services.

- The senior clinical staff person must be accessible to the organization's clinical staff as defined by the organization in written policy and/or process documentation. If either the senior clinical staff person and/or staff are working remotely, then it must be apparent how to contact the senior clinical staff person and the time frame within which this person must respond if not readily available.

- Regarding the issue of "unrestricted" licenses in Core 31(a): URAC intends for this term to apply to those restrictions that would have a material impact on a clinical staff person's ability to perform relevant job functions for the organization. For example, a surgeon's restrictions due to arthritis do not have an impact on the ability to provide medical guidance to the organization. On the other hand, restrictions due to unethical conduct would be relevant.

- Qualifications in Core 31(b) include experience, credentials, certifications, etc. URAC expects organizations that provide health-related and/ or pharmacy services, products, or management, that there is a senior clinical staff person for oversight, typically an M.D. or D.O. For example, a Health Utilization Management Organization might use an M.D. or D.O. A Pharmacy Benefit Management Organization could use a pharmacist as their senior clinical staff person; a Dental Care Organization could use a D.D.S. or D.M.D.

- Residencies and similar programs are sufficient to meet the intent of Core 31(c).

- URAC does not currently require any certifications for senior clinical staff persons that are not M.D.s or D.O.s.

- Update 08/24/2015 for element Core 31(d): Sources of primary source verification for board certification include the AMA master file, AOA master file, the Education Commission for Foreign Graduates, and Special Board of Registry.

Points to Remember

- The clinical expertise of the senior clinical staff person is applicable to the population served by the program.
- Though the senior clinical staff person may be part time, work remotely, or be a contracted individual instead of a full time employee, it is incumbent upon the organization to provide evidence that this individual is qualified pursuant to according to the URAC standards and fulfills the accountabilities identified in the URAC standards.
- Note: Organizations with a "temporary" or "acting" senior clinical staff person will be presented to URAC committees on a case-by-case basis. Such applications may be pended at the discretion of the URAC accreditation department.
- Organizations that conduct business functions covered by the accreditation through off-shoring or outsourcing performed outside of the United States (see definitions for these terms) must ensure that they do not violate restrictions that may be imposed by state licensure boards.
- Identify in the job description the years of experience required in post graduate experience.
- URAC does not recognize the "board eligible" designation.
- URAC only recognizes U.S. board certifications; URAC does not recognize international board certifications for senior clinical staff persons and peer reviewers.

Scope of Standards

- This standard applies to clinical leadership for the program covered by the accreditation.

- Core 31(d) is not applicable to organizations applying for the following accreditations: Dental Network, Dental Plan, and Dental Plan with Health Insurance Marketplace.

Evidence for Meeting the Standard - Desktop Review Materials

- Job description for senior clinical staff person for the organization's program, or for a consultant senior clinical staff person, a contract with clinical qualifications and a description of the functions required by the standard.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview with senior clinical staff person.
- Staff files for senior clinical management staff person will be examined for licensure, board certification (as applicable), and past work history. A printout of on-line verification of these credentials is acceptable. Past experience can be obtained from a CV, job application, or resume.

Bright Ideas

- Utilize a standard job description format to include all of the elements of standards.

Related Standards

- CORE 19 - Quality Management Program Requirements

CORE 32 - Senior Clinical Staff Responsibilities

A senior clinical *staff* person's program responsibilities include: (No Weight)

(a) Provides guidance for clinical operational aspects of the program; (3)

(b) Is responsible for oversight of clinical decision-making aspects of the program; (Mandatory)

(c) Has periodic consultation with practitioners in the field; **and** (3)

(d) Ensures the organizational objective to have qualified clinicians accountable to the *organization* for decisions affecting *consumers*. (Mandatory)

Interpretive Information/Commentary

- A clinically qualified and experienced staff person in a leadership position is the most appropriate person to oversee the clinical aspects of an organization's program.

- Clinicians with the requisite clinical knowledge are responsible (must make a decision) and accountable (obligated to explain why they decided one way versus another) to the organization for decisions affecting the clinical services that the organization provides to consumers. The clinician would be responsible and accountable to the organization through a contract (either directly or through another company) or as employed staff for the organization.

- For organizations providing services covered by the accreditation to multiple clinical areas, URAC will verify that there is a senior clinical staff person, other clinicians, or a combination of the two available to cover the clinical areas where decisions are made affecting consumers. For example, a pediatrician may be designated as the senior clinical staff person, but for non-pediatric medical necessity appeals, the organization will have designated clinical staff and/or consultants with the credentials and experience in those clinical areas.

- Typically URAC looks for one individual to fulfill the role of senior clinical staff person; however, in large, complex organizations there may be more than one person assuming this role for the program functions covered by the accreditation. In those cases where there is more than one senior clinical staff person, URAC will need to see supporting documentation for all of these individuals (e.g., job description, credentials, etc.) Through this documentation and onsite verification such as interviews, URAC will verify clinical leadership for all of the clinical areas pertinent to the accreditation. By way of example, an organization may have a physician fulfill this role in the credentialing department, but may also have a chiropractor as the senior clinical staff person for the credentialing of chiropractors, physical therapists, etc.

- URAC does not currently require any certifications for senior clinical staff persons that are not M.D.s or D.O.s.

Points to Remember

- Include the components of the standard addressing the guidance, responsibility, and networking activities for the senior clinical staff person in a job description.
- Though the senior clinical staff person may be part time, work remotely, or be a contracted individual instead of a full time employee, it is incumbent upon the organization to provide evidence that this individual is qualified pursuant to according to the URAC standards and fulfills the accountabilities identified in the URAC standards.
- If the senior clinical staff person is employed by the organization the job description must address all elements of the standard.
- If the senior clinical staff person is a contractor the written agreement must address all elements of the standard.
- Examples of periodic consultation with practitioners in the field includes participating in advisory board, panel meetings, individual consultations with providers, internal criteria review, documented peer to peer conversations, and/or soliciting feedback from specialists.
- Note: Organizations with a "temporary" or "acting" senior clinical staff person will be presented to URAC committees on a case-by-case basis. Such applications may be pended at the discretion of the URAC accreditation department.

Scope of Standards

- This standard applies to clinical leadership for the program covered by the accreditation.

Evidence for Meeting the Standard - Desktop Review Materials

- Job description for senior clinical staff person for the organization's program, or for a consultant senior clinical staff person, a contract with clinical qualifications and a description of the functions required by the standard.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview with senior clinical staff person.
- Staff files for senior clinical management staff person will be examined for licensure, board certification (as applicable), and past work history. A printout of on-line verification of these credentials is acceptable. Past experience can be obtained from a CV, job application, or resume.

Bright Ideas

- Utilize a standard job description format to include all of the elements of standards.

Related Standards

- CORE 19 - Quality Management Program Requirements

CORE 33 - Financial Incentive Policy

If the *organization* has a system for reimbursement, bonuses or incentives to *staff* or health care providers based directly on *consumer* utilization of health care services, then the *organization* implements mechanisms addressing how the *organization* will ensure that *consumer* health care is not compromised. (Mandatory)

Interpretive Information/Commentary

- Financial incentives are ones that could result in inappropriate care.
- Financial incentives could negatively influence the provision of health care services. For example, this negative influence could result in an in appropriate:
  - Increase in the level of care;
  - Decrease in the level of care; and/or
  - Denial of care.

- The term "level of care" reflects the intensity of care provided within a given setting and in different settings. For instance, generally nursing homes offer "light" and "heavy" long term care, short term intensive rehabilitation and short term terminal care. There are also primary, secondary and tertiary care settings offering increasingly complex technical and specialized health services, with each subsequent setting providing more intense treatment.
- In this context, "consumer utilization of health care services" includes (but is not limited to):
  - Costs (either as a total amount or a savings percentage);
  - Total utilization in a population;
  - Utilization rates.

- "Total utilization" and "utilization rates" are essentially different ways of looking at the same issue.
- Total utilization is a simple number, for example: "Our population had x hospital days in the past month, compared to y the previous month." Utilization rates are expressed as a percentage: "Our hospital utilization rate increased z percent from one month to the next."
- The mechanism does not require a case-by-case review of individual consumer health records.

Points to Remember

- URAC does not prevent an organization from providing financial incentives; it does require that if financial incentives are based directly on consumer utilization of services, then the organization must put in place ways to protect consumers.
- If an organization does not use financial incentives, then it needs to submit a policy and an attestation from senior management statement indicating this. Simply citing in AccreditNet that the standard is "not applicable" does not fulfill the documentation requirements for this standard.

- Mechanisms that an organization could use to ensure that consumer health care is not compromised include (but are not limited to):
  - Audits of case files;
  - Overall assessment of causes of utilization pattern variation;
  - Off-setting financial incentives that relate to quality;
  - Review of state and federal laws that may prohibit a bonus or incentive based on consumer utilization of health care services.

Scope of Standards

- Any financial incentive based directly on consumer utilization of health care services provided to program staff. (Please see the definition of "staff.") This standard may not be applicable for programs or staff that do not provide health services or make clinical decisions.

Evidence for Meeting the Standard - Desktop Review Materials

- If the standard is applicable, submit a policy and procedure describing financial incentives for program staff that identifies criteria used for providing the financial incentive and the mechanisms for ensuring that quality of care is not compromised.
- If not applicable, submit a policy and an attestation by senior management stating that the organization does not use financial incentives based directly on consumer utilization of services.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview program staff and management regarding the nature of any financial incentive programs and ways to verify that consumer health care is not compromised.

Bright Ideas

- During orientation of new staff, provide them with realistic vignettes describing various situations where a conflict of interest may or may not exist including those involving financial incentives for staff. Have them analyze the situations to determine if there is a conflict and if so, have staff describe the nature of the conflict and discuss their responses in a group session. This will help them learn to apply this abstract concept to relevant, real-life situations that they may encounter.
- Include a discussion of financial incentives in the ethics training for orientation and ongoing annual education.

Related Standards

- CORE 4 - Regulatory Compliance
- CORE 21 - Quality Management Documentation

CORE 34 - Access to Services

The *organization* implements written policies and/or documented procedures to ensure *access* to services covered by the accreditation. (Mandatory)

Interpretive Information/Commentary

- Core 34 does not only refer to network adequacy. It refers to any services that the organization provides relevant to the accreditation.

- This standard applies the organization's services. For Health Plan and Health Network applicants, standard NM 2 evaluates access to providers separately.

- It is up to the organization to define its own access standards and performance metrics.

Points to Remember

- Policies should define access standards as well as provide a description of how the company monitors its performance with respect to its access standards.
- Many programs use policies addressing call center statistics and/or GeoAccess reports to measure access to program services. After establishing acceptable standards, measurements should periodically be taken to ensure consumer and client access to services.
- Customer complaint logs may be referenced to assess for problems with access to service such as not receiving letters, or ease of reaching program staff for inquiries.

Scope of Standards

- This standard applies to consumer and client access to program services covered by the accreditation.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures describing the organization's process for ensuring access to services covered by the accreditation.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Review of Meeting minutes where data related to access to services is shared with the QM committee, including trending of this performance measure and any action plans related to identified issues.
- Interviews with staff involved in consumer and client access to program services with management.
- Review of access reports.

Bright Ideas

- Develop network adequacy standards in consultation with clients and/or consumers to ensure that expectations are clearly defined.

Related Standards

- CORE 21.h
- CORE 35 - Consumer Complaint Process

CORE 35 - Consumer Complaint Process

The *organization* maintains a formal process to address *consumer complaints* that includes: (No Weight)

    (a) A process to receive and respond in a timely manner to *complaints*; (Mandatory)

    (b) Notice (written or verbal) of final result with an explanation; (4)

    (c) Informs *consumers* of the avenues to seek further review if an additional *complaint* review process is available; (4)

    (d) Evidence of meeting the *organization's* specified time frame for resolution and response; **and** (4)

    (e) Reporting analysis of the *complaints* to the quality management committee. (3)

Interpretive Information/Commentary

- Further complaint review processes may or may not be available. When available, organizations refer consumers back to the client (health plan) or state agency as applicable.

- This standard applies to all complaints outside of the scope of the utilization management appeals process addressed in URAC's Health Utilization Management and Workers' Compensation Utilization Management standards.

- Organizations that are not applying for utilization management accreditation that may receive a request for a review or an appeal related to medical necessity must have written policies and/or documented procedures for forwarding them to the entity that handles utilization reviews and appeals.

- Unresolved complaints that are not medical necessity issues must be addressed through a complaint resolution process.

- Core 35 is not just referring to an individual consumer, but also to a provider acting on a health care consumer's behalf.

Points to Remember

- It is important to have a tracking mechanism for all complaints received (even if the complaint is resolved by front line staff).
- The complaint policy should identify the time frame for responding to complaints and the method of response (written or verbal).
- Documentation of the final results of the complaint by verbal notice or a copy of the written notice with explanation is required to meet the standard.
- Policies include the notification process to consumers describing any further complaint review processes.

- Policy language should include mechanisms to evaluate if complaint resolution and response time frames are met.

Scope of Standards

- This standard refers to complaints (refer to definition) about program services.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures describing the organization's process for collecting and resolving consumer complaints about program services, tracking and trending of complaints, and reporting of complaints to the QMC.
- If applicable include:
  - Letter templates used to respond to complaints, if written notice is given.
  - Template or computer screen shot of the tool used to collect and document complaints.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- A log listing complaints.
- Review of random selection of complaints for survey of compliance with URAC standards and the organization's policy.
- QM meeting minutes where complaint data is shared with the relevant QM committee, including trending of this performance measure and any action plans related to identified issues.
- Interview with program management and staff regarding the collection and resolution of complaints.

Bright Ideas

- Develop a template (contact report) to document all complaints and appeals. The template should include the following: date, time, type or category of complaint; contact information; establish a coding system to track categories of complaints and appeals for data analysis, tracking and trending.
- Establish written policies and/or documented procedures for routing information related to complaints and/or appeals to the appropriate business unit for review and response (i.e., identify types of complaints that should be routed to the payer, or contracted health plan). As part of the policy and procedure, establish turn-around-times from the respective areas to respond to the member representative/coordinator.

Related Standards

- CORE 21 - Quality Management Documentation

Health Care System Coordination

CORE 36 - Coordination with External Entities

The *organization* establishes and implements mechanisms to promote collaboration and communication with applicable external entities to coordinate health services for consumers. (1)

Interpretive Information/Commentary

- In the interest of safe, quality health care, organizations must establish processes to promote cooperation and effective communication with other organizations.

- Applicant organizations will not be penalized for those instances where an external entity refuses to cooperate with the coordination efforts of the organization.

Points to Remember

- Policies should address case types and functions for which external organizations are utilized to provide coordinated services.
- When an organization uses contracted vendors, written policies and/or documented procedures need to describe how coordination and communication with the external entity will occur.
- This standard is not applicable if the organization's contracts with clients do not allow coordination of consumer health services with external entities.

Scope of Standards

- This standard applies to organizations that coordinate consumer health services with external entities.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and documented procedures reflecting the organization's process for sharing information and coordinating care for health care consumers, including guidelines for referring to external entities.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interviews with staff to discuss care coordination procedures, including guidelines for referring to external entities.
- Case documentation exemplifying care coordination with external entities.

Bright Ideas

- Provide periodic reports to the quality management committee on external coordination activities and issues.

Related Standards

- CORE 16 - Confidentiality of Individually-Identifiable Health Information

- CORE 21 - Quality Management Documentation
- CORE 35 - Consumer Complaint Process
- CORE 38 - Consumer Safety Mechanism

Consumer Protection and Empowerment

CORE 37 - Consumer Rights and Responsibilities

The *organization* implements a mechanism for informing *consumers* of their rights and responsibilities. (4)

Interpretive Information/Commentary

- Providing information about rights and responsibilities empowers consumers.
- For Case Management Accreditation (07/01/2013):
  - The organization implements written policies and/or documented procedures to promote the autonomy of consumers and support consumer, family and/or caregiver decision-making. Such documentation addresses:
    - Education of consumers on their rights;
    - The process by which consumers are informed of choices regarding services;
    - The right of consumers to have input into the case management plan;
    - The right of consumers to refuse treatment or services, including case management services and the implications of such refusal relating to benefits eligibility and/or health outcomes;
    - The use of end of life and advance care directives as applicable;
    - The right of consumers to obtain information regarding the organization's criteria for case closure;
    - The right of consumers to receive notification and a rationale when case management services are changed or terminated; and
    - Alternative approaches when the consumer, family and/or caregiver are unable to fully participate in the assessment phase.

Points to Remember

- Mechanism to inform consumers of their rights and responsibilities may include newsletters, Web site postings, and mailings.

Scope of Standards

- This standard includes communication practices between organizations and consumers and applies to organizations that interface with the consumer.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures or marketing/communications program documentation covering how consumer rights and responsibilities information is conveyed to consumers.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Review of records and documentation demonstrating the process for informing consumers of their rights and responsibilities.

- Interview program staff regarding mechanisms for sharing consumer rights and responsibilities information with consumers.

Bright Ideas

- Establish an interdepartmental team to develop a process for an annual review of materials used to communicate consumer rights and responsibilities information, including paper and electronic media.

Related Standards

- CORE 4 - Regulatory Compliance
- CORE 21 - Quality Management Documentation

CORE 38 - Consumer Safety Mechanism

The *organization* has a mechanism to respond on an urgent basis to situations that pose an immediate threat to the health and safety of *consumers*. (Mandatory)

Interpretive Information/Commentary

- The intent of this standard is for the organization to establish at least one process within their organization that addresses the ability of the organization to respond in a timely manner to situations that may expose consumers to health and safety risks. Standard Core 38 may relate to or have the intent fulfilled by the Consumer Safety Quality Improvement Project (QIP) identified by the organization. See standard Core 24 related to Consumer Safety.

Points to Remember

- The organization must have in place mechanisms to respond to reports of immediate threats to consumer safety, such as suicide threats, child abuse, spousal abuse, elder abuse, drug recalls and medical device recalls. Other safety issues could be addressed such as notifying members regarding harmful medication interactions.
- Even if an organization does not interact with consumers on a regular basis, the standard would be applicable. For example, if a medical record review revealed a situation that poses an immediate threat to the health of a consumer, the organization would respond by notifying a responsible party of the finding.

Scope of Standards

- This standard applies to the consumer safety initiatives that the organization puts in place to respond on an urgent basis to immediate threats to the health and safety of consumers. The safety program may be contained within the department or it may be organization-wide.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures addressing consumer safety initiatives to respond on an urgent basis to immediate threat to the health and safety of consumers.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interviews with staff to verify how they handle identified situations that threaten consumer safety and welfare and their access to reference materials as appropriate.

Bright Ideas

- During orientation provide staff with realistic examples of situations that might present a potential or actual threat to consumer safety and welfare within the context of providing services. Explain the organization's process and resources for addressing urgent or emergent situations that activate the advocacy role of the staff.
- Conduct periodic mock simulations of calls from a consumer where the staff must respond to a suicide threat, or a report of child, spouse or elder abuse and review the response process at staff meetings.

- Create a centralized notification and documentation process that links identified quality of care issues involving consumer safety and welfare to the organization's quality department or risk management department.
- Assure that personnel have immediate access to emergency phone numbers by including them in the corporate or personal phone directories or on a shared drive on the organization's Intranet.

Related Standards

- CORE 4 - Regulatory Compliance

CORE 39 - Consumer Satisfaction

The *organization* implements a mechanism to collect or obtain information about *consumer* satisfaction with services provided by the *organization*. (3)

Interpretive Information/Commentary

- Examples of mechanisms to collect or obtain information about consumer satisfaction include (but are not limited to) surveys, focus groups, complaints/grievances, etc.

- URAC recognizes CAHPS® studies as meeting the intent of URAC's Consumer Satisfaction standards requiring a mechanism to collect or obtain information about *consumer* satisfaction with services provided by the organization. CAHPS® refers to a family of surveys that ask consumers to evaluate the interpersonal aspects of health care in which *consumers* are the best or an important source of information. The CAHPS® program is managed by the Agency for Healthcare Research and Quality. Note: The acronym CAHPS stands for the Consumer Assessment of Healthcare Providers and Systems (formerly the Consumer Assessment of Health Plans Survey).

Points to Remember

- Satisfaction surveys or trending of complaints and compliments can be used to measure satisfaction.

Scope of Standards

- This standard refers to consumer satisfaction information regarding the program. This standard may not be applicable to programs that do not interact with consumers.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures describing the organization's process for collecting information about consumer satisfaction with program services.
- Or satisfaction survey templates.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Sample meeting minutes where data related to consumer satisfaction with program services is shared with the QM committee, including trending of this performance measure and any action plans related to identified issues.
- Discuss consumer satisfaction with program services with management and quality staff.

Bright Ideas

- If tracking satisfaction using positive and negative comments be careful to control for changes in the population served.

Related Standards

- CORE 21 - Quality Management Documentation

CORE 40 - Health Literacy

The *organization* will implement written policies and/or documented procedures addressing *health literacy* that: (No Weight)

    (a) Require *consumer* materials to be in *plain language*; (Leading Indicator)

    (b) Assess the use of *plain language* in *consumer* documents; **and** (Leading Indicator)

    (c) Provide relevant information and guidance to *staff* that interfaces directly with, or writes content for, *consumers*. (Leading Indicator)

Interpretive Information/Commentary

- Health literacy is a critical issue affecting health care outcomes and costs.

- Please note that "health literacy" and "plain language" are defined terms.

- One way to meet standard element (b) is to establish a target grade level against which you would evaluate consumer materials.

- Relevant information includes various documents such as Fleishman-Kincaid, language to be used, policies, procedures, examples of consumer communications that are covered, etc.

- There are state and federal regulations as well as the organization's contractual requirements that affect implementation of processes promoting health literacy. This includes the requirement to have standard consumer documents in multiple languages, written at a certain grade level, etc.

Points to Remember

- Policies must define plain language and your goals for health literacy for your organization.
- Policies should include the mechanisms used to assess consumer materials for use of plain language.
- Policies must provide for guidance to staff on communicating in ways understandable to the consumer, without using complex medical terms or jargon.
- Organizations are not expected to change those documents or sections of documents that must be written with specific language due to federal or state law; however, where changes can be made, the organization uses plain language.
- Information on plain language may be found at www.plainlanguage.gov.
- Leading indicators [L] are non-weighted, optional elements highlighting effective practices not yet widely adopted in health care. They may not be designated as "not applicable" since they are optional. Leading indicators are not reported to the Accreditation or Executive Committees and are not considered when making an accreditation level determination. For more information, please see the scoring information included in the introductory section of this guide.

Scope of Standards

- Any documents used to communicate with health care consumers are within the scope of this standard.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures or communications program description addressing health literacy for the population(s) served, including use of plain language for written materials produced by the organization, tools to access for plain language, guidance to staff on communicating with consumers.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Proof of approval of communication materials using plain language.
- Interview with program management to discuss health literacy.
- Interview with staff tasked with writing and editing written consumer materials.

Bright Ideas

- Create a table of marketing materials that tracks approvals, revisions, content, amount in stock, target audiences, available languages, and reading levels.

Related Standards

- CORE 4 - Regulatory Compliance
- CORE 10 - Review of Marketing and Sales Materials
- CORE 21 - Quality Management Documentation

Health Plan, Version 7.3

Network Management

P-NM 1 - Scope of Services

The *organization* defines the scope of its services with respect to: (No Weight)

(a) The types of health care services offered within the *provider network*; **and**
(4)

(b) The geographic area served by the *provider network*.
(4)

Interpretive Information/Commentary

- Organizations must define the following:
    - *What services does the organization provide?* [P-NM 1(a)] – What types of health services are provided through the health network? Does the organization provide for a full range of health services, or are services limited to a particular specialty or specialties?
    - *Where does the organization provide its services?* [P-NM 1(b)] – What is the geographic area within which the organization claims to provide the services described under P-NM 1 (a)? Is the organization national in scope? Is its service area limited to certain states, counties, or regions?
    - *For whom is the network providing services?* What population(s) are served by the provider network?

- Throughout the accreditation process, URAC will evaluate the organization against the representations made under this standard. For example, if the organization states that its service area includes an entire state, then URAC will expect it to meet standards for access throughout that state. If the organization focuses on a particular specialty, URAC will expect the organization to have adequate numbers of providers in that specialty.
- Applicant organizations seeking to become Qualified Health Plans (QHPs) in order to offer health benefit plans on a Health Insurance Exchange (Exchange) are subject to the Patient Protection and Affordable Care Act (ACA) regulations, including §156.230 and section 2702(c) of the PHS Act as they relate to the types of providers that need to be accessible to Health benefit plan enrollees. The regulations apply to all networks providing services through an Exchange.

Points to Remember

- Documentation submitted with the application should demonstrate compliance with both subsections of this standard.
- In the description of the network, include demographic or census data that describes the composition of the population served. For example, some networks may serve primarily pediatric or geriatric populations, rural or urban areas; large ethnic groups (e.g., Hispanic, Native American, Asian, etc.)

- Include in the description all lines of business that are included in the scope of the network being submitted for the accreditation such as commercial lines of business, Medicare, Medicaid, etc. Identify the service areas for each line of business. For example, if Medicare Advantage is only being offered in approved areas, then this should be stated in the documentation submitted for this standard.
- When providing documentation of the geographic service area of a state or regional network, be sure to include any surrounding areas/states in which the network is providing services.
- Some of this information may be included in the Member and/or Provider Manual.

Scope of Standards

- This standard applies to the services offered, geographic area and populations served by the health plan that is the subject of this accreditation application.

Evidence for Meeting the Standard - Desktop Review Materials

- Network Program Description
- Business Plan
- Marketing Plan
- Strategic Plan
- Service Area Maps
- Geographic Access Analyses
- Provider and/or Member Manuals

- Applicable State and Federal Regulations
- Documentation of regulatory compliance comparing applicable regulations to the types of clinical services offered in the service areas covered by health benefit plans affected by the regulation.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview with network management leadership to assess familiarity with organization's services, service area, and consumer demographics.

Bright Ideas

- Include a color coded service area map on the organization's web site that includes zip codes. Develop a web based "search feature" that will allow a member to identify providers by specialty by zip code or region.
- Indicate in the provider directory that a provider may be bilingual or multi-lingual and list languages. Develop a web-based "search feature" that may allow a member to search for a provider based on the primary language of the member.
- Indicate in the provider directory (either web based or paper documents) whether or not the provider is accepting new patients.
- Develop a network program description that includes the information about the health plan or network's composition; include an annual review of the program description and revise as needed.

- As new services areas or lines of business are added to the scope of organization's network, establish a process that includes a review and update of all documentation regarding the network.
- Establish a process to review and update the web based information on a regularly scheduled basis.
- Include hospital affiliations information/admitting privileges for physicians in the provider directory information.

Related Standards

P-NM 2 - Provider Network Access and Availability

With respect to both *access* and availability of *providers* to provide care to *consumers*, the *organization*: (No Weight)

(a) Establishes goals;
(3)

(b) Measures actual performance in comparison to those goals and reports the results to the organization's quality management committee; **and**
(4)

(c) Makes improvements where necessary to maintain the *provider network* and meet contractual requirements.
(3)

Interpretive Information/Commentary

- Under Standard P-NM 1, the organization defines the "what, where, and who" of its services. Standards P-NM 2 through P-NM 3 require the organization to describe how it will actually go about meeting the service goals described under P-NM 1.
- Standard P-NM 2 addresses the overall composition of the network. How many providers of what types are necessary to meet the health needs of eligible persons? How should these providers be distributed in the service area to meet the service needs of the population?
- This standard also requires the organization to define goals for network access and availability, to measure how well it is actually doing in comparison to the defined goals, and to make improvements where necessary.
- This standard does not require the organization to meet access and availability goals in every area for every type of provider. However, if the organization finds it is not meeting goals in a certain area, it should implement a plan to improve access and availability for that area.
- Organizations must establish, measure, and improve upon separate goals for both access and availability.
- The organization can define its goals for access to care by geographic dispersion. For example, the organization might establish a goal to have at least one primary care provider for every ten square miles in the service area. Alternatively, the organization might use travel times as a criterion. For example, the organization might establish a goal that there is a primary care provider within a thirty-minute travel time throughout the service area. In either case, the organization should establish separate, specific criteria for each of the types of health care providers with whom it contracts.
- Examples of improvement: in a densely populated area, the organization may need to contract with more providers to ensure that eligible persons are able to get appointments without unnecessarily long waiting periods.
- Applicant organizations seeking to become Qualified Health Plans (QHPs) in order to offer health benefit plans on a Health Insurance Exchange (Exchange) are subject to the Patient Protection and Affordable Care Act (ACA) regulations, including §156.230 and section 2702(c) of the PHS Act as they relate to maintaining a network that is sufficient in number, geographic distribution, and types of providers to assure that all services will be accessible without reasonable delay.

Points to Remember

- To demonstrate compliance with this standard, it will not be sufficient for the organization to show that it establishes geographic access and availability goals. In addition, the organization must show that it periodically assesses its own performance against those goals. This assessment will not be meaningful unless it is done in the same or comparable units as the goals. Thus, for example, it is not helpful in assessing an organization's performance against a goal of "all urban members within 10 miles of a primary care provider" to show that "90 percent of members are happy with the geographic dispersion of providers in the network." Rather, a meaningful measure of performance against this goal would assess what percentage of urban members are within 10 miles of a PCP.
- A common error by applicants for accreditation has been to submit documentation regarding geographic dispersion of participating providers as evidence of compliance with P-NM 2(b). However, this subsection does not deal with geography, but with the ability of consumers to receive care in a timely fashion. Thus, both goals and performance measures addressing P-NM 2(b) should relate to such issues as off-hours availability, waiting time for appointments, and the like.
- The organization should review all state and federal regulatory requirements and individual client agreements for network access and accessibility requirements. Often times, organizations will have identified gaps within the network due to geography or specialty areas. In the event the network is not meeting the accessibility requirements, the organization should be able to demonstrate processes for working toward improvements or solutions to the identified "accessibility gaps" within the network.

- Include documentation to address the culturally sensitive needs of the population. For example, some networks may serve primarily pediatric or geriatric populations, rural or urban areas; or large ethnic groups such as Hispanic, Native American, Asian, or other.
- Document network access and availability as key performance measures in the organizational quality management program. Include network accessibility as a standing agenda item for the quality improvement committee; submit accessibility reports to the QI committee.

Scope of Standards

- This standard applies to all health benefit plans included within the scope of the organization's application for accreditation.
- This standard applies to access and availability of services throughout the organization's service area and across all provider types.

Evidence for Meeting the Standard - Desktop Review Materials

- Network Program Description
- Business Plan
- Marketing Plan
- Strategic Plan
- Geographic Access Analysis
- Availability Analysis
- Member surveys addressing provider availability

- "Secret shopper" calls testing provider availability during "off-hours" times and testing ability of member to get timely appointment
- Reports of onsite examination of appointment records
- Applicable client requirements
- Applicable State and/or Federal Regulations
- Written policy and/or documented procedure of how access and availability is measured

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview with network management leadership to assess (1) understanding of the requirement for both access and availability goals, and (2) willingness and capacity to implement action plans to address performance deficiencies in achieving these goals.
- QM Committee minutes demonstrating analysis of access and availability goals and, if appropriate, discussion, action taken to make improvements in areas where not meeting goal.

Bright Ideas

- Utilize a script for network personnel to use to conduct "secret shopper" calls to evaluate accessibility of the network; establish a data base to capture the responses to the calls and report the results on a monthly basis.
- Analyze member complaint data for specific complaints regarding network accessibility.
- Monitor after hour triage calls related to utilization of services to possibly identify problems with access to care.
- Analyze utilization report such as the rate of ER utilization as a key indicator that may have a causal relationship to lack of network accessibility.
- Include questions in the member satisfaction survey that specifically address waiting times to schedule appointments and the amount of time spent in the waiting room.
- Analyze paid claims data on an annual basis to evaluate the most prevalent types of services provided to the population.
- As part of the annual network analysis, obtain updated census data to evaluate cultural needs of the population served.
- Establish a link on the website for members to submit emails to the network customer service or provider relations department regarding any problems or complaints related to accessibility.
- Distribute the results of the geographical analysis reports to the provider contracting department for follow up regarding recruitment of providers to meet the accessibility standards.
- Include in the member explanation of payment (EOB) documents, a place for members to notify the plan/network of address changes or other related information.
- As part of orientation and ongoing professional development, include training for documentation and reporting of network accessibility complaints received by the member or provider customer services departments.
- Review out of network/area authorization and claims data as part of the network accessibility evaluation.
- Conduct periodic web based data integrity audits to assure the network web site information is current and accurate.

Related Standards

P-NM 3 - Provider Selection Criteria

The *organization* establishes *provider* selection criteria that address: (No Weight)

> (a) Quality of care;
> (Mandatory)
>
> (b) Quality of service; **and**
> (Mandatory)
>
> (c) The business needs of the *organization*.
> (4)

Interpretive Information/Commentary

- At a minimum, provider selection criteria must address quality of care, quality of service, and the business needs of the organization. The provider must be informed that he/she must meet these criteria. Most organizations either include the criteria in their service agreements or through a provider manual that is bound to the service agreement.
- This standard addresses how the organization selects individual providers to meet its access and availability goals. For example, if the organization needs five specialist physicians in a certain area and receives ten applications, what are the criteria it uses to select those to whom it will offer contracts?
- One purpose of this standard is to assure that the organization has a mechanism to inform the provider as to what is expected of them to participate in the network.
- In NM 3(a), organizations may use their own definition of "quality of care." Alternatively, URAC suggests the following definition promulgated by the Institute of Medicine: "Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." Many organizations state that participation in medical management programs such as utilization management (UM), quality management (QM) and credentialing is required as part of the organization's quality of care program. Some organizations refer to their credentialing process to meet this standard (see the credentialing section for these standards).
- Provider selection criteria – especially for care criteria – are most likely implemented through the organization's credentialing process (see the credentialing section for these standards).
- NM 3(b) addresses such issues as responsiveness of the provider's office staff, cleanliness of the provider's office, hours of operation, etc.
- NM 3(c) is intended to allow the organization flexibility in not accepting providers that otherwise meet the criteria for quality and service. For example, if the organization already has enough qualified primary care providers, it might not accept another qualified primary care provider based on business needs.
- Provider selection criteria may also address special needs of a population. For example, an organization serving an area with an abundance of Spanish-speaking individuals may want to ensure that an office of primary care physicians (PCPs) includes some staff fluent in Spanish.
- For most provider networks, the criteria should address primary care, specialty care, mental health and chemical dependency services, inpatient facilities, and ancillary providers.
- For specialty networks, the criteria should reflect the types of specialty providers in the network.

Points to Remember

- It will be particularly useful for the organization to draw a clear distinction in its application between documentation submitted to demonstrate compliance with each of the three subsections of this standard. "Care" and "service" are distinct concepts, and the provider selection criteria for each element will likewise be distinct.

Scope of Standards

- This standard applies to selection criteria for all participating providers across all provider types.

Evidence for Meeting the Standard - Desktop Review Materials

- Network Plan Description
- Business plan
- Marketing plan
- Strategic plan
- Credentialing plan description and/or credentialing policies and procedures that describe provider selection criteria, including any requirements for on-site quality audits.
- Summary of minimum criteria for participating providers
- Geographic mapping of provider locations
- Provider service agreements
- Reports of provider profiling
- Provider manual

- Related policies and procedures
- Written policy and/or documented procedure of how quality of service is monitored

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview with network management leadership regarding current issues in network development to assess implementation of selection criteria.
- QM Committee minutes demonstrating tracking and trending of quality of service at provider level.

Bright Ideas

- Include a copy of the provider selection criteria as an enclosure with the welcome packet to new providers.
- Establish an internal reporting template to document any reported quality of care or service related issues; route the reported issues to the appropriate area for resolution.
- Conduct initial and ongoing PR visits with providers to include such topics as: preventive care/wellness guidelines, accessibility standards, demographics of membership, care management programs, claims submission, communication guidelines, etc.
- Utilize provider profiling tools or claims data to evaluate utilization of services by provider type.
- Monitor after hour triage calls related to utilization of services to possibly identify problems with access to care.

- Provide information and/or educational opportunities regarding the requirements for medical record documentation.
- If feasible, as part of the application process, conduct onsite office site visits to evaluate critical elements for documentation of access to care, quality of care and services and medical record documentation.

Related Standards

P-NM 4 - Out of Network and Emergency Services

To the extent it is contractually responsible, the *organization* implements written policies that assure *consumers'* access to: (No Weight)

> (a) Covered services that are not available from *participating provider*s; **and**
> (Mandatory)

> (b) Emergency care, both within and outside the *organization's* service area.
> (Mandatory)

Interpretive Information/Commentary

- Organizations have an obligation to provide for consumers' medical care, even when necessary care is not available within the provider network, or when the consumer has a medical emergency.

- The organization's policies regarding emergency services must address events both within and outside the organization's service area.

- Organizations must ensure that all out of network mental health and/or substance use disorder (MH/SUD) benefits are complaint with the Mental Health Parity and Addiction Equity Act (MHPAEA).
    - An organization (i.e., health plan) that provides MH/SUD benefits any classification of benefits must provide them in every classification in which medical/surgical benefits are provided, including out-of-network classifications for emergency services.
    - Please reference the standards found in the Compliance Program and Mental Health Parity sections of this accreditation for more information on parity, including mental health parity, as it would be addressed as part of a compliance program.

Points to Remember

- Note: All elements of the standard are mandatory.
- To be effectively implemented, written policies and/or documented procedures that meet the intent of this standard must be understood not only by network management staff, but also by any employee of the organization that may be called upon to explain to the consumer the policy regarding consumer access to emergency services or providers of services not available within the network.
- Consumer documents should include information about how to obtain emergency care, including the organization's policy on when and how to directly access emergency care services.

Scope of Standards

- This standard applies to all health benefit plans included within the scope of the organization's application for accreditation.

- Standard element P-NM 4(a) concerning services not available from participating providers applies to all covered services.

- The element concerning emergency care [P-NM 4(b)] applies both within and outside of the service area.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures addressing out of network services.
- Written policies and/or documented procedures addressing emergency services
- Consumer documents explaining the organization's policy for obtaining emergency or out of network care. Sample letters to consumers describing the policies for obtaining emergency or out of network care.
- Sample scripts for customer service representatives describing the policies for obtaining emergency or out of network care.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview with management of network management department to examine examples of implementation of policies, and examination of documents illustrating such examples.
- Report of denied emergency room visits.

Bright Ideas

- Include information in enrollee welcome packets specific to how to access services; consider distribution of "quick reference guides", such as a pocket or wallet card, regarding access to emergency care services.
- Provide updates and/or reminder messages in the member newsletter regarding access to emergency services.
- Conduct communication training (for all the organization's personnel who interact with consumers) for how to provide assistance and instruction to consumers for accessing emergency care services.
- Establish a schedule to review the organization's after hours voice mail messages to assure that consumers are receiving clear instructions on how to seek direct access to emergency care, including 911 services.
- Provide information to the consumers regarding how to directly access care outside of the network service area.

Related Standards

P-NM 5 - Participating Provider Representation

The *organization* develops and implements a formal strategy to ensure that the perspective of participating *providers* is represented in *provider network* management processes, with an emphasis on: (No Weight)

(a) Participation by non-employee participating *providers* on committees that address clinical and provider payment policies; **and**
(4)

(b) Representation of the types of *practitioners* that most frequently provide services to *consumers*.
(4)

Interpretive Information/Commentary

- Providers are the critical element of a network, and it is very important for an organization to ensure that providers are involved in network decision-making.
- The key to this standard is implementing a realistic strategy to involve participating providers in network management. URAC recognizes that providers may not always be available or willing to participate in network activities. To meet this standard, the organization needs to demonstrate a good faith effort to involve participating providers. Such efforts include sending letters to providers, working with local medical societies, etc.
- In addition, organizations should advise providers as to what protections are provided to all participants of their committees. Organization can provide this information verbally or in writing.
- Primary and specialty care representatives must be adequately represented.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-MR 5(a)-(c). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There is a table following this document that contains a complete listing of the MLR standard elements for this accreditation.

- For this standard, it is important to remember that "participating provider" does not include providers who serve as employees in a management function, such as medical director or case manager, for the organization.

- Assure that an adequate number of primary care physicians and specialists are participating on key committees and also are representative of the network composition and services provided. For example, a pediatrician and an OB/GYN specialty provider would be excellent provider types to participate on the committees to address the needs of a Medicaid population.

Scope of Standards

- This standard applies to representation of providers participating in the network.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures regarding involvement of participating providers in network management.
- List of all committee members including providers (please identify each individual's credentials and relationship to the organization).
- Three examples of recent committee minutes that indicate attendance/participation by providers (redact all PHI).

- Evidence of training on confidentiality for committee members.
- Confidentiality statement template that non-employee committee members would sign.
- Description of how providers can have input into the network management process.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview with the medical director to address physician participation in committees and the recruitment of physicians to serve on committees.
- Meeting minutes for the Physician Consultative Committee, the Operating Committee, the Utilization Management Committee and the Peer Review Committee over the past year – a sample of the minutes (and sign-in sheets) will be selected for review on site.

- Review of confidentiality statements signed by non-employee physicians and other providers providing representation on committees that address provider network management processes.

Bright Ideas

- Establish a physician advisory committee (focus group) that contains representatives of PCP and specialty areas to provide feedback and suggestions to the network or plan.
- Conduct focus groups by geographic area that include representatives of the participating providers to provide input to the plan.
- Establish a provider information line or Web site link for providers to contact the organization with suggestions and feedback.
- Conduct provider satisfaction surveys on an annual basis.
- Establish charters for all committees that include the committee purpose, committee representation requirements (that includes physician participation), meeting schedules and accountability.
- Conduct an annual evaluation of the provider committee representation needs based upon geographical analysis of the network and member population.
- When the organization adds a new line of business, such as Managed Medicaid or Medicare Advantage, or specialty services or networks, conduct a re-assessment of the physician committee representation.

Related Standards

P-NM 6 - Participating Provider Relations Program

The *organization* implements a *participating provider* relations program to include: (No Weight)

> (a) Implementation of a *participating provider* communications plan, to address at least: (No Weight)

>> (i) Orientation of new *participating providers*; (4)

>> (ii) Updates of network activities; (4)

>> (iii) Changes in fee schedules or contracting provisions; (4)

>> (iv) Provider dispute resolution mechanisms; (4)

>> (v) Informing *participating providers* how to obtain benefit, eligibility, formulary, *complaint* and *appeals* information; **and** (4)

>> (vi) Mechanisms for the availability and distribution of current *provider* manuals (or other documents describing the relationship between the *organization* and *participating providers*). (4)

> (b) Assistance for *participating provider*s and their staff regarding *provider network* issues; (4)

> (c) At least 30 days advance notification of changes in fee schedules and contracting provisions; **and** (4)

> (d) Mechanism(s) to receive suggestions and guidance from *participating providers* about how the *provider network* can best serve *consumers*. (3)

Interpretive Information/Commentary

- Organizations must ensure that participating providers are aware of the information necessary to provide care to the organization's consumers and are able to comply with the organization's administrative requirements.
- The organization may delegate the provider communications program. In that case, Core standards on delegation would apply.
- Methods of meeting this standard include (but are not limited to):
  - An orientation packet sent to each new participating provider;
  - A newsletter sent periodically to participating providers;
  - Designated staff available to answer providers' questions.

- "Orientation" under P-NM 6(a)(i) means providing enough information so that the provider can effectively participate in the network. This might include policies and procedures that the provider must follow, billing procedures, an orientation meeting with the provider or the provider's staff, and the contact information. This information is often included in a "provider handbook."

- P-NM 6(a)(v) – mechanisms can be electronic sources. Also see NM 11. "Mechanisms" under P-NM 6(d) includes any means through which the provider can provide feedback regarding the performance of the organization. This might include contact information for a provider relations representative or the organization's senior clinical staff person.
- While it is not a requirement of the standard, URAC strongly encourages organizations to include access to formulary information as part of their provider communications plan.
- If the organization uses the most current version of the Committee on Operating Rules for Information Exchange (CORE) promulgated by the Council for Affordable Quality Healthcare (CAQH), it shall be deemed to be in compliance with P-NM 6(a)(iv) mechanism to obtain benefits and eligibility verification.

Points to Remember

- It is important to remember that, because the obligation to maintain the provider communications program includes all providers, URAC will look for evidence that no type of provider (such as facilities) are left out. Thus, if an important means of communication to providers is through a provider manual, for example, URAC will look for evidence that provider manuals are provided to providers of all types.
- Provider manuals and/or provider newsletters may be available electronically through the network's Web site.

- Some organizations have begun to fulfill components of this standard's requirements through the establishment of provider advisory councils and advisory counsels of providers' administrative staff members.
- It is recommended that the provider communications plan be written, or at least summarized in a single document addressing all the elements of provider communications.

- Include a written policy and/or documented procedure that states what mechanisms the organization has in place to receive suggestions and guidance from participating providers and their personnel (e.g., dedicated provider call line, provider surveys, etc.)

Scope of Standards

- This standard applies to all health benefit plans included within the scope of the organization's application for accreditation.
- This standard applies to communications with all elements of the provider network.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures describing the network's provider communications program
- Written policies and/or documented procedures describing the network's provider dispute mechanism
- Sample of orientation packages
- Sample training agendas
- Sample of onsite schedules and agendas
- Sample copies of newsletters- flag the sub elements of the standards that may be evidenced in the provider newsletters.

- URL for the company website
- Sample copies of correspondence
- Samples of contract addenda, amendments or changes to the provider manual
- Sample notice of changes in fee schedules, if applicable, showing date of notice and effective date
- Correspondence, customer service logs demonstrating office staff or providers with administrative assistance.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview of provider relations management regarding orientation of new providers and their staffs, ongoing communications between the organization and participating providers and provider's staff, and the existence of any committees or councils that serve to meet some of the requirements of this standard.
- Copy of contracting department and/or provider relations department procedures.

Bright Ideas

- Develop a checklist for the provider orientation packet that includes the provider manual, recent copies of newsletters, member handbooks, benefit plan information, fee schedules, formularies, calendar of events for educational workshops, information about operational expectations such as service, quality and consumer safety, clinical guidelines, network information to include service area, demographics of the plan/network population served, etc.
- Establish individual provider files (paper or electronic) that include documentation of all correspondence such as orientation checklist, training, site visits, and other related documentation.
- Develop and distribute a one page "quick reference" guide with phone numbers and contact information based on type of inquiries.

- Establish a list of Frequently Asked Questions "FAQ" and responses that may be accessed on line.
- Develop an electronic "Provider News Blast" that contains monthly provider updates.
- Provide a dedicated Web portal for provider e-mail enquiries and responses.
- Develop and distribute by paper and/or electronic media, a quick reference guide regarding the process for obtaining authorizations (include type of information needed for authorization requests) and accessing the provider appeals process.

Related Standards

P-NM 7 - Participating Provider Written Agreements

The *organization* has *written* agreements with all *participating providers*. (Mandatory)

Interpretive Information/Commentary

- P-NM 7 is straightforward – there must be a written agreement with every participating provider. At the time of initial accreditation, all written agreements must comply with P-NM 8. Going forward, written agreements for all types of providers (e.g., practitioners, facilities, etc.) must include all sub-standards listed in P-NM 9.
- When contracting with provider groups, the organization may have a single written agreement with the entire group.

Points to Remember

- The term "written agreement" is defined to include the contract and any attachments or addenda. Therefore, if the organization needs to revise contracts to comply with this standard, it may amend existing contracts, issue an addendum, or make changes to the provider manual (if the provider manual is a binding document) rather than re-executing the contracts in their entirety.
- If a provider is listed in the organization's provider directory, then the organization must have a written agreement with that provider that meets the intent of these standards. Additionally, please note that the organization must complete the credentialing process (see the credentialing section of these standards) prior to listing a provider in the directory.
- If some of the written agreements are not in full compliance with P-NM 7 and P-NM 8, then the organization may include the provider manual or related documents that are referenced for contract compliance. The organization must demonstrate that the providers did indeed receive the provider manual or related documents for the referenced sections. The organization should note (for the URAC reviewer) the sections that may be referenced for compliance to meet the elements of the standards.
- The organization should submit samples of provider service agreements that represent all types of providers who participate in the network (e.g., individual practitioners, MD, DO, allied health care professionals, health care agencies, facilities, etc.)
- Written agreements reviewed on-site should include any amendments pursuant to standard P-NM 11 - Other Participating Provider Agreement Documentation.

Scope of Standards

- This standard applies to all health benefit plans included within the scope of the organization's application for accreditation.

- URAC refers to provider directories (both paper and online) to define the scope of these standards. If a provider is listed in the organization's provider directory, then the organization must have a written agreement with that provider that meets the intent of these standards.

Evidence for Meeting the Standard - Desktop Review Materials

- Sample written provider service agreement and any amendments pursuant to standard P-NM 11 for each category of participating provider (if different templates used for different provider types).
- Templates are acceptable for submission of materials for desk top review. If the contract templates vary by provider type, include a sample template for each type of provider contract in the desktop submission. The templates submitted should be an accurate representation of the types of signed contracts that will be reviewed during the on-site visit.
- Provider manual or other organizational documents that describe the relationship between the organization and its participating providers, for each category of participating provider.
- A list of all significant revisions of provider service agreements within the last two years, along with the date and a brief description of the nature of each such revision.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Current copies of the organization's provider directory. A random sample of provider names will be selected for review of executed contracts.
- Interview with network relations management team, for the purpose of assessing strategies, recent developments, and plans for the near future regarding provider contracting.

Bright Ideas

- Conduct an annual audit of provider files to assure that all participating providers have current, fully executed agreements on file. Include a review of the provider manual and other related documents (that may be referenced for standards compliance) as part of the annual review of written policies and documented procedures.
- Scan all executed provider contracts and addenda into individual provider files; include in the file the original effective date and date of any contract revisions.
- Identify an individual to perform tasks as a contract coordinator with responsibilities to review all new and existing provider contracts, contract amendments or addenda for compliance with P-NM 8-11.
- Develop a data base of all types of written services agreements for all providers to include the original effective date and date(s) of revisions.
- Develop a template that includes the elements of P-NM 8 and P-NM 9 to utilize for an audit for compliance of all contracts or contract templates; review all contract templates with the legal department to verify compliance with all contract elements.
- Categorize the contract templates by provider types; evaluate the network composition to assure that contract templates have been developed for all provider types that are included in the network.
- Annually review all contract templates with the compliance department and/or legal departments for compliance with any changes in regulatory or accreditation contract requirements.
- Maintain a formal document that includes all major contract revision types to include contract template name, key changes, date implemented and documented business reason or regulatory/accreditation requirements that substantiated the revision.
- Organize all contract template documents with a unique identifier that includes the most recent revision date; include this information in the footer of all contract templates.
- Develop a "contract execution checklist" that verifies all contacting activities have been completed at the time the contract is execute.

Related Standards

P-NM 8 - Participating Provider Written Agreement Exclusions

The *organization's written agreements* with participating providers do not include: (No Weight)

(a) Any clauses or language that could restrict *participating providers* from discussing matters relevant to *consumers'* health care; **nor**
(Mandatory)

(b) A definition of "medical necessity" that emphasizes cost/resource issues above clinical effectiveness.
(Mandatory)

Interpretive Information/Commentary

- Standard P-NM 8 prohibits "gag clauses" that could prevent providers from discussing treatment options with patients. It also prohibits written agreements that emphasize cost over quality. This standard applies to all existing written agreements. If the organization has these provisions in existing contracts, those written agreements must be amended prior to initial accreditation.

Points to Remember

- At the time of initial accreditation, all written agreements must comply with standard NM 8.
- Standard P-NM 8 prohibits "gag clauses" that could prevent providers from discussing treatment options with patients. It also prohibits written agreements that emphasize cost over quality. This standard applies to all existing written agreements. If an organization has these ("gag clause") provisions in existing contracts, those written agreements must be amended prior to initial accreditation.

- All elements of this standard are mandatory.

Scope of Standards

- This standard applies to all health benefit plans included within the scope of the organization's application for accreditation.
- URAC refers to provider directories (both paper and online), to define the providers that are included within the scope of these standards. If a provider is listed in the organization's provider directory, then the organization must have a written agreement with that provider that meets the intent of these standards.
- This standard relates to all provider contracts (i.e., inclusive of facility contracts).

Evidence for Meeting the Standard - Desktop Review Materials

- Sample provider service agreement and any amendments pursuant to standard P-NM 11 for each category of participating provider (if different templates used for different provider types).

- Provider manual or other organizational documents that describe the relationship between the organization and its participating providers, for each category of participating provider.

- A list of all significant revisions of provider service agreements within the last two years, along with the date and a brief description of the nature of each such revision.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Current copies of the organization's provider directory. A random sample of provider names will be selected for review of executed contracts.
- Interview with network relations management team, for the purpose of assessing strategies, recent developments, and plans for the near future regarding provider contracting.

Bright Ideas

- Consult with the organization's legal department to conduct a review of the definitions included in the provider contracts.

Related Standards

P-NM 9 - Written Agreement Inclusions

All new and revised *written agreements* (see P-NM 7) executed by the *organization* include the following elements: (No Weight)

(a) A listing of all individuals or entities who are party to the *written agreement*; (2)

(b) Conditions for participation as a *participating provider*; (4)

(c) Obligations and responsibilities of the *organization* and the *participating provider*, including any obligations for the *participating provider* to participate in the *organization*'s management, *complaint*, or other programs; (Mandatory)

(d) Events that may result in the reduction, suspension, or termination of network participation privileges; (4)

(e) The specific circumstances under which the network may require access to *consumers'* medical records as part of the *organization*'s programs or health benefits; (4)

(f) Health care services to be provided and any related restrictions; (Mandatory)

(g) Requirements for *claims* submission and any restrictions on billing of *consumers*; (4)

(h) *Participating provider* payment methodology and fees; (2)

(i) Mechanisms for dispute resolution by *participating providers*; (Mandatory)

(j) Term of the contract and procedures for terminating the contract; (Mandatory)

(k) Requirements with respect to preserving the confidentiality of patient health information; **and** (Mandatory)

(l) Prohibitions regarding discrimination against *consumers.* (Mandatory)

Interpretive Information/Commentary

- At the time of initial accreditation, all written agreements must comply with standard P-NM 8. Going forward, written agreements for all types of providers (e.g., practitioners, facilities, etc.) must include all sub-standards listed in P-NM 9.
- The term "written agreement" is defined to include the contract and any attachments or addenda. Therefore, if the organization needs to revise contracts to comply with this standard, it may amend existing contracts, issue an addendum, or make changes to the provider manual (if the provider manual is a binding document) rather than re-executing the contracts in their entirety.

- P-NM 9 requires the organization to have a written agreement form that complies with all elements of the standard (a "compliant written agreement"). At the time of initial accreditation, the organization is not required to have all existing written agreements based on the compliant written agreement. However, the compliant written agreement must be implemented on a "going forward" basis. In other words, starting at the time of application for accreditation, all new contracts must be based on the compliant contract.
- For standard P-NM 9(a), it is not necessary to name every single client of the organization.
- A sample fee schedule is sufficient to meet the intent of P-NM 9(h).
- If all of the organization's written agreements comply with P-NM 9, then P-NM 11 would be not applicable. If some of the written agreements do not comply, then the organization needs to include the appropriate information in its provider manuals or other similar documents. For example, if the written agreements do not include a description of dispute resolution mechanisms (see NM 9(i)), then the provider manual would have to include that information.
- In addition to meeting the requirement of standard P-NM 9 that the organization "fill in the gaps" in its provider contracts through the use of provider manuals and/or other documents that describe the organization-provider relationship, the organization must bring the non-compliant provider contracts into compliance the next time it revises those contracts. For these purposes, "revision" means any modification of the contract through amendment or other mechanism other than one which results in a change in fees to be paid to the provider.
- P-NM 10 is intended to apply in circumstances when the health plan/health network contracts with a provider group that, in turn, has contracts with individual providers. In such cases, the standards require that the contract between the plan/network and the provider group comply with P-NM 9. Moreover, P-NM 10 requires that the provider group bind sub-contracting providers to the same requirements. During the accreditation process, URAC will examine group contracts between the plan/network and provider groups to ensure these conditions are met. URAC will not examine contracts between the provider group and their sub-contracting providers.
- Organizations should reference their provider manual in order to resolve disputes. An example of when to access the provider manual could include disputes over the de-contracting of network physicians.

Points to Remember

- If some of the written agreements are not in full compliance with P-NM 9, then the organization may include the provider manual or related documents that are being referenced for contract compliance. The organization must demonstrate that the providers did indeed receive the provider manual or related documents for the referenced sections. The organization should note (for the URAC reviewer) the sections for compliance to meet the elements of the standards.
- The organization should submit samples of provider service agreements that represent all types of providers who participate in the network/plan (e.g., individual practitioners, MD, DO, allied health care professionals, health care agencies, facilities, etc.)
- P-NM 9(d): Events that may result in the reduction, termination, or suspension of network privileges should be clearly stated in the contract. For example, if a provider's license is revoked, the contract would clearly state the provider may be terminated immediately from the network.

Scope of Standards

- This standard applies to all health benefit plans included within the scope of the organization's application to accreditation.

- URAC refers to provider directories (both paper and online) to define the providers that are included within the scope of these standards. If a provider is listed in the organization's provider directory, then the organization must have a written agreement with that provider that meets the intent of these standards.

Evidence for Meeting the Standard - Desktop Review Materials

- Sample provider service agreement template and any amendments relevant to P-NM 11 for each category of participating provider (if different templates are used for different provider types). Specify page and section numbers within each contract template where each element of the standard is found.
- Provider manual or other organizational documents that describe the relationship between the organization and its participating providers, for each category of participating provider.
- A list of all significant revisions of provider service agreements within the last two years, along with the date and a brief description of the nature of each such revision.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Current copies of the organization's provider directory. A random sample of provider names will be selected for review of executed contracts.
- Interview with network relations management team for the purpose of assessing strategies, recent developments, and plans for the near future relative to provider contracting.

Bright Ideas

- Establish ongoing communications with the credentialing department for updates to changes in provider participation status or events that may require contract termination.

Related Standards

P-NM 10 - Written Agreement Subcontracting

To the extent that a *written agreement* allows for sub-contracting with *participating providers,* the *written agreement* specifies that all sub-contracts will be subject to the terms of the *written agreement* as they pertain to the elements required in NM 8 and 9.
(Mandatory)

Interpretive Information/Commentary

- The term "written agreement" is defined to include the contract and any attachments or addenda. Therefore, if the organization needs to revise contracts to comply with this standard, it may amend existing contracts, issue an addendum, or make changes to the provider manual (if the provider manual is a binding document) rather than re-executing the contracts in their entirety.
- P-NM 10 is intended to apply in circumstances when the health plan/health network contracts with a provider group that, in turn, has contracts with individual providers. In such cases, the standards require that the contract between the plan/network and the provider group comply with P-NM 9. Moreover, P-NM 10 requires that the provider group bind sub-contracting providers to the same requirements. During the accreditation process, URAC will examine group contracts between the plan/network and provider groups to ensure these conditions are met. URAC will not examine contracts between the provider group and their sub-contracting providers.

Points to Remember

- If some of the written agreements are not in full compliance with P-NM 7, 8 and 9, the organization may include the provider manual or related documents that are referenced for contract compliance. The organization must demonstrate that the providers did indeed receive the provider manual or related documents for the referenced sections. The organization should cite (for the URAC reviewer) the specific sections that demonstrate compliance with the standard elements.
- The organization should submit samples of provider service agreements that represent all types of providers who participate in the network/plan (e.g., individual practitioners, MD, DO, allied health care professionals, health care agencies, facilities, etc.)

Scope of Standards

- URAC refers to provider directories (both paper and online) to determine the providers included within the scope of these standards. If a provider is listed in the organization's provider directory, then the organization must have a written agreement with that provider that meets the intent of these standards.

Evidence for Meeting the Standard - Desktop Review Materials

- Sample provider service agreement and any amendments relevant to P-NM 11 for each category of participating provider (if different templates used for different provider types).
- Provider manual or other organizational documents that describe the relationship between the organization and its participating providers, for each category of participating provider.

- A list of all significant revisions of provider service agreements within the last two years, along with the date and a brief description of the nature of each such revision.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Current copies of the organization's provider directory. A random sample of provider names will be selected for review of executed contracts.
- Interview with network relations management team, for the purpose of assessing strategies, recent developments, and plans for the near future regarding provider contracting.

Bright Ideas

- Establish a policy and procedure to include an e-verification of receipt of all electronic distribution of provider manuals and/or provider manual updates.

Related Standards

P-NM 11 - Other Participating Provider Agreement Documentation

For existing *provider written agreements* not in compliance with P-NM 9, the *organization's* provider manuals (or other documents describing the relationship between the organization and participating providers): (No Weight)

(a) Address the items listed in P-NM 9 and not addressed in the *written agreement*; **or**
(4)

(b) Provide instructions on how to obtain the items listed in P-NM 9 and not addressed in the *written agreement*.
(4)

Interpretive Information/Commentary

- P-NM 11 is not applicable if all of the organization's written agreements comply with P-NM 9. If some of the written agreements do not comply, then the organization needs to include the appropriate information in its provider manuals or other similar documents. For example, if the written agreements do not include a description of dispute resolution mechanisms (see P-NM 9 (i)), then the provider manual would have to include that information.

Points to Remember

- If some of the written agreements are not in full compliance with P-NM 7 and 8, then the organization may include the provider manual or related documents referenced for contract compliance. The organization must demonstrate that the providers did indeed receive the provider manual or related documents for the referenced sections. The organization should cite (for the URAC reviewer) the specific sections that demonstrate compliance with the standard elements.
- The organization should submit samples of provider service agreements that represent all types of providers who participate in the network/plan (e.g., individual practitioners, MD, DO, allied health care professionals, health care agencies, facilities, etc.)
- The provider manual must be binding.

Scope of Standards

- This standard applies to all health benefit plans included within the scope of the organization's application for accreditation.
- URAC refers to provider directories (both paper and online) to determine the providers included within the scope of these standards. If a provider is listed in the organization's provider directory, then the organization must have a written agreement with that provider that meets the intent of these standards.

Evidence for Meeting the Standard - Desktop Review Materials

- Sample provider service agreement and any amendments relevant to P-NM 11 for each category of participating provider (if different templates used for different provider types).
- Provider manual or other organizational documents that describe the relationship between the organization and its participating providers, for each category of participating provider.

- A list of all significant revisions of provider service agreements within the last two years, along with the date and a brief description of the nature of each such revision.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Current copies of the organization's provider directory. A random sample of provider names will be selected for review of executed contracts.
- Interview with network relations management team, for the purpose of assessing strategies, recent developments, and plans for the near future regarding provider contracting.

Bright Ideas

Establish ongoing communications with the credentialing department for updates to changes in provider participation status or events that may require contract termination.

Related Standards

P-NM 12 - Provider Network Disclosures

If the *organization* receives a written request from a *participating provider*, the *organization* discloses within 45 days: (No Weight)

(a) The list of *clients* or other payers that are entitled to any contract rate under the *organization*'s contract with the *participating provider*; **and**
(4)

(b) The specific *client* or other payer by whom a contract rate was applied to a particular *claim* under the *organization*'s contract with the *participating provider*.
(4)

Interpretive Information/Commentary

- This standard is intended to address the "silent PPO" issue. It allows participating providers to identify the contract under which a discount was taken.
- "Silent PPOs" are arrangements where a PPO brokers access to its provider network to other PPOs or payers without providers' knowledge. For example, PPO X may sell access to its provider network to PPO Y. When an eligible person from PPO Y receives service from a physician in PPO X's network, PPO Y takes the contract discount, although the physician never signed a contract with PPO Y.

Points to Remember

- This standard may be "not applicable" for some organizations. In such a case, the organization must submit a signed attestation of URAC's design (see application materials) indicating that it does not engage in the practices that are the subject of this standard and that should it change its practices in this regard, it will notify URAC of such change.

Scope of Standards

- This standard applies to all organizations that engage or intend to engage in any practices under which it could be characterized as a "silent PPO."

- For purposes of this standard, "silent PPO" means any arrangement with another payer or client (as defined in this Accreditation Guide) by which that payer or client, otherwise unaffiliated with the applicant, receives the benefit of the fees negotiated under the written service agreement with participating providers, where the eligible person or member did not present the participating provider with evidence that he or she is eligible for the benefit taken under the written service agreement with the participating provider or, is not a member or eligible person whose membership or eligibility can be confirmed by the applicant's mechanism to communicate to participating providers member eligibility and benefits.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures describing the organization's approach to replying to provider inquiries regarding claims payment.

- Evidence of implementation of policies and procedures, such as a letter to a participating provider in which the organization makes the disclosures required by this standard.
- If the organization does not engage in "silent PPO" practices, then this standard is not applicable. The organization must submit a signed statement of attestation upon submission of its application for accreditation.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interviews with managers in charge of responding to provider enquiries covered by this standard.

- Copy of contracting department procedures.

- List of payers entitled to any contract rate under the health plan's contract with a participating provider.

Bright Ideas

- Identify key individual(s) within the organization who would have the primary responsibility as a contact person to respond to provider enquiries regarding claims payments and/or fee schedule requests.
- Develop a data base, or enter information into a contact management system, to record all correspondence and information sent to a requesting participating provider.
- Prior to releasing claims/fee related information, establish a verification policy and procedure to assure the identification of the requesting provider prior to release of information.
- Develop ongoing monitoring systems for fee schedule maintenance (updates).

Related Standards

P-NM 13 - Participating Provider Violation Mechanism

The *organization* implements a mechanism consistent with its *written agreements* to address alleged violations by *participating provider*s of the requirements of the *organization*. (4)

Interpretive Information/Commentary

- Standards P-NM 13 through P-NM17 require the organization to implement processes addressing significant disputes or problems with participating providers. These processes must respect providers' rights, but must also protect consumers.
- Pay attention to linking the written agreement to standards P-NM 13 through P-NM 17.

Points to Remember

- The provider dispute process only applies to contracted providers of the network or plan. Not all contracted provider disputes are subject to the dispute process. For example, if the provider contract is explicit and states if medical licensure is revoked, or the provider is convicted of claims fraud as events for termination of the contract, then the provider dispute process covered in P-NM 13 through P-NM 17 is not required to be available to the provider.
- P-NM 13 through P-NM 17 are not applicable to provider medical necessity appeals. Medical necessity appeals are addressed under the Utilization Management standards.
- If the organization has not received any provider disputes at the time of the application submission for accreditation or re-accreditation, an attestation statement to this effect should be included as part of the supporting documentation for these standards.

Scope of Standards

- Standards P-NM 13 through P-NM 17 establish two tracks for provider dispute resolution. One track is for disputes involving professional competence or conduct that result in a change in provider status; for all other types of disputes, an administrative dispute resolution mechanism is available.

- Medical necessity appeals are not included within the scope of these provider dispute resolution standards.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures regarding provider disputes and non-medical necessity appeals.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- List of provider disputes, complaints/grievances and non-medical necessity appeals made by providers over the past year – for a review of selected files documenting the organization's handling of provider disputes within the scope of these standards.
- Provider dispute files to include documentation of panel/committee proceedings and correspondence.
- List of disciplinary actions taken against providers over the past year – a sample of files will be requested onsite for review.

- Interviews with the medical director and senior network management staff to assess understanding and implementation of provider dispute resolution policies/procedures.

Bright Ideas

- Submit the dispute resolution policies and procedures to the quality improvement committee for initial review and approval as well as annual review. Remember to note the review and approval of the dispute resolution policies and procedures in the QIC meeting minutes.
- Establish internal policies and procedures for conducting each level of dispute resolution process. Establish a data base or utilize a contact management system to document all disputes received and all events related to the dispute resolution process.
- Develop an electronic form/template for the participating providers to use to submit a formal dispute.
- Develop a template for correspondence for responses to each level of the dispute resolution; send all correspondence (responses) by registered mail.
- Provide an orientation and ongoing training to all employees covering when and how to report potential provider issues related to administrative issues, quality of care issues or provider competency.
- Provide education to all identified employees regarding the work flow and processes related to a reported provider dispute.
- Include examples of a contract violations in provider information. Clarify the difference between the various dispute resolution processes (e.g., provider medical necessity appeals, contract issues, participation status, etc.)

Related Standards

P-NM 14 - General Requirements for Provider Dispute Resolution Mechanisms

The dispute resolution mechanism described in P-NM 15 and P-NM 16 relies on written policies and/or documented procedures that include: (No Weight)

(a) That the dispute resolution mechanism is available to any *participating provider* who wishes to initiate it;
(Mandatory)

(b) The methods to initiate such a mechanism; (4)

(c) The methods for participating providers to present relevant information; (4)

(d) A clear description of the dispute resolution process; (4)

(e) Explicit time frames from initiation of the dispute resolution mechanism to notification of the outcome to the participating provider;

(4)

(f) At least annual review of these policies and procedures with the involvement of participating providers.

(4)

(g) Written notification to the provider of the dispute determination.

(Mandatory)

Interpretive Information/Commentary

- Standards P-NM 13 through P-NM 17 require the organization to implement processes to address significant disputes or problems with participating providers. The processes must respect providers' rights but must also protect consumers.
- P-NM 14(a) -The provider dispute process only applies to contracted (participating) providers of the network or plan.
- Not all contracted provider disputes are subject to P-NM 13 through P-NM 17. For example, if the provider contract is explicit and states if medical licensure is revoked, or the provider is convicted of claims fraud as events for termination of the contract; the provider dispute process addressed in P-NM 13 through P-NM 17 is not required to be available to the provider.
- If a provider has been issued a dismissal notice from the network, then the provider is considered participating up through the last day of participation as indicated on the notice *unless* the notice is received on or after the last participation day, in which case the provider must be given reasonable time to initiate the dispute mechanism. Ideally this time frame would be stated in the dismissal notice.
- Disputes that are found in favor of the provider at any level do not need to go to the next level.
- Pay attention to linking the written agreement to standards P-NM 13 through P-NM 17.

- If the organization has not received any provider disputes at the time of the application submission for accreditation or re-accreditation, an attestation statement should be included as part of the supporting documentation for these standards.

Points to Remember

- P-NM 14(d): Dispute policies include descriptions of the process for both panel disputes [P-NM 15] and administrative disputes [P-NM 16].
- If a standing committee such as a credentialing or QI committee is used for either of the two panels contemplated in P-NM15, then written policies and/or documented procedures include a mechanism for an ad hoc appointment of a peer-matched provider who meets the qualifications described in that standard in the event such a provider is not a regular member of the standing committee.
- P-NM 14(f) requires documentation of the annual review of provider dispute policies, including identification of the participating providers involved in the process.
- This is not the same as fair hearing and/or arbitration. This process is intended to resolve issues before going to fair hearing and/or arbitration

Scope of Standards

- Standards P-NM 13 through P-NM 17 establish two tracks for provider dispute resolution. One track is for disputes involving professional competence or conduct that result in a change in provider status; for all other types of disputes, an administrative dispute resolution mechanism is available.
- Medical necessity appeals are not included within the scope of these provider dispute resolution standards.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures regarding provider disputes and non-medical necessity appeals.
- Documented evidence of annual review of provider dispute policies, to include involvement by participating providers.
- Templates of correspondence to providers describing how to initiate the dispute resolution process and for notice of decisions.
- Sections of the contract or provider manual that address the process for requesting a dispute under the scope of these standards.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- List of provider disputes, complaints/grievances and non-medical necessity appeals requested by providers over the past year – for a review of selected files documenting the organization's handling of provider disputes within the scope of these standards. For initial health plan applicants, provide a list of provider disputes received since the date of application submission.
- Provider dispute files to include documentation of panel/committee proceedings and correspondence.
- List of disciplinary actions taken against providers over the past year – a sample of files will be requested onsite for review.

- Interviews with the medical director and senior network management staff to assess understanding and implementation of provider dispute resolution policies/procedures.

Bright Ideas

- Submit the dispute resolution policies and procedures to the quality improvement committee for initial and annual review and approval . Remember to note the review and approval of the dispute resolution policies and procedures in the QIC meeting minutes.
- Establish internal policies and procedures for conducting each level of dispute resolution process. Establish a data base or utilize a contact management system to document all disputes received and all events related to the dispute resolution process.
- Develop an electronic form/template for the participating providers to utilize for submitting a formal dispute.
- Develop a template for correspondence for responses to each level of the dispute resolution; send all correspondence (responses) by registered mail.
- Develop a checklist for staff to use to ensure compliance with policies/procedures for each type and level of dispute.
- Include the "step by step" process for submitting a provider dispute in the provider manual.
- Identify the individual(s) within the organization who is responsible for the receipt and processing of a reported provider dispute.

Related Standards

P-NM 15 - Disputes Concerning Professional Competence or Conduct

The *organization* implements a mechanism to resolve disputes with *participating providers* regarding actions by the *organization* that relate to a *participating provider's* status within the *provider network* and any action by the *organization* related to a *provider's* professional competency or conduct. That mechanism: (Mandatory)

> (a) Specifies that all disputes are referred to a first-level panel consisting of at least three qualified individuals, of which at least one must be a participating provider who is not otherwise involved in network management and who is a clinical peer of the participating provider that filed the dispute;
> (Mandatory)
>
> (b) Includes the right to consideration by a second-level panel and the methods to request such consideration; **and**
> (Mandatory)
>
> (c) Provides for consideration to a second-level panel consisting of at least three individuals that comply with element (a) of this standard and that were not involved with the first-level panel.
> (4)

Interpretive Information/Commentary

- Standards P-NM 13 through P-NM 17 require the organization to implement processes to address significant disputes or problems with participating providers. The processes must respect providers' rights, but must also protect consumers.
- Pay attention to linking the written agreement to standards P-NM 13 through P-NM 17.
- Standard P-NM 15 requires two levels of disputes to two different panels. Each panel should be comprised of three individuals who were not involved in earlier decisions. Also, each panel requires at least one practitioner who is a clinical peer of the provider and is not involved in the day-to-day operations of the organization.
- Refer to the contract specifications that are defined by P-NM 9.

Points to Remember

- The provider dispute process applies only to contracted providers of the network or plan.
- Disputes related to professional competence or conduct are related to potential quality of care and/or patient safety issues and are addressed under this standard..
- P-NM 15 allows access to two levels of dispute resolution by two different panels. Each panel must be comprised of three qualified individuals who were not involved in earlier decisions.
- P-NM 15(b) and (c) apply to disputes that are not resolved at the first level [P-NM 15(a)]. Disputes that are found in favor of the provider at any level do not need to go to the next level.
- P-NM 15(a) and (c): Each panel of three requires participation of at least one practitioner who is a clinical peer and is not involved in the day-to-day operations of the organization, including participation on other committees.

- If a standing committee such as a credentialing or QI committee is used for either of the two panels required in P-NM 15, policies and procedures should provide for a mechanism for an ad hoc appointment of a peer-matched provider who meets the qualifications described in that standard in the event such a provider is not a regular member of the standing committee.
- In the documentation of committee proceedings submitted with the application, be sure to clearly indicate which member of the committee is the clinical peer of the provider who is the subject of the dispute.
- Not all contracted provider disputes are subjected to the panel process. For example, if the provider contract is explicit and states if medical licensure is revoked, or the provider is convicted of claims fraud as events for termination of the contract; the provider dispute process addressed in P-NM 13 through P-NM 17 is not required to be available to the provider.
- If the organization has not received any provider disputes at the time of the application submission for accreditation or re-accreditation, an attestation statement should be included as part of the supporting documentation for the applicable standards.
- This is not the same as fair hearing and/or arbitration. This process is intended to resolve issues before going to fair hearing and/or arbitration

Scope of Standards

- Standards P-NM 13 through P-NM 17 establish two tracks for provider dispute resolution. One track is for disputes involving professional competence or conduct that result in a change in provider status; for all other types of disputes, an administrative dispute resolution mechanism is available.
- Medical necessity appeals are not included within the scope of these provider dispute resolution standards.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures regarding provider disputes and non-medical necessity appeals.
- Blinded samples of a practitioner's request for a dispute resolution that include examples of both professional competency and conduct appeals [P-NM 15] and administrative appeals [P-NM 16]. *Unblinded documentation is not acceptable for submission*.
- Blinded examples of documentation generated through the dispute resolution process, including correspondence with providers. *Unblinded documentation is not acceptable for submission*.
- Blinded meeting minutes of committees with responsibility for provider disputes and appeals. *Unblinded documentation is not acceptable for submission*.
- If the organization has not received any provider disputes at the time of the application submission for accreditation or re-accreditation, an attestation to that effect should be included as part of the supporting documentation for these standards.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- List of provider disputes, complaints/grievances and non-medical necessity appeals made by providers over the past year – for a review of selected files documenting the organization's handling of provider disputes within the scope of these standards. For initial health plan applicants, provide a list of provider disputes received since the date of application submission.
- Provider dispute files to include documentation of committee proceedings and correspondence.

- List of disciplinary actions taken against providers over the past year – a sample of files will be requested onsite for review.
- Interviews with medical director and senior network management staff to assess understanding and implementation of provider dispute resolution policies/procedures.

Bright Ideas

- Submit the dispute resolution policies and procedures to the quality improvement committee for initial review and annual review and approval. Remember to note the review and approval of the dispute resolution policies and procedures in the QIC meeting minutes.
- Establish internal policies and procedures for conducting each level of dispute resolution process. Establish a data base or utilize a contact management system to document all disputes received and all events related to the dispute resolution process.
- Develop an electronic form/template for the participating providers to utilize for submitting a formal dispute.
- Develop a template for correspondence for responses to each level of the dispute resolution; send all correspondence (responses) by registered mail.
- Develop a checklist for staff to utilize to ensure all steps of the dispute process are implemented according to policy.
- Conduct training of all employees regarding the procedures for identification and reporting suspected provider professional competence or conduct issues.
- Develop an electronic template/format to document and report suspected professional competence or conduct issues that is easily accessible via the organization's intranet.

Related Standards

P-NM 16 - Disputes Involving Administrative Matters

The organization implements a mechanism to resolve disputes with *participating providers* not covered by P-NM 15 that offers the disputing provider the right to consideration by an authorized representative of the organization not involved in the initial decision that is the subject of the dispute. (Mandatory)

Interpretive Information/Commentary

- The administrative dispute resolution process gives a provider the right to consideration by an authorized representative of the organization not involved in the initial decision of the subject of the dispute.
- Dispute resolution processes must respect providers' rights, but must also protect consumers.
- Pay attention to linking the written agreement to standards P-NM 13 through P-NM 17.
- If the organization has not received any provider disputes at the time of the application submission for accreditation or re-accreditation, an attestation to that effect should be included as part of the supporting documentation for these standards.

Points to Remember

- The provider dispute process only applies to contracted providers of the network or plan.
- Examples of disputes triggering the administrative dispute resolution mechanism described in P-NM 16 include issues with timely filing of claims, network accessibility issues and not submitting requested medical records.
- This is not the same as fair hearing and/or arbitration. This process is intended to resolve issues before going to fair hearing and/or arbitration

Scope of Standards

- Standards P-NM 13 through P-NM 17 establish two tracks for provider dispute resolution. One track is for disputes involving professional competence or conduct that result in a change in provider status; for all other types of disputes, an administrative dispute resolution mechanism is available.
- Medical necessity appeals are not included within the scope of these provider dispute resolution standards.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures regarding provider disputes and non-medical necessity appeals.
- Blinded samples of a practitioner's request for a dispute resolution that include examples of both professional competency and conduct appeals [P-NM 15] and administrative appeals [P-NM 16]. *Unblinded documentation is not acceptable for submission.*
- Blinded examples of documentation generated through the dispute resolution process, including correspondence with providers. *Unblinded documentation is not acceptable for submission.*
- Blinded meeting minutes of committees with responsibility for provider disputes and appeals. *Unblinded documentation is not acceptable for submission.*

- If the organization has not received any provider disputes at the time of the application submission for accreditation or re-accreditation, an attestation to that effect should be included as part of the supporting documentation for these standards.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- List of provider disputes, complaints/grievances and non-medical necessity appeals made by providers over the past year – for a review of selected files documenting the organization's handling of provider disputes within the scope of these standards. For initial health plan applicants, provide a list of provider disputes received since the date of application submission.

- List of disciplinary actions taken against providers over the past year – a sample of files will be requested onsite for review.

- Interviews with the medical director and senior network management staff to assess understanding and implementation of provider dispute resolution policies and procedures.

Bright Ideas

- Establish internal policies and procedures for conducting each level of dispute resolution process. Establish a data base or utilize a contact management system to document all disputes received and all events related to the dispute resolution process.
- Develop an electronic form/template for the participating providers to utilize for submitting a formal dispute.
- Develop a template for correspondence for responses to each level of the dispute resolution; send all correspondence (responses) by registered mail.
- Develop a checklist for staff to utilize to ensure all steps of the dispute process are implemented according to policy.
- Conduct training of all employees regarding the procedures for identification and reporting suspected provider professional competence or conduct issues.
- Develop an electronic template/format to document and report suspected professional competence or conduct issues. Make the template easily accessible via the organization's intranet.

Related Standards

P-NM 17 - Participating Provider Suspension Mechanism for Consumer Safety

The *organization*: (No Weight)

(a) Implements a mechanism to immediately suspend, pending investigation, the participation status of a *participating provider* who, in the opinion of the medical director (or clinical director), is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of *consumers*; (Mandatory)

(b) Investigates such instances on an expedited basis; **and** (Mandatory)

(c) Makes the dispute resolution process available to any *participating provider* subject to suspension of participation status. (Mandatory)

Interpretive Information/Commentary

- Standards P-NM 13 through P-NM 17 require the organization to implement processes to address significant disputes or problems with participating providers. The processes must respect providers' rights, but must also protect consumers.
- Pay attention to linking the written agreement to standards P-NM 13 through P-NM 17.
- P-NM 17 ensures that the organization can immediately suspend a provider, however, it also permits the provider access to a dispute mechanism to appeal the decision.

Points to Remember

- Documentation for compliance with this standard includes written policies and/or documented procedures describing the mechanisms to immediately suspend a participating provider. The procedures for expedited investigation as well as the dispute resolutions process available to the participating provider whose network participation is suspended should be fully documented.
- If a standing committee such as the credentialing or QI committee is used for either of the two panels contemplated in P-NM 15, then written policies and documented procedures should provide a mechanism for an ad hoc appointment of a peer-matched provider who meets the qualifications described in that standard in the event such a provider is not a regular member of the standing committee.
- In the documentation of panel/committee proceedings submitted with the application be sure to clearly indicate which member of the committee is the clinical peer of the provider who is the subject of the dispute.
- If the organization has not received any provider disputes at the time of the application submission for accreditation or re-accreditation, an attestation to that effect should be included as part of the supporting documentation for these standards.
- Include a description of what steps are taken during suspension, such as how the provider is listed in the directory during the investigation.

Scope of Standards

- Standards P-NM 13 through P-NM 17 establish two tracks for provider dispute resolution. One track is for disputes involving professional competence or conduct that result in a change in provider status; for all other types of disputes, an administrative dispute resolution mechanism is available.
- Medical necessity appeals are not included within the scope of these provider dispute resolution standards.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures regarding provider disputes and non-medical necessity appeals.
- Blinded samples of a practitioner's request for a dispute resolution that include examples of both professional competency and conduct appeals [P-NM 15] and administrative appeals [P-NM 16]. *Unblinded documentation is not acceptable for submission.*
- Blinded examples of documentation generated through the dispute resolution process, including correspondence with providers. *Unblinded documentation is not acceptable for submission.*
- Blinded meeting minutes of committees with responsibility for provider disputes and appeals. *Unblinded documentation is not acceptable for submission.*
- If the organization has not received any provider disputes at the time of the application submission for accreditation or re-accreditation, an attestation to that effect should be included as part of the supporting documentation for these standards.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- List of provider disputes, complaints/grievances and non-medical necessity appeals made by providers over the past year – for a review of selected files documenting the organization's handling of provider disputes within the scope of these standards. For initial health plan applicants, provide a list of provider disputes received since the date of application submission.
- List of disciplinary actions taken against providers over the past year – a sample of files will be requested on-site for review.
- Interviews with the medical director and senior network management staff to assess understanding and implementation of provider dispute resolution policies/procedures.

Bright Ideas

- Conduct training for the organization's employees regarding the policies and procedures to identify and report issues that may appear to pose a significant risk to the health, welfare, or safety of consumer. Assure that all departments who have employees that communicate with consumers have proper orientation and training regarding the identification of potential patient safety issues.
- Establish organizational reporting procedures to document and report any situations that pose a significant risk to the health, welfare or safety of the consumer.
- Develop a process to document the suspension of a provider within the provider data base; develop an internal notification process of a provider suspension that include a distribution to all key departments such as member services, utilization management, credentialing/ network management, claims, etc.

Related Standards

Credentialing

P-CR 1 - Practitioner and Facility Credentialing

The *organization* implements a credentialing program to verify the professional qualifications of *participating providers,* at a minimum: (No Weight)

> (a) All *practitioners* that are *participating providers* and that provide covered health care services to consumers; **and**
> (Mandatory)
>
> (b) *Facilities* that provide covered health care services to *consumers* including:
> (No Weight)
>
>> (i) Acute inpatient facilities such as hospitals;
>> (Mandatory)
>>
>> (ii) Free-standing surgical centers;
>> (Mandatory)
>>
>> (iii) Home health agencies; **and**
>> (Mandatory)
>>
>> (iv) Skilled nursing facilities.
>> (Mandatory)

Interpretive Information/Commentary

- P-CR 1(a) requires that the credentialing program include all participating practitioners who are contracted to provide health care services to consumers.
- URAC will use the organization's provider directory as the list of providers – both practitioners and facilities – that fall within the scope of the credentialing program.
- If the organization chooses to list practitioners at a contracted facility in its provider directory, then those practitioners must be credentialed regardless of whether or not the organization contracts directly with the practitioner.

- Credentials collected for health care facilities include (as applicable), but are not limited to the following information:
  - State licensure information (if that type of facility is eligible for a state license).
  - Medicare or Medicaid certification status via OIG (if such certification is available for that type of facility)
  - A copy of the facility's liability insurance policy declaration sheet.
  - Any other information necessary to determine if the facility meets the network-based health benefits plan participation criteria that the network-based health benefits plan has established for that type of facility.
  - A signed and dated statement from an authorized representative of the facility attesting that the information submitted with the application is complete and accurate to the facilities' knowledge.
  - A signed and dated statement from an authorized representative based health benefits plan to collect any information necessary to verify the information in the credentialing application.
  - Accreditation status (e.g., JCAHO (aka "TJC"), CARF, AAAHC, etc.)

- Some applicant organizations contract almost exclusively with groups practicing in various types of outpatient locations or with clinics, such as:
  - Behavioral health group practices delivering outpatient therapy in their professional practice offices; and
  - Free-standing clinics where physical, occupational and speech therapists provide clinical services.

- The organization applying for URAC accreditation credentials the individual practitioners providing clinical services in group practice settings and free-standing clinics even if the individual practitioners are not listed in the organization's provider directory or do not contract directly with the network organization.
- The organization may delegate credentialing to a network, group or clinic organization with which they contract. In this case:
  - Delegation oversight is required as specified in the standards; and
  - The delegated entity (e.g., network, group practice or free-standing clinic, etc.) is credentialing according to the standards.

Points to Remember

- Note that all elements of this standard are mandatory.
- The organization must complete the credentialing process prior to listing a provider on its online or paper provider directory.
- The scope of the credentialing program must include the individual practitioners listed in the directory, facilities and non-physicians as applicable. Physicians who are employees of a facility as hospitalists and who are not listed in the provider directory would not be included within the scope of these credentialing standards.

- Include the following information in the documented evidence for meeting the standard. Failure to do so will affect attainment of a total compliance score:
  - Description regarding the types of practitioners credentialed and recredentialed (i.e., those listed in the provider directory);
  - Complete description of the decision-making processes for credentialing and recredentialing; and
  - Criteria for granting provider network participation and accurate accounting of the verification sources used.

- There are a couple of ways to document formal approval of the credentialing plan, program description, charter or credentialing policies and procedures, herein collectively called the "credentialing plan" or "plan":
  - Individually signed/dated policies and procedures;
  - A signed/dated master list of policies and procedures; or
  - Signed/dated meeting minutes documenting formal approval

Scope of Standards

- P-CR 1 and P-CR 2 apply to all practitioners and facilities that are participating providers and that are providing covered health care services to consumers that are listed in the organization's provider directory. The organization represents to its membership that the providers listed are participating providers. This may include, as applicable:
  - MDs/DOs
  - Chiropractors
  - Non-Physicians including nurse practitioners, physician assistants, nutritionists, etc.
  - Alternative Medicine Providers – massage therapists, acupuncturists, etc.
  - Mental Health Providers – psychologists, certified addiction specialists, etc.
  - Acute in-patient facilities such as hospitals
  - Free-standing surgical center.

Evidence for Meeting the Standard - Desktop Review Materials

- Formally approved credentialing plan, program description, charter or credentialing policies and procedures, herein collectively called the "credentialing plan" or "plan."
- One sample of credentialing committee meeting minutes showing that providers applying for participation in the network have completed the credentialing process.
- PDF copy of complete provider directory as provided to the consumer. Web site access is not sufficient.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview with staff and the senior clinical staff person regarding the scope of the credentialing program.

Bright Ideas

- As part of the QI work plan, establish a task for the annual review of the credentialing plan or related policies and procedures.

- Add a "standing" agenda item for the credentialing committee (or appropriate committee that reviews and approves the credentialing plan) to annually review and approve the credentialing plan.
- If "new" or additional provider types are added to the network, assure that the scope of the credentialing plan is updated to reflect the changes in the network and scope of the credentialing activities.
- Maintain an ongoing review of regulatory requirements that may include revisions or additions to requirements for the credentialing program.

Related Standards

P-CR 2 - Credentialing Program Oversight

The senior clinical staff person of the *organization* is responsible for oversight of the clinical aspects of the credentialing program. (Mandatory)

Interpretive Information/Commentary

- This standard addresses the staff leadership of the credentialing program.
- The senior clinical staff person does not need to oversee day-to-day operations of the credentialing staff, but must maintain overall responsibility for the clinical aspects of credentialing.
- The clinical staff person should be an M.D. or D.O. unless it is a specialty network, in which case it should be the senior staff person from that network.

Points to Remember

- Note: Organizations with a "temporary" or "acting" senior clinical staff person will be presented to URAC committees on a case-by-case basis to determine if their situation meets the intent of the standards.
- Aspects of P-CR 2 addressing oversight of the clinical aspects of credentialing can be included in a job description or credentialing plan outlining senior staff accountabilities.

Scope of Standards

- Standard P-CR 2 applies to the clinical leadership for the credentialing program.

Evidence for Meeting the Standard - Desktop Review Materials

- Job description/contract for senior clinical staff person for the credentialing program.
- Credentialing plan describing the senior clinical staff person's role and accountabilities.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview with staff and the senior clinical staff person regarding his or her role and responsibilities.
- The personnel file for the senior clinical staff person will be reviewed to verify credentials, experience and job description or contract.

Bright Ideas

- As part of the personnel file review, review the job description of the senior clinical staff member to assure that responsibilities related to credentialing program oversight are included within the job description.
- Include the qualifications of the senior clinical staff member and the stated roles and responsibilities for oversight of the credentialing program within the credentialing plan or applicable written policies and documented procedures.

Related Standards

P-CR 3 - Credentialing Committee

The *organization* establishes a credentialing committee that: (No Weight)

    (a) Includes at least one *participating provider* and who has no other role in *organization* management; (Mandatory)

    (b) Discusses whether *providers* are meeting reasonable standards of care; (3)

    (c) Accesses appropriate clinical peer input when discussing standards of care for a particular type of *provider;* (4)

    (d) Has final authority to: (4)

        (i) Approve or disapprove applications by *provider*s for *organization* participation status; **or** (Mandatory)

        (ii) Delegate such authority to the *senior clinical staff person* for approving *clean credentialing applications*, provided that such designation is documented and provides reasonable guidelines; (4)

    (e) Maintains minutes of all committee meetings and documents all actions; (4)

    (f) Provides guidance to *organization* staff on the overall direction of the credentialing program; (3)

    (g) Evaluates and reports to *organization* management on the effectiveness of the credentialing program; (3)

    (h) Reviews and approves credentialing policies and procedures; **and** (4)

    (i) Meets as often as necessary to fulfill its responsibilities, but no less than quarterly. (3)

Interpretive Information/Commentary

- There must be a credentialing committee that is responsible for:
    - The overall direction of the credentialing program
    - Approving or disapproving applications for network participation.
- Note: The committee does not need to individually discuss every credentialing application, but every application must pass through the committee process for final determination.
- This standard stresses the importance of having a peer group make the final credentialing determination for a provider. While the organization's staff may make a recommendation regarding a provider, it is vital that a peer committee exercise final authority over which providers to admit into the network.
- The committee must have access to appropriate specialty expertise. For example, if the committee is discussing the credentials of a cardiologist, and the committee members feel they need additional input, they should be able to consult with a cardiologist.

- If a credentialing application is clean, then it does not need to go to the Credentialing Committee. Please note that "clean application" is a defined term.
- P-CR 3(d)(ii) Refers to delegating authority to the *senior clinical staff person*, not to another staff person.
- To ensure that P-CR 3(d) is uniformly applied, an established process needs to be defined and followed by the organization.
- Reviewers will verify the process for credentialing clean applications that have been approved.
- The organization will determine the criteria for a clean application. At a minimum, a clean application is one that does not require credentialing committee review because (a) there are no issues that would require committee review, (b) the file meets the minimum URAC credentialing standards identified in the credentialing chapter of these standards, and (c) the file meets any additional criteria determined by the Organization.
- P-CR 3(g) refers to examples of evaluation and reports of organization management on the effectiveness of the credentialing program, which can include timeliness, volume, percentage of clean applications, and percentage of complaints.
- It is not necessary for the specialty expertise to be a standing committee member.

Points to Remember

- P-CR 3(b): Credentialing meeting minutes must indicate that a discussion took place when determining whether an applicant with issues may or may not participate in the network. The level of detail recorded in the minutes regarding that discussion is up to the organization.
- P-CR 3(a) and (c): Include the name and specialty of the participating committee members in the meeting minutes.
- P-CR 3(c): When accessing an appropriate clinical peer in order to discuss whether a particular type of provider is practicing reasonable standards of care, the clinical peer does not have to, but certainly may attend the Credentialing Committee meeting either in person or telephonically. The clinical peer's input may be presented via the Credentialing Committee chairperson or other clinical committee member, which must be reflected in the committee meeting minutes.
- P-CR 3(d)(ii): Written policies and documented procedures must depict the criteria for a "clean application."

Scope of Standards

- Standard P-CR 3 focuses on the responsibilities of the organization's credentialing committee.

Evidence for Meeting the Standard - Desktop Review Materials

- Organizational chart showing key positions, senior executive staff, key committees and departments.
- Credentialing plan describing the role and responsibilities of the credentialing committee. All aspects of P-CR 3 must be addressed in these formally approved documents.

- Submit sample copies (blinded for PHI) of the Credentialing Committee meeting minutes which illustrate:
  - Approval/disapproval of provider applications for network participation status;
  - Committee membership including at least one participating provider who is a practitioner (identify credentials and clinical area of practice);
  - Access to appropriate clinical peer input; and
  - Review and approval of credentialing policies and procedures.

- Sample reports to organizational management on the effectiveness of the credentialing program.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview with clinical director and management personnel who are members of the Credentialing Committee.
- Credentialing Committee minutes for the last 3 years. Initial Health Plan applicants may submit Credentialing committee meeting minutes for three months prior to application submission.
- Access to reports that address the effectiveness of the credentialing program and meeting minutes that reflect that they were forwarded to organizational management.

Bright Ideas

- Establish a standardized agenda for the credentialing committee to include the review of "clean applications" and discussions of additional credentialing file reviews.
- To assure that all existing and new committee members have completed signed confidentiality and conflict of interested statements, establish a standing agenda item to annually review confidentiality and conflict of interest requirements at all committee meetings or include the confidentiality statement on the committee "sign in sheet" for each committee meeting.
- Include in the annual QI work plan an evaluation and review of the effectiveness/activities of credentialing program/plan.
- Develop a reporting format that includes the number of providers credentialed and aggregate counts by provider type and specialty.

Related Standards

P-CR 4 - Credentialing Program Plan

The *organization* maintains a written description for its credentialing program that: (No Weight)

(a) Is approved by the credentialing committee;
(3)

(b) Defines the scope and objectives of the credentialing program; (3)

(c) Defines the roles and responsibilities of the credentialing committee, the medical director (or clinical director), and the credentialing staff; (3)

(d) Defines the *organization's* criteria for qualification as a *participating provider* (see P-NM 3); (Mandatory)

(e) For each type of *provider* credentialed by the *organization*, defines the information collected during the credentialing process; (4)

(f) Describes how the information collected during the credentialing process is verified; (Mandatory)

(g) Includes rules about how credentialing information and files are maintained and stored; (Mandatory)

(h) Includes a statement that the *organization* will not discriminate against any *provider* seeking qualification as a *participating provider*; (4)

(i) Describes the process for ensuring that *providers* are credentialed and approved by the credentialing committee, or if a *clean credentialing application,* by a designated *senior clinical staff person* prior to being listed in any *provider* directory; (Mandatory)

(j) Describes the process for removing a *provider* from *provider* directories if the *provider*: (No Weight)

   (i) Ceases to comply with credentialing criteria as determined through the processes of continuous compliance monitoring or recredentialing; **and** (Mandatory)

   (ii) Is not recredentialed within the time frame required by the *organization's* approved credentialing plan; **and** (Mandatory)

(k) Is reviewed and updated by the credentialing committee at least *annually*. (2)

Interpretive Information/Commentary

- The organization must have a written document that describes its credentialing process. This document can be in the form of a plan, charter, or written policies and documented procedures.

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- URAC reviewers will evaluate the organization for compliance with its credentialing program description (charter or policies and procedures) as well as with URAC Standards.
- The Credentialing program description should reflect the organization's goals for provider access and availability (as described in P-NM 2).
- P-CR 4(d): The written program description must include the selection criteria (as required in P-NM 3), acceptable levels of verification (i.e., primary or secondary verification) and acceptable verification sources.
- P-CR 4(h): The organization maintains a written description for its credentialing program that includes a statement that the organization will make credentialing decisions based on multiple criteria related to professional competency, quality of care and the appropriateness by which health services are provided. Discrimination based on an individual's gender, sexual orientation, gender identity, age, race religion, disability, ethnic origin, national origin and any other such prejudicial policies will not be made.

Points to Remember

- It is a good idea to provide a credentialing plan that gives a comprehensive "snapshot" of the organization. The URAC reviewers will rely on this information to interpret other information provided by the Applicant and to clearly understand the part of the organization involved in the accreditation. The goal is to ensure that the organization operates consistently according to its own documents as well as URAC standards.
- A credentialing plan can be outlined to address each issue included in standard CR 4.
- CR 4(a): Document approval of the credentialing plan by the committee in the meeting minutes.
- CR 4(b): If the organization delegates credentialing activities, include information (in the credentialing plan) regarding the delegated entities and delegation oversight activities.
- CR 4(g): The credentialing plan should describe protections for confidentiality of credentialing files.
- CR 4(k): Document the Credentialing Committee's annual review and update of the credentialing program description in the meeting minutes.

Scope of Standards

- The focus of this standard is the credentialing program within the organization.

Evidence for Meeting the Standard - Desktop Review Materials

- Credentialing plan (may also be called a credentialing program description, charter or written policies and documented procedures) that describes the credentialing process.
- Medical or Clinical Director job description.
- Job description for the credentialing staff.
- Policy and procedure regarding how the credentialing information is maintained and stored.
- Policy statement regarding participating provider discrimination.
- Policy and procedure ensuring that providers are credentialed prior to being listed in any provider directory (may be included in the Credentialing Plan).
- Policy and procedure for removing a provider from provider directories (may be included in the Credentialing Plan).
- Credentialing Committee minutes documenting annual credentialing plan review and update.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Current credentialing plan with any recent updates since submittal of the application for accreditation.

- Reviewer will interview management and staff regarding the issues identified in standard CR 4.

Bright Ideas

- Distribute the "draft" credentialing plan electronically to the committee members to review and comment prior to the committee meeting for final approval.
- Establish a standing agenda item on the credentialing program work plan that includes review and documentation of the approval of the credentialing plan by the committee.

Related Standards

P-CR 5 - Credentialing Application

The organization requires that each *practitioner* who applies for participation in the *provider network*, and is within the scope of the credentialing program, submit a credentialing application that includes at least the following information: (No Weight)

(a) History of education and professional training, including *board certification* status; (Mandatory)

(b) State *licensure* information, including current *license(s)* and history of *licensure* in all jurisdictions; (Mandatory)

(c) Evidence of current Drug Enforcement Agency (DEA) certificate or state controlled dangerous substance certificate, if applicable; (Mandatory)

(d) Proof of liability insurance; (Mandatory)

(e) Professional liability *claims* history; (Mandatory)

(f) History of sanctions; (Mandatory)

(g) History of loss or limitation of privileges or disciplinary activity; (Mandatory)

(h) Hospital affiliations or privileges, if applicable; (Mandatory)

(i) Disclosure of any physical, mental, or substance abuse problems that could, without reasonable accommodation, impede the *practitioner's* ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of patients; (Mandatory)

(j) A signed and dated statement attesting that the information submitted with the application is complete and accurate to the *practitioner's* knowledge; **and** (Mandatory)

(k) A signed and dated statement authorizing the *organization* to collect any information necessary to verify the information in the credentialing application. (Mandatory)

Interpretive Information/Commentary

- This standard details the required elements of a credentialing application for practitioners. The attestation in the application must be signed and dated by the applicant.
- The organization must require a credentialing application of every provider that applies for participation in the organization's provider network and that falls within the scope of the credentialing program.
- These standards are silent on the structure of credentialing applications for facilities. Organizations should use their best judgment when designing an application for a particular type of facility, with the goal of evaluating the facility's qualifications against the organization's provider selection criteria.

- There are a number of standard credentialing applications that organizations may choose to use. In some states, regulations may require organizations to use a certain standard application. The applications must meet or exceed URAC standards (i.e., include all of the elements listed in CR 5). If the application does not meet URAC standards, then it is suggested to include attachments to the applications in order to comply with URAC Standards.
- If an applicant organization uses the Universal Provider Datasource ("UPD" - online system used to collect credentialing data) developed by the Council for Affordable Quality Healthcare (CAQH), then it shall be deemed to be in compliance with CR 5.
- CR 5(h): The term "applicable" applies to those practitioners such as outpatient psychiatrists who do not admit patients and therefore do not have hospital privileges.
- To meet the requirement for CR 5(c) the organization may either collect a copy of the certificate or the certificate number.
- A cover sheet, also known as a declaration sheet, is sufficient to prove attainment of liability insurance under CR 5(d). Another option would be to collect an attestation from the insurance company.
- Update 1/28/2015: If the organization collects a liability insurance cover sheet to meet CR 5(d), the cover sheet must include the practitioner name, the expiration date, and the liability covered. The cover sheet must be current and valid when presented to the credentialing committee (see also "Points to Remember"). If the cover sheet does not include the practitioner name, then there are two other options for submission:
  - A photocopy of those covered under the liability insurance must be submitted to URAC on company letterhead, or
  - The policy must state the types of healthcare practitioners covered by the policy. Examples include "employed healthcare practitioners" or "contracted healthcare practitioners." In addition to the policy language identifying the types of healthcare practitioners covered by the policy, applicant organizations would provide URAC a list of practitioners, along with their relationship with the organization (employed or contracted), on company letterhead.

- CR 5(e): Professional liability claims history is defined as cases that are settled or have resulted in an adverse judgment against the provider.
- For subsection (f), the practitioner should identify sanctions from state licensing boards as well as Medicare/Medicaid. Sanctions can be verified through the issuing organization and through the NPDB if your organization is eligible to access the NPDB.
- CR 5(f): History of sanctions should include a minimum of 5 years licensure/privilege history, if the practitioner has been in practice that long.
- CR 5(j) & (k): An electronic signature is acceptable to meet these requirements. Written policies and/or documented procedures should be in place to establish controls and manage risk for electronic signatures. Examples of acceptable signatures include faxed, digital, electronic, scanned, or photocopied signatures.
- The criteria listed in this standard are required for all types of health care provider credentialing programs. Further information can be obtained at: Universal Credentialing Data Source, promulgated by the Council for Affordable Quality Healthcare (CAQH) at http://www.caqh.org/ucd.php.
- Be sure to review the Core standards related to information management (e.g., Core 13, 14 & 15) and how it applies to credentialing application information.

Points to Remember

- Please note that all elements of this standard are mandatory.
- P-CR 5(a) and (b): The application should request the information needed to satisfy credentials to be verified pursuant to P-CR 9 (i.e., state licensure and board certification if applicable or highest level of education).
- P-CR 5(b): The credentialing application must provide sufficient space for practitioners to include history of licensure in all jurisdictions.
- P-CR 5(d): In lieu of a current and valid liability cover sheet, also known as a declaration sheet, a letter from the insurance company indicating a future start date for the practitioner's liability insurance is acceptable to URAC. In addition to the physician's name, this letter would describe the liability coverage.
- P-CR 5(d): URAC does not accept an attestation from a practitioner as "proof of liability insurance."
- P-CR 5(f): The application form should require disclosure of sanction history for an initial applicant (the organization may indicate a time frame for this, such as "within the past 5 years") and all sanctions that have occurred since last credentialed for a recredentialing applicant.
- Assuming that the credentialing application is an otherwise "clean" application without any other issues, the credentialing committee may approve the application with a prospective network participation start date on or after the date the liability insurance goes into effect. This will allow the organization to continue processing the application; however, the physician may not begin to see or treat patients until that future network participation start date. In addition, the physician must forward a copy of the liability cover sheet to the organization upon receipt from the insurance company. This will complete the credentialing application.

Scope of Standards

- All types of credentialed providers must complete a credentialing application.

Evidence for Meeting the Standard - Desktop Review Materials

- Credentialing plan that requires submittal of a completed application form for providers applying to the network.
- Sample template of the credentialing application(s) for each type of practitioner (if different templates used for different practitioner types).

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- The organization should be prepared to pull 35 to 40 initial credentialing and recredentialing files containing completed credentialing applications signed by the provider that include the elements required by P-CR 5.

Bright Ideas

- Develop a verification checklist to review all applications (upon receipt) for completion; create identification codes for all required elements. The verification checklist should include a section for the staff reviewing the credentialing application to sign and date that the verification was done. Initials can be used to address specific line items.

- Create a data base to track all credentialing information and include a completion status code to identify any incomplete applications. For all incomplete applications, include the follow up activities (information needed) and the date due for follow up within the report.
- Create a weekly credentialing application status review report.
- Identify any individual(s) responsible for documentation of receipt, review and tracking of the completion status of all applications.
- Image and file all application documents upon receipt.
- Provide a secure practitioner portal via the Internet for electronic filing of applications.

Related Standards

P-CR 6 - Credentialing Confidentiality

The *organization*: (No Weight)

    (a) Ensures the confidentiality of credentialing information; **and** (Mandatory)

    (b) Limits access to credentialing files to authorized personnel only. (Mandatory)

Interpretive Information/Commentary

- Organizations must take steps to protect the confidentiality and security of credentialing information. If paper credentialing files are maintained, the organization should have a written policy and/or documented procedures to address the security of the files. For example:
  - Regarding hard copy files: Storage, in-process files on desks, etc.
  - Regarding electronic files: Access to the files limited by password or other security device, etc.

Points to Remember

- Please note that all elements of this standard are mandatory.
- The organization must document staff training on the confidentiality of credentialing files as well as others that must handle credentialing information, such as the Credentialing Committee.
- P-CR 6(b): Access applies to both hard copy as well as electronic file copies of credentialing information. Temporary or contracted employees and committee members should complete confidentiality training and sing confidentiality statements as required by the organization.
- P-CR 6(b): Ensure that access to credentialing files is limited to authorized personnel only. Paper files that are stored in locations used by many staff (e.g., in hallways, near copy machines, etc.) must be kept locked at all times. Perform a periodic assessment of all paper file storage locations to ensure proper security and storage of files.
- PCR 6(b): Establish guidelines for storage, maintenance and destruction of credentialing documents (refer to standard Core 13).

Scope of Standards

- This standard encompasses the credentialing process, staff and committee responsibilities and the organization's confidentiality procedures as they apply to both hard copy and electronic credentialing information.

Evidence for Meeting the Standard - Desktop Review Materials

- Credentialing plan that delineates confidentiality policies and procedures, including how limited access to credentialing files, both hard copy and electronic, is maintained.
- Credentialing plan that elaborates on how credentialing staff, including any temporary personnel and credentialing committee members are trained on confidentiality policies and procedures.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Inspection of credentialing file storage areas (for both approved and in-process paper and electronic credentialing files) to verify confidentiality and limited access to credentialing files.
- Evidence of credentialing staff training in the confidentiality of credentialing information, which may include meeting minutes documenting training, certificates of training and signed confidentiality statements in personnel files, workshop sign-in sheets, copies of e-mail updates on confidentiality issues, results of written tests or audits used to verify understanding of confidentiality procedures, etc.
- Evidence of confidentiality training for committee members who must have access to credentialing information including meeting minutes and confidentiality statements signed by the committee.
- Staff interviews regarding their role and responsibilities regarding storage of and access to hard copy and electronic credentialing files.

Bright Ideas

- Assign security levels to users to limit computer access to the credentialing application files based on the employee's job description and responsibilities.
- For paper file maintenance, provide an additional level of security using access cards or combination locks to limit access to credentialing file storage area file cabinets, which should be locked.
- Limit the number of individuals who may access the credentialing file room. Establish a system for logging when and who is taking files out of the file room.
- As part of information management and security programs, conduct ongoing monitoring of access to the credentialing file room. Establish procedures to prohibit unauthorized personnel from entering the credentialing department.
- As part of the quality management program and ongoing URAC compliance monitoring, conduct a quarterly assessment of the access and security of the credentialing department**.**

Related Standards

P-CR 7 - Review of Credentialing Information

The *organization* implements mechanisms to review credentialing information for completeness, accuracy, and conflicting information. (3)

Interpretive Information/Commentary

- Organization staff must review an applicant's credentialing information before consideration by the Credentialing Committee. If any information is missing, incorrect, or inconsistent, organization staff should conduct additional review and attempt to obtain correct or complete information.
- One way to meet this standard is to have a credentialing staff member (other than the one that did the initial credentialing work) review the file to ensure that all necessary information is present. Once the file has been reviewed, a notation to that effect should be placed in the file.
- Prudent practice would be to develop a quality auditing process. For example, perform quality audits on 25% of completed credentialing files for the elements indicated in P-CR 7.

Points to Remember

- This standard addresses the way in which the organization checks for the completeness, accuracy and consistency of credentialing application information as compared to credentialing verification information.

- Written policy and/or documented procedures state the specific mechanisms taken by the organization to verify completeness, accuracy and consistency of the credentialing application.

Scope of Standards

- Credentialing files submitted to the Credentialing Committee and/or senior clinical staff person.

Evidence for Meeting the Standard - Desktop Review Materials

- Credentialing plan describing the mechanism for checking completeness, accuracy, and conflicting information in the credentialing files to be submitted to the Credentialing Committee.
- Sample checklist or form used to note that a credentialing file has been reviewed prior to committee.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Survey of 35-40 credentialing files to verify that mechanism for checking completeness, accuracy, and conflicting information is in place and has been implemented.
- Interview with credentialing staff on the process of reviewing a credentialing file.

Bright Ideas

- Conduct inter-rater studies by having staff complete a "mock file review." Implement quality improvement activities when the findings vary among staff. Develop a verification checklist to review all applications (upon receipt) for completion; create identification codes for all required elements. The verification checklist should include a section for the staff reviewer to sign and date.
- Create a data base to track all credentialing information. Include a completion status code to identify any incomplete applications. For all incomplete applications, include the follow up activities (information needed) and the date due for follow up within the report.
- Create a weekly application status review report.
- Identify an individual(s) responsible for documentation of receipt, review and tracking of the completion status of all applications.
- Image and file all application documents upon receipt.

Related Standards

P-CR 8 - Credentialing Communication Mechanisms

The *organization* implements mechanisms to: (No Weight)

> (a) Communicate with *providers* about their credentialing status upon request; **and** (4)

> (b) Prior to review, accept additional information from *providers* to correct incomplete, inaccurate, or conflicting credentialing information. (4)

Interpretive Information/Commentary

- Providers must be able to obtain information about the status of the credentialing application and have the opportunity to provide accurate information if there is a problem.
- P-CR 8(a) addresses a mechanism for providers to access his/her status during the credentialing or recredentialing process from an organization representative. Many organizations submit cover letters sent with the application with the statement, "Should you have any question during the credentialing process, please contact (name of contact) at (contact's number)." Other organizations submit phone logs, e-mails, or other correspondence.
- P-CR 8(b) gives the practitioner an opportunity to correct the incomplete, inaccurate, or conflicting information.
- P-CR 8(b) does not preclude the credentialing committee from requesting additional information. The fact that a provider can supply corrected information does not prevent the organization from factoring the inconsistency into the credentialing process. For example, if the information submitted on the credentialing application was intentionally misleading, then that can be considered in the credentialing process even if the provider later submitted correct information.

Points to Remember

- Standard P-CR 8(a) is a frequently missed standard upon desktop review. The organization should submit evidence describing how it responds to a provider's request for the status of his or her credentialing application.
- A flowchart is very helpful to illustrate the various decisions in the workflow that can occur when checking credentialing applications [P-CR 7] and obtaining additional information from providers [P-CR 8(b)].
- This standard provides the health care practitioner or facility an opportunity to resolve problems with missing, inaccurate, and inconsistent information collected during the credentialing process.

Scope of Standards

- P-CR 8 includes all providers applying for network participation.

Evidence for Meeting the Standard - Desktop Review Materials

- Credentialing plan that describes how providers can find out about the status of their applications and how the credentialing staff obtains additional information if the application is incomplete, inaccurate, or contains conflicting information.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Survey of 35-40 credentialing files to verify that mechanism for obtaining complete and accurate information, and for resolving conflicting information found in the credentialing file.
- Interview with credentialing staff on the process for correcting problems with credentialing file information.

Bright Ideas

- Establish a centralized process to receive, review and document receipt of additional information submitted.
- Develop job aids/workflows for the staff to clearly define the steps involved in requesting and obtaining the additional credentialing documents.
- Identify an individual to be responsible for the final quality assurance process for verification of the completion of the credentialing application document.
- Run weekly reports regarding the completion status of the credentialing applications.
- Conduct periodic audits of credentialing files in process and files completed.
- Post credentialing policies and procedures on the provider Web site portal. Include information regarding submission of additional information that may include the following:
  - The time frame for changes to be submitted
  - The format for submitting corrections
  - The person to whom the corrections or additional information should be submitted
  - Verification of receipt of information submitted.
  - Develop a credentialing application follow up letter template (macro) designed to allow for inserting a list of the information needed to complete the application. Include the contact name and phone number of the individual responsible for processing the credentialing documents.
  - Provide a direct provider information line or access to a provider Web site portal to submit additional application information or to check the status of the application processing.
  - Develop policies and procedures to update the information on the provider Web site portal on a regular basis (i.e., weekly, monthly, etc.)

Related Standards

P-CR 9 - Primary Source Verification

The *organization* verifies the following *practitioner* credentials using primary sources: (No Weight)

(a) *Licensure* or *certification* as minimally required to engage in clinical practice; **and** (Mandatory)

(b) *Board certification*, if applicable, or highest level of education or training. (Mandatory)

Interpretive Information/Commentary

- For certain credentials, the organization must verify their accuracy using appropriate sources.
- Primary verification is defined as "verification based on information obtained directly from the issuing source of the credential." For example, to verify license, the organization needs to contact the State Board directly.
- Primary Source Verifications:
  - A written verification must indicate that it has been verified from an issuing source. This can occur through a document from the issuing entity that includes the letterhead of the issuing entity addressed to the organization. It can also include a signature and date from the issuing entity on a form sent by the organization.
  - Telephone verifications are also acceptable. The call must be documented, including the name and signature of the organization staff person making the call, the date of the call, and the name of the person at the issuing entity with whom the organization staff person spoke.
  - Electronic verifications include using the Internet or modem, tapes, diskettes, or other electronic medium derived from primary or secondary sources. URAC on-site reviewers should be able to confirm use of such sources through electronic or hard copy records and documentation.
  - Tapes purchased from the state boards can be used. The organization must demonstrate through a library of tapes, purchase orders indicating that the data is frequently updated, or records of checks issued.
- P-CR 9(a) requires that all license or certification verifications must include the expiration date of the license or certification, the date it was verified, and whether there are any sanctions on the license or certification. The license or certification must be current and valid when presented to the credentialing committee.
- For certain types of clinicians, certification is required as entry into practice. Primary source verification of such certificates is required by P-CR 9(a). Verifications must include the expiration date of the certificate, the date it was verified, and whether there are any sanctions on the certificate. The certificate must be current and valid when presented to the credentialing committee.
- Sources of primary source verification may include state licensing board, school/residency/training program, board certification via the AMA master file, AOA master file, the Education Commission for Foreign Graduates, or Special Board of Registry.

- An organization may rely on the verification activities of state licensing boards. For example, if the state board verifies education using primary verification, then the organization does not need to repeat the state board's work. In cases where the organization does rely on state board verification, should be noted in the credentialing file. State medical boards vary in their verification activities, so the organization should confirm that a particular state board does verify a credential before relying on that state board.
- P-CR 9(b) is required for initial credentialing only, unless the provider's board certification is the type that expires, or if there is no record of the verification in the practitioner's record.
- If not board certified, P-CR 9(b) requires that a practitioner's education or training, whichever is higher, must be verified using primary sources.
- P-CR 9(b): URAC will verify that the applicant organization's credentialing plan identifies the specific board certifications that it will recognize and use to primary source verify (PSV) board certification.

Points to Remember

- Please note that all elements of this standard are mandatory.
- Proper documentation of a verification includes identification of the individual conducting the verification, which may be done using initials, employee number, or other abbreviated means as long as the organization is able to trace the verification back to the person who did it.
- Primary verification is verification based on information obtained directly from the entity issuing the credential.
- Not all types of providers can become board certified. If a physician has multiple board certifications, then at a minimum the organization must verify the board for the specialty under which the practitioner will be listed in the directory.
- All steps outlined in the credentials verification process described in the organization's credentialing plan, which must specify primary verification for licensure and board certification, should be followed.

Scope of Standards

- This standard addresses primary verification of state licensure or certification, and board certification (or highest level of education or training).

Evidence for Meeting the Standard - Desktop Review Materials

- Credentialing plan describing the primary verification process and the credentials to be verified through primary sources.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Survey of 35-40 credentialing files to verify that mechanism for obtaining primary source verification of licensure or certification, and board certification if applicable, or highest level of education or training.
- Interview/observation of credentialing staff on performing primary source verification of these credentials.

Bright Ideas

- If not using an electronic credentialing application system for primary source documentation, develop a template to document primary source verification activities. Include the name and job title of the individual who conducted the primary source verification.
- Provide a template to the staff with the contact information for all primary source entities. Include HTML links to Web sites, phone numbers and contact information.
- Develop a grid based on provider type to outline the requirements for primary source verification (by state). Place this document on the organization's intranet or within the credentialing application system.

Related Standards

P-CR 10 - Consumer Safety Credentialing Investigation

The *organization* implements a mechanism to conduct additional review and investigation of credentialing applications where the credentialing process reveals factors that may impact the quality of care or services delivered to *consumers*. (Mandatory)

Interpretive Information/Commentary

- The organization should have a process for identifying which credentialing applications require further review prior to consideration by the Credentialing Committee.
- The Credentialing Committee defines the parameters for further review of credentialing applications through the approved credentialing plan.
- Some credentialing applications require further investigation of missing information, inconsistent information or malpractice issues. The senior clinical staff person is often involved with the summary of these issues, which are presented to the Credentialing Committee along with the files for discussion.

Points to Remember

- The policy addresses parameters or triggers of potential quality of care issues that require further investigation.

Scope of Standards

- This standard addresses the additional review process where factors have been identified that may impact the quality of care or services delivered to consumers.

Evidence for Meeting the Standard - Desktop Review Materials

- Credentialing plan regarding additional review and investigation of quality of care issues discovered during the credentialing process.
- Job description or sections of the credentialing plan describing the senior clinical staff person's role in any additional investigations.
- Job description or sections of the credentialing plan describing staff responsibility for additional review and investigation of quality of care issues.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview with the senior clinical staff person responsible for oversight of the clinical aspects of the program.
- Interviews with credentialing staff.
- Survey of credentialing files identified as needing additional review and investigation.

Bright Ideas

- Establish interdepartmental policies and procedures to document and report all potential quality of care issues through the Quality Improvement (QI) program. Establish documentation procedures to report any documented quality of care issues to the credentialing department. Conversely, the Credentialing Committee should have established reporting to the QI Committee regarding any documented quality of care issues and/or actions taken by the Credentialing Committee.
- Develop processes to document quality of care issues within the provider data information system for review and evaluation by the senior clinical quality staff and the Credentialing Committee.
- Establish a communication mechanism between credentialing and other key departments within the health plan for notification of changes in a provider's participation status (related to quality of care or other violations or misconduct).

Related Standards

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P-CR 11 - Credentialing Application Review

The *organization* implements a mechanism to provide for review and approval of the credentialing application prior to any applicant's designation as a *participating provider*. (Mandatory)

Interpretive Information/Commentary

- All credentialing applications must be approved by the Credentialing Committee or senior clinical staff person (if a clean application) before a provider is designated as a participating provider in the organization's network (pursuant to standard P-CR 3).
- The only exception to this requirement is when a provider is granted a temporary "provisional" participation status based upon clinical issues. The senior clinical staff person should approve such status and the organization should move the credentialing process forward as quickly as possible for providers with provisional status.
- "Provisional" participation status may be granted for a limited time when justified by continuity or quality of care issues.
- This standard parallels P-CR 3(d) and is thoroughly discussed in the "Interpretive Information/Commentary" and "Points to Remember" sections for that standard.

Points to Remember

- Please note that this standard is mandatory.
- This standard stresses the importance of having a peer group make the final credentialing determination for a provider. The committee has access to appropriate specialty expertise, and exercises final authority prior to an applicant's designation as a participating provider.
- Providers must not be listed in any provider directory until the credentialing committee has granted participation to the provider.

Scope of Standards

- All credentialing applications go through a review and approval process prior to designating a provider as a participating in a network.

Evidence for Meeting the Standard - Desktop Review Materials

- Organizational chart depicting key positions and committees.
- Credentialing plan defining the process for submitting applications to the credentialing committee for approval.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interviews with clinical leadership and credentialing staff, including management regarding the committee process.
- Review of committee meeting minutes for the last 3 years.
- Copies of two recent provider directories.

Bright Ideas

- Establish a process to verify that approved applications are included in the revisions and/or updates to the provider directory data base.
- Develop written policies and documented procedures for updating the information on the provider Web site portal on a regular basis (i.e., weekly, monthly, etc.)
- Establish quality oversight mechanisms to assess and ensure that Credentialing Committee approval is granted prior to a provider being listed in the provider directory.
- Evaluate the possibility of developing an information system process to provide a "real time" update of the provider directory data base from the credentialing system/database.
- Conduct data integrity audits on a quarterly or monthly basis of the provider data base.
- Establish monthly reporting procedures to notify the QI committee of the credentialing program activities to include the number of providers credentialing, recredentialed and/or de-credentialed providers.
- Establish quality mechanisms to ensure that de-credentialed providers are promptly removed from the directory.

Related Standards

P-CR 12 - Credentialing Time Frame

The *organization* does not submit for initial review any credentialing application that: (No Weight)

(a) Is signed and dated more than 180 days prior to credentialing committee review; **or** (4)

(b) Contains primary or secondary source verification information collected more than six months prior to review. (4)

Interpretive Information/Commentary

- Credentialing data are subject to change over time. Therefore, the organization should not rely on out-of-date information when making credentialing determinations.
- This standard requires that all documentation submitted with the application be within 180 days of the applicant's signature on the attestation page. Rather than having the practitioner re-submit all of the documentation, many organizations have the provider re-sign the attestation that declares that the information on the application and submitted with the application is still valid and accurate.
- URAC recognizes that the Credentialing Committee may consider some credentialing applications more than once as a result of requests for additional information. The time frames in this standard apply to the initial review only.

Points to Remember

- The date the provider signed the application must be 180 days or less prior to credentialing committee review and the credentialing verification dates must be six months or less prior to Credentialing Committee review.
- The intent of this standard is to encourage the organization to submit only current information on each applicant to the Credentialing Committee.
- Requirements for submitting credentialing applications may vary by client and/or state regulatory requirements.

Scope of Standards

- This standard applies to all *providers* submitting a credentialing application.

Evidence for Meeting the Standard - Desktop Review Materials

- Credentialing plan that describes time frames for the credentialing application and verifications pursuant to P-CR 12.
- Sample checklist, form, or report used to verify that prior to credentialing committee review, credentialing applications are dated and verified within specified time frames.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Survey of 35-40 credentialing files to verify that applications and verifications meet time frames specified by the standards.
- Interviews with credentialing staff.

Bright Ideas

- Integrate an electronic calendar into the application tracking mechanism to flag for time frames.
- Include in the credentialing application a checklist to document the date the attestation is signed, when the 180-day time frame expires and the date the credentialing application is reviewed by the Credentialing Committee.

Related Standards

P-CR 13 - Credentialing Determination Notification

The *organization* provides written notification to *provider*s of the determination of the *provider's* credentialing application within ten (10) business days of the determination. (4)

Interpretive Information/Commentary

- Organizations must notify applicants of the outcome of the credentialing process on a timely basis. P-CR 13 also applies to the recredentialing process. Mechanisms for meeting the intent of the standard include:
  - Provide notification in writing to the provider;
  - Provide a list of credentialed/recredentialed providers to the group practice;
  - Recredentialing notification stated in either the provider manual or the provider's contract (i.e., the provider is considered to be recredentialed unless otherwise notified).

Points to Remember

- In order to meet this standard, credentialing determination notification must meet the 10-business day time frame.
- This standard does not provide for the exact nature of the notification; therefore, it may or may not include a copy of a contract or other information pertinent to the organization's dealings with the provider.
- In order to ensure clear communication with the provider and to reduce exposure to risk for all parties, the notification letter should include the clinical specialty or multiple specialties under which the provider will be listed in the directory. The credentialing file should reflect verification of credentials related to those specialties.

Scope of Standards

- This standard establishes the time frame for notifying a provider of the Credentialing Committee's determination.

Evidence for Meeting the Standard - Desktop Review Materials

- Credentialing plan that specifies credentialing notification time frames.
- Sample credentialing notification.
- Audit reports regarding the monitoring of time frames from the time of Credentialing Committee consideration to reporting of determinations to providers.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Survey of 35-40 credentialing files to verify that provider notification of credentialing committee decisions meets the 10-business day time frame specified by the standards.
- Interviews with credentialing staff responsible for notifying providers regarding the credentialing committee's determination after review of the provider's application.

Bright Ideas

- Create a monthly report to assure that credentialing notification letters have been sent to the provider applicants within the designated time frame.
- Assign an individual(s) to be responsible for provider notification activities.
- If the notification letters are system generated, conduct periodic audits of the letters for quality and time frame.
- Send a follow up e-mail to the provider (which requires a response) to confirm receipt of the notification letter.
- At the time of recredentialing, verify accuracy of all information in the provider directory (e.g., changes in address, phone numbers, primary contacts, etc.)
- Offer a provider update information line or link on the company Web site for providers to submit changes/or updates to the information.
- Have a written policy and/or documented procedure in place to update the Web site information on a regularly scheduled basis, (i.e., daily/weekly or monthly updates).
- Update provider directory changes in the member newsletter (i.e., have a "Provider News Corner" in each edition of the member newsletter).

Related Standards

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P-CR 14 - Participating Provider Credentials Monitoring

The *organization* implements: (No Weight)

(a) Processes to monitor *participating providers'* continuing compliance with criteria for network participation; **and** (Mandatory)

(b) Mechanisms to respond in cases where a *participating provider* ceases to comply with criteria (for example, revocation or suspension of a medical license). (Mandatory)

Interpretive Information/Commentary

- While periodic review of credentials is important, organizations should also take steps to monitor ongoing compliance with criteria. This "continuous credentialing" approach can help to identify quality or network issues.
- Networks are expected to routinely monitor reports of disciplinary actions published by state licensing boards and the U.S. Department of Health and Human Services, Office of Inspector General (OIG) on an ongoing basis or periodically query the National Practitioner Data Bank (NPDB).

Points to Remember

- All elements in this standard are mandatory.
- The organization must indicate what actions it would take if it were discovered during continuous credentialing verification that a particular provider has been disciplined.

Scope of Standards

- This standard addresses quality improvement monitoring for continuing compliance with criteria for provider participation in the network; it does not include monitoring for expired credentials, which will be verified at the time of recredentialing.

Evidence for Meeting the Standard - Desktop Review Materials

- Credentialing plan that describes the scope of and process for "continuous credentialing verification" through monitoring for on-going compliance with credentialing criteria, including actions to be taken if a participating provider ceases to comply with the criteria.
- Summary reports or other evidence of monitoring of disciplinary actions published by state licensing boards and the U.S. Department of Health and Human Services, OIG and/or query of the National practitioner Data Bank.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Survey of 35-40 credentialing files to verify implementation of continuous credentialing verification. Reports from HHS, OIG, NPDB, etc., will be observed in the files.
- Periodic "exception" reports from entities that distribute a list of providers who have received some form of disciplinary action (e.g., reports from the state department of insurance, insurance companies providing malpractice coverage, etc.)

- Interview with credentialing staff responsible for monitoring for continuous compliance and disciplinary actions.

Bright Ideas

- Establish procedures for ongoing monitoring of reports of disciplinary actions by the various agencies. Establish a template to report any identified findings and develop an internal distribution process for notification of disciplinary actions.
- Establish guidelines for documentation of the reported findings within the provider data base.
- Identify the individual(s) who are responsible for providing reports of the monitoring and activities.
- Establish processes to verify that the provider data base is updated to include any verified disciplinary actions:
  - Identify the role and responsibilities of an individual(s) for credentialing/provider data base administration and maintenance.
  - Conduct audits on the credentialing files to verify data integrity.
  - Establish monthly reporting procedures to notify the Quality Improvement (QI) committee of the credentialing program activities to include the number of providers credentialing, recredentialed and/or decredentialed providers.
  - Require delegated entities to provide monthly reports on provider participation status and any changes in provider information.

Related Standards

P-CR 15 - Recredentialing

The *organization* recredentials each *participating provider* who is within the scope of the credentialing program at least every three (3) years. (Mandatory)

Interpretive Information/Commentary

- Since some credentials expire, the organization must periodically recheck those credentials. This standard requires the organization to recredential each participating provider every three years.
- When conducting recredentialing, the organization may focus only on those credentials that are subject to change over time. For example, the organization does not need to re-verify education, but it must re-verify board certification if it may have expired. Other examples include liability history since last credentialed.
- The recredentialing process follows standards P-CR 5 through P-CR 13, except that it focuses on information subject to change since the provider was last credentialed.
- The time frame is no later than three (3) years from the date of the initial credentialing approval, to the month. For example, whether the initial credentialing was completed on 7/1, 7/15 or 7/31 of 2003, the organization must recredential no later than the end of July 2006 (7/31/06).

Points to Remember

- Please note that this standard is mandatory.
- In order to complete the recredentialing process, the organization must present the recredentialing applications to the credentialing committee whether or not the provider has any issues for the committee to discuss.

- The organization does not have to re-verify those credentials that do not expire or change over time, such as education. This remains the case when processing late applications for re-accreditation that are processed and presented to the Credentialing Committee as an initial application. This process must be documented in the approved credentialing plan and documentation of the verification of the credential must be in the provider's credentialing file.

- On rare occasion, a provider's recredentialing application will be processed late - after the 3-year/36-month time period. In those cases, the organization may choose to process the provider using an initial credentialing application. Either way, the situation should be addressed in the approved credentialing plan and in either case, the credentials that do not expire or change do not need to be reverified.

  - If a new credentialing file is established, then it should refer back to the old file for the initial verification of the credentials that do not expire or change over time, such as education.

Scope of Standards

- This standard refers to the recredentialing process that must occur at least every three years.

Evidence for Meeting the Standard - Desktop Review Materials

- Credentialing plan delineating the recredentialing process.
- Credentialing Committee meeting minutes (1) showing providers approved/disapproved for recredentialing.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Survey of 35-40 credentialing files to verify implementation of recredentialing process. Approximately 15-20 of the files selected will be for providers recredentialed within the past year from the month before the on-site review.
- Credentialing committee meeting minutes within the past 3 years showing providers approved/disapproved for recredentialing.
- Interview with credentialing management and staff personnel regarding the recredentialing process.

Bright Ideas

- Establish a monthly report of providers that are due within 6 months of the stated re-credentialing date.
- At the time of re-credentialing, verify accuracy of all information in the provider directory (i.e., changes in address, phone numbers, primary contacts, etc.)
- Require delegated entities to provide monthly reports on provider participation status and any changes in provider information.

Related Standards

P-CR 16 - Recredentialing and Participating Provider Quality Monitoring

As part of the recredentialing process, the *organization*: (No Weight)

(a) Requires an application updating any information subject to change; (4)

(b) Verifies through primary or secondary source verification the information that is subject to change; **and** (Mandatory)

(c) Considers any collected information regarding the *participating provider's* performance within the *organization*, including any information collected through the *organization's quality management program.* (3)

Interpretive Information/Commentary

- When recredentialing a provider, the organization must also consider its own experience with the provider. Questions an organization might ask include:
  - Has the provider delivered quality health care to the organization's consumers?
  - Has the provider treated the organization's consumers with respect?
  - Has the provider abided by the organization's requirements?
  - Information from sources such as complaints, practice guidelines, or provider profiles is presented to the Credentialing Committee.
  - The organization should not place economic factors above quality of care factors when considering the participating provider's performance.

Points to Remember

- Documentation must be recorded in the recredentialing file in order to meet the intent of this standard.
- P-CR 16(b): Refer to P-CR 9 for credentials that require primary source re-verification.
- P-CR 16(c): Written credentialing policies and/or documented procedures should describe the mechanism(s) for obtaining provider performance information from other departments (such as the QI department).

Scope of Standards

- This standard applies to all providers eligible for recredentialing.

Evidence for Meeting the Standard - Desktop Review Materials

- Credentialing plan addressing the use of provider performance information in the recredentialing process. Samples (2) of provider profile reports, satisfaction surveys, or other performance data that are submitted to the credentialing committee during the recredentialing process.
- Credentialing Committee meeting minutes (blinded for PHI) documenting information regarding participating provider performance within the organization.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Survey of 35-40 credentialing files to verify the use of provider performance information in the recredentialing process. Approximately 15-20 of the files selected will be for providers recredentialed within the past year from the month before the on-site review.
- Credentialing Committee meeting minutes illustrating discussion of providers with issues as a result of their performance while participating in the network.
- Interview with credentialing staff regarding how information is collected regarding participating provider performance within the organization.

Bright Ideas

- Establish a process for the reporting of consumer complaints to be reported by the Quality Improvement (QI) committee to the Credentialing Committee; review information for a possible trend.
- Conduct periodic audits of the provider data base to assure that complaint/quality information has been documented in the provider data base.

Related Standards

P-CR 17 - Credentialing Delegation

The *organization* complies with the Core standards for any credentialing functions it delegates to another entity. In addition, the *organization*: (No Weight)

(a) Retains authority to make the final credentialing determination regarding any *provider*; (Mandatory)

(b) At least every three (3) years, conducts: (No Weight)

(i) Onsite surveys of each entity that performs credentialing functions on behalf of the *organization*; **or** (4)

(ii) If not conducting a survey onsite, then randomly-requested credentialing files are sent or otherwise made available to the *organization* within a specified amount of hours or days of the request as determined by the *organization*; **and** (4)

(c) Provides an *annual* report on delegated credentialing oversight and if conducted, the report includes the findings of the oversight to the credentialing committee. (3)

Interpretive Information/Commentary

- It is very common for organizations to delegate credentialing activities to facilities, provider groups, or credentials verification organizations (CVOs). In such cases, the organization must ensure that credentialing activities are conducted according to the organization's requirements and consistent with URAC standards.

- Note that general delegation rules apply to credentialing delegation.

- Note that URAC will allow organizations to phase in site visits for delegated credentialing over a three-year period. After the phase-in period, the organization must visit each delegated entity at least once every three years.

- When conducting on-site surveys, the organization should review a random sample of complete credentialing files administered on behalf of the organization. The sample size should be 10 percent of such files, but in no case less than 10 files nor more than 30 files.
- Organizations are ultimately responsible for the oversight of the delegated entity and therefore, need to ensure that the delegated entity is continuously in compliance with URAC standards.
- In lieu of an onsite survey for conducting oversight of delegated entities for credentialing, the organization may randomly select credentialing files to be sent to it within a specified amount of time for the request.
- How copies of the randomly-selected credentialing files are sent is determine by the organization (e.g., via certified mail, electronically, etc.) Another option would be to provide a remote auditor access to a copy of the credentialing database through a proxy using a time-limited password sent telephonically or through encrypted e-mail.

- For element (c), the credentialing committee must be apprised of the credentialing oversight findings on at least an annual basis. If no delegated credentialing oversight occurred in the previous year, then this is reported to the committee in lieu of findings.

Points to Remember

- This standard may be determined to be "not applicable" if the organization does not delegate credentialing functions. If that is the case, then Standards Core 6 through 9 are also not applicable.
- P-CR 17(a): Written credentialing policies and documented procedures should describe the organization's process for retaining final credentialing authority for each provider.

- P-CR 17(b) requires onsite surveys of each delegee at least every three years.
- Many organizations use the term "contractor" for a delegated entity.
- A sample audit of the delegated or contracted entity should include the audit tool used and any summary reports presented to the Credentialing Committee. This information is often kept in a "delegation binder."
- Note that the organization may be partially exempt from the delegation requirements to the extent that it delegates credentialing activities to an accredited organization.
- The delegated entity's credentialing program must meet the URAC credentialing standards.

Scope of Standards

- This standard refers to credentialing functions that are delegated to another entity.

Evidence for Meeting the Standard - Desktop Review Materials

- List of all delegated entities for credentialing, including the number of providers affiliated with each delegated entity and the date of the most recent on-site survey.
- Credentialing plan detailing the organization's delegation program. This would include an outline of the process for conducting the on-site survey from the time the on-site is scheduled to the time the result is communicated to the delegated entity or contractor.
- Delegation contract template that meets standards Core 8 and P-CR 17.
- Audit tool template used to survey delegated entities.
- Sample (1) credentialing meeting minutes (blinded for PHI) illustrating the organization's final credentialing authority for providers credentialed by delegated entities.
- Sample (1) credentialing meeting minutes (blinded for PHI) documenting the organization's decision to delegate or not to delegate to another entity.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Credentialing Committee meeting minutes for the past 3 years including all attachments that document the organization's credentialing delegation.
- Signed delegated agreements or contracts.
- Delegation binders for delegated entities containing correspondence between the organization and the delegated entity as well as documentation of any initial and ongoing oversight of the delegated entity.

- Reports from delegated entities listing the providers that they have credentialed, de-credentialed, and those no longer with the delegated entity.
- Interview with credentialing staff involved with delegated entities.

Bright Ideas

- Establish a standing agenda item for the credentialing committee to review the delegated entity activity reports.
- Establish processes to assure that the providers who have been credentialed by the delegated entity are listed in the provider data base.

Related Standards

Member Relations

P-MR 1 - Marketing Safeguards

The *organization* implements safeguards to ensure that marketing and sales activities performed by the *organization* do not misrepresent: (No Weight)

    (a) The *organization's* benefit plans; (Mandatory)

    (b) *Participating provider* availability and accessibility; (Mandatory)

    (c) Plan coverage including any exclusions and limitations; (Mandatory)

    (d) Administrative requirements; **and** (4)

    (e) *Medical management* requirements. (4)

Interpretive Information/Commentary

- The organization's marketing activities must accurately represent the services that the organization can provide.
- The organization's employees and brokers must be trained to ensure that they are accurately representing the organization's services.
- Marketing activities should be consistent with the information provided under standard P-NM 1. If the organization defines itself as providing certain services in a certain geographic area, then marketing materials should be consistent with those facts.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-MR 1(c). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There is a table following this document that contains a complete listing of the MLR standard elements for this accreditation.
- The organization should submit distinct documentation for each of the elements. Documentation supporting a finding of compliance with one element will not be presumed to support such a finding with respect to another element. Even if all elements are covered in a single training, the organization needs to indicate in the training documentation which part of the training agenda corresponds to which element.

Scope of Standards

- This standard extends to any aspect of the organization's operations that involves communication of the types of information identified in the standard to clients and consumers, regardless of the department from which the communication emanates.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures addressing marketing and sales activities.
- Training manuals, agendas, and sign-in logs for employees, broker and agent training.

- Examples of marketing brochures and other materials distributed to consumers within the past year.
- Member handbook, summary of benefits booklet, or other evidence of coverage documents.
- URL for company website links to marketing materials and plan information.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Onsite review of recent brochures, Web site links and other marketing materials. Interview of marketing staff and any other employees involved in the types of communication that are the subject of this standard to assess thoroughness of training.
- Member/customer service employees should be able to demonstrate accessibility to current and accurate information related to benefit plan administration, provider/network information, administrative requirements and medical management requirements.

Bright Ideas

- Develop a written policy and/or documented procedure for all training materials to be reviewed and approved by all related departments.
- Establish an interdepartmental team to establish a process for annual review (audit) of all marketing, communication and training materials, to include both paper and electronic marketing media.
- Review training program materials at least annually and revise the training program materials based on annual revisions to policies and procedures, changes in benefits, product offerings, etc.
- For all written marketing materials and other communication materials, create a unique identification number to track the documents. Also include in the footer the revision date as part of the unique identification number.
- Establish a data base (master list) of all marketing materials to include name of document, identification number, date created, date last reviewed and date of most recent revision.
- Maintain a master file (paper or electronic) of all communication and marketing materials.
- Establish procedures for ongoing Web site maintenance and updates.

Related Standards

P-MR 2 - Consumer and Employer Purchaser Information Disclosure

Information available to *consumers* and employer purchasers about the organization's products includes: (No Weight)

(a) Descriptions of the processes the *organization* uses to provide information and support to *consumers*: (No Weight)

(i) For whom English is not their primary language; **and** (4)

(ii) With special needs, such as cognitive or physical impairments. (4)

(b) List of providers that are in the provider network; (4)

(c) Descriptions of *participating provider* compensation arrangements. (4)

(d) Tools the *organization* makes available to assist in self-managing care; (4)

(e) *Consumer* satisfaction statistics; (4)

(f) Administrative requirements; (4)

(g) *Medical management* requirements; (4)

(h) How the health benefits program works; (4)

(i) Financial responsibilities for *consumers*, including potential out-of-pocket costs such as deductibles, co-pays, co-insurance, annual and lifetime co-insurance limits, and changes that could occur during the enrollment period; (4)

(j) Health benefits decision-making responsibilities for *consumers*; (4)

(k) Condition-specific criteria for benefits; (4)

(l) Coordination of benefits; (4)

(m) Descriptions of the processes that the organization uses to ensure compliance with regulatory health care parity requirements, including regulations pertaining to mental health and/or substance usage disorders (MHPAEA) if applicable; **and** (4)

(n) Plan coverage including any exclusions and limitations. (Mandatory)

Interpretive Information/Commentary

- In addition to providing basic information to prospective members, organizations should also provide more qualitative information to allow prospective members to make an informed choice of the organization.
- Under this standard, qualitative information must be provided to employer purchasers.

- The description required under P-MR 2(c) does not have to include specific amounts, but must describe the basic compensation arrangement. For example: "The primary care physician is paid a monthly fee (capitation). A certain portion of the fee is withheld and paid at the end of the year, adjusted based on utilization and referral patterns."

- P-MR 2(c) and (e): Upon request from consumers and prospective consumers, the organization should provide descriptions of provider compensation requirements and consumer satisfaction statistics. Organizations frequently use consumer newsletters to communicate this type of information.

- "Administrative requirements" in P-MR 2(f) refers to processes and paperwork that consumers must complete in order to access care from the organization.
- The information provided under P-MR 2(k) should provide enough information to allow a consumer to understand any benefits provisions that affect a specific health condition. For example, a prospective enrollee may wish to know whether the benefits package includes any special provisions that address coverage and exclusions for diabetes.
- P-MR 2(l) refers to coordination with other health coverage programs in which a consumer may be enrolled.
- P-MR 2(m) refers to care parity including mental health parity.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-MR-2(a)(i), PMR2(a)(ii), P-MR 2(b), P-MR 2(d), P-MR 2(e), P-MR 2(g), P-MR 2(h), P-MR 2(i), P-MR 2(j), P-MR 2(k), and P-MR 2(l). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contains a complete listing of the MLR standard elements for this accreditation.
- P-MR 2(a): The organization should identify the primary language needs of consumers and provide materials to individuals for whom English is not the primary language.
- The information for P-MR 2(a) should reflect the organization's processes to assist consumers whose needs may not be met through the organization's standard information or processes.
- Examples of ways that organizations may meet the cognitive and physical needs requirements of P-MR 2(a)(ii) include:
  - Appropriately seeking family or caretaker involvement for a consumer who may not be able to manage their own health care decision-making.
  - Providing alternative media formats for hearing and/or visually impaired consumers.
- P-MR 2(b): A paper or online provider directory is not the only mechanism for communicating the information required by this standard. Rather, employees often are called upon to respond to consumer inquiries regarding provider availability. Evidence should demonstrate that employees have received sufficient training and are guided by policies and procedures to carry out their duties under this standard.
- "Tools" for self-management in P-MR 2(d) may include interactive Web site tools, voice response tools, access to health risk appraisals, disease state information phone libraries or written educational materials.
- P-MR 2(g): Medical management requirements may include (but are not limited to) plan notification requirements, requirements for certification of hospital stays or procedures, etc.

- In P-MR 2(i), "financial responsibilities" includes (but is not limited to): what benefits are provided upon enrollment, the amount of deductible (whether per member or per family), any gaps in coverage, what services count toward exhausting the deductible, any co-pays, co-insurance the consumer is responsible for, and the out of pocket maximum.

- MR 2(j): Examples of health benefits decision-making responsibilities for consumers include (but are not limited to) decisions such as purchasing generic vs. brand-name medications, decisions regarding health care requiring out-of-pocket costs, etc.
- MR 2(l): Information on coordination of benefits includes coverage rules in instances of multiple sources of coverage.
- MR 2(m): Addresses health care parity including mental health parity. Plan coverage is key information to share with consumers and employer purchasers.
- This standard requires that the types of information specified in the standard be "available;" therefore, there is an expectation that each type of information be provided, at the very least, upon request of the consumer. A fair test of this availability would be for the reviewer, at any point in the process, to be able to call the organization's customer service line, request the information, and receive it in a timely manner.
- The information available to consumers can be provided by access to the organization's Web site; however, for those consumers who do not have Internet access, the organization should have processes in place to provide this information to consumers via other media.

Scope of Standards

- This standard applies to all of the organization's consumers and employer purchasers.
- This standard applies to all consumers with enquiries prior to and after enrollment about the types of information described in this standard.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures addressing the information available to consumers and employer purchasers.
- Member handbook, summary benefit plan or evidence of coverage document.
- Provider directory.
- URL for the company's consumer Web site.
- Examples of consumer educational/self-management tools.
- Training manuals, agendas, and sign-in logs, for trainings of employees, brokers, and agents.
- Examples of marketing brochures and other materials distributed to consumers and employer purchasers in the last year.
- Results of consumer satisfaction surveys.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Review of recent consumer education materials, produced since the submission of the application for accreditation.
- Interview senior management to assess commitment to and resources dedicated to providing information regarding providers to consumers and employer purchasers.
- Review of the organization's consumer Web site.
- Onsite review of current marketing materials.

- Calls to customer service representatives to request information covered by this standard.
- Interview marketing and customer service managers to assess:
  - Understanding of and commitment to written policies and documented procedures.
  - Adequacy of employee, agent, and broker training.

Bright Ideas

- Establish an ongoing inter rater reliability program to evaluate customer service responses. As a part of this program, the organization may conduct supervisory reviews of a percentage of taped calls (or transcribed phone scripts) to evaluate accurate and appropriate responses.
- Establish a new consumer (member) enrollee outreach program that includes a follow up call to the member to review key elements of the member handbook.
- Develop a template for health risk appraisal to be completed during the initial contact of the new enrollee outreach program to ascertain the need for health education or additional assessment/evaluation for care management programs. Based on the outcome of the health risk appraisal, establish a written policy and/or documented procedure to refer any potentially high risk members to case management, disease management and/or member education programs.
- Conduct annual training for employees specific to member benefits and communication programs.
- Evaluate consumer self-management tools on an annual basis.
- Conduct "secret shopper" calls to evaluate quality of customer support responses.
- Conduct role play scenarios for orientation of all employees who will have direct contact with consumers, (i.e., member services, utilization management, case management, disease management, claims inquiry/coordination of benefits.)
- Document and analyze consumer complaints to identify ongoing process improvements with member communication and benefits administration.

Related Standards

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P-MR 3 - Consumer Input and Surveys

The *organization* gathers information about *consumer* satisfaction with the *organization's* services by: (No Weight)

(a) Collecting experience of care ratings on a standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey; (4)

(b) Obtaining input as to whether the health care provided helped the consumer stay well or get better; **and** (4)

(c) Implementing a mechanism to solicit and respond to *consumers'* suggestions and guidance about how the *organization* can best serve its membership. (3)

Interpretive Information/Commentary

- To respond to the needs of consumers, organizations must have a mechanism to collect their feedback.
- Organizations should set a target for the percentage of consumers from whom ratings and input will be obtained and should measure the success of its performance against the established target at least annually. Performance in obtaining consumer ratings, input and suggestions must be reported no less than annually to the Quality Management Committee.
- In order to meet the intent of P-MR 3(a), organizations will need to report their results on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to URAC.
- P-MR 3(a) requires use of the Consumer Assessment of Health Plans Survey (CAHPS) survey; whereas, P-MR 3(b) requires gathering self-reported outcomes information from consumers.
- P-MR 3(c) requires methods both to solicit and respond to consumer suggestions. The response is not required to be specific to an individual consumer suggestion, but can be.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-MR 3(a)-(c). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.

- Collection of consumer input without follow up is not sufficient to meet the intent of this standard. The organization needs to demonstrate that it has a system of logging, tracking and responding to that input, either on an individual basis by addressing an individual consumer's feedback with them, or at an organizational level by implementing a policy change in response to a consumer request.

- The Consumer Assessment of Health Plans Survey (CAHPS) is available on the Agency for Health Care Research and Quality web site (http://www.ahrq.gov) URAC encourages organizations to coordinate with clients when collecting information from consumers.
  - <u>Update 12/12/2014</u>: The following question can be used to meet element (b): H1. In the last 12 months, how often did you and a doctor or other health provider talk about specific things you could do to prevent illness? (Never, Sometimes, Usually, or Always)

- Consumer communications for the purpose of gathering input and feedback may be in multiple formats, including written, telephonic, electronic and/or web-based.

- Please see Core 39 - Consumer Survey, which complements this standard [P-MR 3] as well as P-MR 4, which requires reporting of data and its analysis as part of the Quality Management program.

Scope of Standards

- This standard applies directly to consumers receiving health care services from the health plan organization.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures addressing consumer satisfaction and feedback methods, data gathering, analysis and response.
- Consumer communications plan.
- Examples of CAHPS Survey results.
- Examples of self-reported outcomes data from consumers.
- Examples of suggestions and/or feedback received from consumers.
- Examples of documentation of responses to consumer suggestions and/or feedback.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Examination of logs of consumer feedback, written and oral.
- Review of survey results and analysis of data.

Bright Ideas

- Provide results of surveys, utilization statistics and other related plan information for the consumer on the Web site or publish this information in a member newsletter.
- Provide a link to the Web site for the consumers to e-mail the plan with suggestions or feedback. Provide an electronic template to file a complaint, appeal or grievance.
- Establish a consumer advocacy group or "community council' that includes consumer participation to provide feedback and suggestions to the health plan.
- Include a section in the satisfaction survey to provide suggestions/ recommendations to the health plan.

Related Standards

P-MR 4 - Evaluation of Consumer Survey Data and Feedback

The *organization*: (No Weight)

(a) Analyzes *consumer* survey data and feedback to identify trends and opportunities for improvement; **and** (3)

(b) Reports the data collected from *consumers* to the quality management committee. (3)

Interpretive Information/Commentary

- Analysis of consumer survey data includes analysis by relevant sub-populations.
- Organizations must document that they analyzed consumer survey data and feedback for trends and opportunities for improvement and whether any trends were discovered.
- Consumer satisfaction data, a summary of self-reported outcomes data, and a summary of changes made as a result of consumer input must be reported no less than annually to the Quality Management Committee (please see the definition of "annual").

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-RM 4(a)-(b). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.
- Action should follow identification of opportunities for improvement.

Scope of Standards

- This standard applies directly to consumers receiving health care services from the health plan organization.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures addressing consumer satisfaction and feedback methods, data gathering, analysis and response.
- The most recent report to the Quality Management Committee on satisfaction data, self-reported outcomes data, and changes made as a result of consumer input.
- Corporate documents demonstrating that policy-making committees were provided with consumer input and satisfaction data, and this information was considered when making policy or determining procedures.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Review of survey results and analysis of data.
- Examination of committee minutes at which consumer satisfaction and feedback is discussed.

Bright Ideas

- Develop a process for all departments who interact with consumers to report and document consumer feedback to the QI department.
- Collect and report positive feedback as well as criticism.
- Share consumer feedback and satisfaction trends with employees using newsletters, posters, announcement boards and/or staff meetings.

Related Standards

P-MR 5 - Online Access

The communications plan provides that *consumers* have online access to: (No Weight)

(a) *Organization* information; (4)

(b) Health care information; **and** (4)

(c) Have the ability to enroll in a *health benefits plan*. (1)

Interpretive Information/Commentary

- Organizations should use the Internet as a vehicle to provide information to consumers.
- P-MR 5(a): Examples of "organization information" include contact information, provider directory, how to submit a complaint, member/enrollee rights and responsibilities.
- P-MR 5(c): It is acceptable to provide consumers the ability to enroll through an employer's site.

- Information made available to consumers must include access to information about health and health care. Such information needs may be addressed by enabling links to trusted Web sites.
- Information posted on the organization's Web site must be vetted for content currency and accuracy in accordance with Core 10(c).
- Clinical health information posted on the organization's Web site must have the input and approval of the Senior Clinical Staff Person/Medical Director or other qualified designee.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-MR 5(a)-(c). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There is a table following this document that contains a complete listing of the MLR standard elements for this accreditation.
- The purpose of this standard is to encourage organizations to communicate with consumers via the Internet. However, a word of caution is in order: Should that communication involve the collection of individually identifiable health information (IIHI) or protected health information (PHI), standards involving privacy and security of consumer information come into play including the applicable regulatory requirements for confidentiality, security and privacy (see standards Core 15- Information Confidentiality and Security, and 16- Confidentiality of Individually-Identifiable Health Information).
- Consumers should have a user ID and password to access any secure areas of the Web site. Passwords should be changed and updated according to the organization's security policies and procedures.
- Organizations may want to consider referencing URAC's Health Web Site Accreditation Program for guidelines on Web site design.

Scope of Standards

- This standard applies to the information addressed in the organization's communication plan for consumers and includes all information posted on the organization Web site.

- This standard does not include the information provided by other Web sites to which links are enabled. However, the organization is expected to review and select those Web sites with caution.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures relating to Web site design, maintenance, and oversight.
- Documentation of review and approval of clinical health content included on the Web site by the Senior Clinical Staff Person/Medical Director or qualified designee.
- Documentation of the last review of the Web site content for currency and accuracy.
- Criteria used to review and select web sites for which links are enabled for access to health and health care information.
- URL (Internet address) of the organization's Web site.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Guided "tour" of the organization's Web site.

Bright Ideas

- Provide a quick reference guide/or payroll stuffer on how to access and utilize the consumer Web site for plan information and access to member services information.
- Provide a link on the Web site for the consumer to provide changes to demographic information such as change of address information, phone numbers, etc.
- Provide the capability from the Web site to download appropriate forms and reference information (e.g., health care claims, preauthorization forms, drug formulary information, etc.)
- Members may be directed to access self-management tools and/or disease state management programs tools via the Internet.
- Review the listings of URAC-accredited Web sites offering educational health content.

Related Standards

P-MR 6 - Health Literacy Support for Consumers

The *organization* will implement written policies and/or documented procedures addressing *health literacy* that: (No Weight)

(a) Lowers to the extent practicable the cognitive effort required to use health care information; (4)

(b) Displays the information in a way that highlights information important to the *consumer*; **and** (4)

(c) Evaluates the organization's success in achieving health literacy for consumers. (Leading Indicator)

Interpretive Information/Commentary

- P-MR 6(a): Organizations can select decisions support tools, coverage, clinical or other types of information as a starting point for evaluating information that consumers need to use in terms of lowering the cognitive effort.
  - The use of pictures and plain language, as well as software programs that report on the use of jargon and suggest alternate language, are some of the approaches that can be used to meet the intent of this standard element.
- P-MR 6(b): URAC will evaluate an organization's approach for determining how to display consumer information and verify that it was implemented for at least two (2) sets of information relevant to the consumer (e.g., documents, Web site displays, health education materials, etc.).
- P-MR 6(c): This standard element requires assessing consumers' level of understanding pertinent information. The organization also needs to establish metrics by which it will evaluate progress towards consumer health literacy.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-MR 6(a)-(b). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There is a table following this document that contains a complete listing of the MLR standard elements for this accreditation.

- See the URAC definition of "plain language" and "health literacy" found in the front of this accreditation guide.

Scope of Standards

- This standard applies to policies and procedures addressing health literacy efforts in presenting important consumer-oriented health information.
- Progress in achieving health literacy among consumers participating in the health plan can be demonstrated in various ways, ranging from a systematic review and revision of consumer-oriented health information based on a selected readability index to consumer surveys designed to evaluate their understanding of, and reaction to consumer-oriented health information.

Evidence for Meeting the Standard - Desktop Review Materials

- Policies and/or documented procedures addressing health literacy efforts supporting consumers participating in the health plan.
- Two examples of consumer information materials using pictures and/or plain language to communicate health information. The organization needs to present the "before" and "after" version of the document or if purchased from a third-party vendor, share materials provided by the vendor on the health literacy level of the consumer-oriented health information.

- Screen shots of relevant pages on the organization's Web site containing important health information content supporting health literacy.
- If performed, an evaluation of progress in achievement of health literacy among consumers participating in the health plan.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Guided "tour" of the organization's Web site.
- Review of sample health information materials for consumers addressing health literacy in presentation of content.

Bright Ideas

- Federal guidelines for health literacy provide guidance on appropriate reading levels to achieve plain language. See the DHHS web site for a list of references at http://www.health.gov/communication/literacy/quickguide/resources.htm.
- Another source is the Rhode Island Project for Health Literacy which provides guidelines for written materials (http://hari.org/rihlp/?page_id=40).
- State reading level guidelines are summarized in a national survey conducted by Health Literacy Innovations published at (www.idph.state.ia.us/health_literacy/common/pdf/hli_medicaid_survey.pdf).

- Additional assistance for achieving health literacy can be found through Health Literacy Innovations (www.healthliteracyinnovation.com), including the selection of readability indices.

Related Standards

P-MR 7 - Consumer Communications Plan

The communications plan provides that at the time of enrollment, consumers are provided with materials that clearly explain: (No Weight)

(a) Instructions on how to receive assistance via e-mail, telephone, or in person; (4)

(b) The scope of covered benefits and general coverage guidelines; (Mandatory)

(c) Any obligations for *consumers* to cooperate with the *organization's* medical management programs; (4)

(d) How to access covered benefits, including: (No Weight)

(i) Requirements for prior authorization; (Mandatory)

(ii) Accessing emergency services and out-of-service-area services; (Mandatory)

(iii) Ongoing access to current drug formulary; **and** (Mandatory)

(iv) Ongoing access to an up-to-date provider directory; (Mandatory)

(e) How to access information needed for effective financial decision-making, including: (No Weight)

(i) Cost-sharing features under the benefits plan; (Mandatory)

(ii) Specific benefits and coverage exclusions; (Mandatory)

(iii) Review of authorization processes necessary for coverage; **and** (4)

(iv) Seeking care once the *consumer's* personal health account or other health benefit resources have been exhausted; (Leading Indicator)

(f) How to obtain the cost of *covered benefits*; (Leading Indicator)

(g) Information and tips to assist in interactions, such as "Financial decision-making for health care," "What questions to ask your health care provider," etc.; (4)

(h) How to obtain prevention and wellness information; (4)

(i) How to obtain *evidence-based* health information and content for common *conditions*, diagnoses, and the treatment, diagnostics and interventions; (4)

(j) Information on the importance of weighing cost/benefit information of selecting a health care treatment; **and** (4)

(k) *Complaint* and *appeals* processes available to *consumers*. (Mandatory)

Interpretive Information/Commentary

- P-MR 7 lists the specific information that the organization must convey to consumers through materials provided at enrollment. The information conveyed to consumers may vary; for example, consumers enrolled in different benefit structures would receive customized information. However, all consumers must receive the general information listed in P-MR 7.
- Access to the provider list on a Web site is generally acceptable. However, the organization must have provisions for instances when a consumer does not have Internet access. For example, periodic mailings of provider additions and terminations may compensate when computer access is an issue. Organizations must be able to print the directory when requested to do so.
- For standard element P-MR 7(d)(iv), please refer to standard P-OPS 5, which clearly defines what is meant by "up-to-date" for a provider directory.
- P-MR 7(d) does not require disclosure of the information listed elements (i) through (iv) at the time of enrollment, but does require consumer guidance on how to obtain this information.
- P-MR 7(e): As consumers may take on increased financial and decision-making responsibilities with regards to their health care, they will need to know how much their benefits cost.
- P-MR 7(i) is similar to P-MR 7(d) in that both require the provision of helpful information to consumers, empowering them to make informed and responsible choices about their health care.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-MR 7(a), P-MR 7(b), P-MR 7(c), P-MR 7(d)(i)-(iv), P-MR 7(e)(i)-(iii), P-MR 7(g), P-MR 7(h), P-MR 7(i), P-MR 7(j), and P-MR 7(k). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.
- The member handbook, summary benefits plan and/or evidence of coverage are frequently used as evidence for meeting the elements covered under this standard. Other documents and/or Web site content may add to the information in the member handbook.
- P-MR 7(e)(iv)and P-MR 7(f) are leading indicators. Leading indicators [L] are non-weighted, optional elements highlighting effective practices not yet widely adopted in health care. They may not be designated as "not applicable" since they are optional. Leading indicators are not reported to URAC's Accreditation or Executive Committees and are not considered when making an accreditation level determination. For more information, please see the scoring information included in the introductory section of this guide.

Scope of Standards

- This standard addresses all consumers who enroll with the organization and the information provided to those consumers by the organization.

Evidence for Meeting the Standard - Desktop Review Materials

- Written Communications Plan.
- Business Plan.

- Marketing Plan.
- Strategic Plan.
- Member Handbook, summary benefit plan and/or evidence of coverage documents, including general coverage guidelines.
- Member Rights and Responsibilities documents.
- Newsletters.
- Correspondence to consumers.
- Written policies and/or documented procedures addressing the organization's consumer communications plan, including ongoing access to an up-to-date provider directory.
- Written policies and/or documented procedures for providing consumer information on how to access information needed for effective financial decision-making and information on the importance of weighing cost/benefit information of selecting a health care treatment.
- Written policies and/or documented procedures for providing consumers with information and tips to assist in interactions.
- Written policies and/or documented procedures for providing consumers with information about how to obtain prevention and wellness information.
- Training manuals, agendas, and sign-in logs, for trainings of employees, brokers, and agents.
- Examples of enrollment literature and other materials distributed upon enrollment to consumers in the last year.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Onsite review of recent enrollment materials.
- Complaint and appeals logs/documentation.
- Interview marketing and customer service managers, as well as any other managers involved in the enrollment process, to assess:
  - Understanding of, and commitment to policies and procedures.
  - Adequacy of employee, agent, and broker training.

Bright Ideas

- Mail or provide a new enrollee welcome packet at the time of enrollment that contains the following:
  - Member handbook;
  - Quick reference guide summarizing benefits;
  - Quick reference guide for important phone numbers and Web sites;
  - How to access care in urgent or emergent situations;
  - How to access care when out of area;
  - Consumer rights and responsibilities;
  - Provider directory or Web site address for provider directory;
  - Information and tips to assist in interactions;
  - Claims filing information;
  - Access to information about medical management services and programs;
  - Medical management authorizations requirements and appropriate documents/forms;
  - Access to information about effective financial decision-making and on the importance of weighing cost/benefit information of selecting a health care treatment;
  - Health risk appraisals, health education/wellness/disease statement management programs, etc.; and
  - Post the customer/consumer satisfaction survey results on the website; include information such as enrollment and disenrollment statistics.

- Include important phone numbers related to accessing urgent or emergent care on the back of the member ID card.
- Provide diseases state management information/updates in the quarterly member/consumer newsletter and on the organization's Web site.
- Provide an interactive Web-based portal for members to request evidenced based health guidelines /disease state information.

Related Standards

P-MR 8 - Covered Benefit Disclosure

The communications plan provides that *consumers* are informed prior to changes in *covered benefits.* (4)

Interpretive Information/Commentary

- If a consumer's covered benefits are changed, then they must receive notice before the change goes into effect.
- For example, if co-payments are raised from $10 to $15 for primary care office visits, consumers must be notified before the new co-payments go into effect.
- In some cases, the organization may not directly notify consumers – the consumer's employer or plan sponsor may give notice. This is acceptable provided that the organization can assure that the information gets to the consumer.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-MR 8. For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.
- The written communication plan states the specific notification methods. Consumers must learn of changes in covered benefits before those changes are effective.

Scope of Standards

- This standard covers all changes in covered benefits, regardless of how those changes are communicated.

Evidence for Meeting the Standard - Desktop Review Materials

- Formal communication plan and/or written policies and documented procedures addressing consumer communications.
- Summary listing of all changes in covered benefits in the last two years, including the date of these changes.
- Sample communications (e.g., letters, newsletters, etc.) to consumers regarding changes in covered benefits within the last two years. See also standard P-MR 7(e)(i)-(ii).

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview with managers responsible for notifying consumers of benefit changes.

Bright Ideas

- Create a job title for a communications coordinator whose primary role will be to monitor any/all benefit or program changes and coordinate/manage an interdepartmental implementation team for all benefit or program changes.
- Develop internal training/in-service programs for employee benefit program changes.

- Develop Webinar training programs for brokers, client/employer group benefit administrators, providers or employees who may be in different locations.
- Use direct mailings/post cards, public service announcements, payroll stuffers, newsletters and/or website notifications to communicate upcoming changes at least thirty days prior to the implementation date.
- Develop an "opt in" list service to distribute electronic notifications of benefit program updates/changes.
- Provide pre-recorded telephone messages for consumers and clients regarding upcoming programs or benefit changes.
- Provide advance notification of benefit/program changes to participating providers who may offer information to patients in the office, clinics or facility settings.

Related Standards

P-MR 9 - Health Risk Assessment Tool

Upon enrollment, the *organization* provides *consumers* with access to a *health risk assessment tool* that: (No Weight)

(a) Collects information about the *risk factors* associated with the various *risk-types* addressed in the tools; (3)

(b) Is *evidence-based*; (3)

(c) Is reviewed by the *organization's* senior *clinical staff* person (see Core 10) or clinical oversight body; (3)

(d) Reports to the individual *consumer* an overall *health risk assessment tool* score; (Leading Indicator)

(e) Utilizes biometric screening and other screening results; **and** (Leading Indicator)

(f) Provides suggested actions to an individual *consumer* to assist the *consumer* in managing personal health. (Leading Indicator)

Interpretive Information/Commentary

- A health risk assessment tool is a critical first step in engaging and assessing risk and health status in the target population.
- A health risk assessment tool may be administered electronically (including online), in written form, or verbally. If administered verbally, the results would be captured on paper or electronically for use in analysis, reporting, and records keeping.
- A health risk assessment can be made available through the health plan organization or through an intermediary such as a vendor or employer. The organization needs to ensure that all covered consumers have access to this assessment tool.
- The assessment and questions contained within the HRAT should be based on sound peer-reviewed research and clinical evidence that is academically credible. It is not the intention of URAC to limit or constrain an organization's development of a health risk assessment tool. One tool will not be favored over another, nor will any particular research set be viewed as more relevant. Instead, it will be the responsibility of the organization to provide URAC with appropriate evidence and rationale behind their choices in using a particular strategy or research.
- The organization's senior clinical officer or a clinical oversight body must review and approve the tool prior to its distribution. This approval will ensure that the tool is clinically up-to-date, utilizes appropriate evidence-based information, and is appropriate for implementation for plan members. The clinical oversight body may be any group within the health plan organization whose charter includes clinical oversight, such as the Quality Improvement Committee, a Medical Advisory Committee or other leadership group such as an Executive Committee whose members include the Medical Director(s).
- The collection of individually identifiable health information (IIHI) or protected health information (PHI) via the HRAT, must be compliant with standards involving privacy and security of consumer information including the applicable regulatory requirements for confidentiality, security and privacy (see standards Core 15 - Information Confidentiality and Security and Core 16- Confidentiality of Individually-Identifiable Health Information).

- P-MR 9(d), (e) and (f) are leading indicators. Leading indicators [L] are non-weighted, *optional* elements highlighting effective practices not yet widely adopted in health care. They may not be designated as "not applicable" since they are optional. Leading indicators are not reported to URAC's Accreditation or Executive Committees and are not considered when making an accreditation level determination. For more information, please see the scoring information included in the introductory section of this guide.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-MR 9(a), P-MR 9(b), and P-MR 9(c). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.
- An HRA tool assists in managing risk and promoting the health and wellness of health plan members/enrollees.
- Although the type and frequency vary, health screenings, such as screenings that assess biometric readings, can provide useful and reliable quantifiable data about a particular target population. Such data can then be used to further stratify the target population into groups for disease management, case management or wellness programs.
- P-MR 9(d): LEADING Indicator - The organization demonstrates that there is a process to report the overall health risk assessment tool score to the individual member.
- P-MR 9(e): LEADING Indicator - The HRA tool may include biometric screening, self-reported data or health plan data. Documentation to meet the standard may include highlighted questions in the HRA tool to cite references to the screening results.
- P-MR 9(f): LEADING Indicator – Suggested actions may be provided to the consumer through a variety of mechanisms including electronic or web-based recommendations and information sources, referral to disease management, case management or wellness programs, and/or referral to their PCP, etc.

Scope of Standards

- This standard applies to the use of a health risk assessment tool for members/enrollees covered by the health plan's books of business included in this accreditation (e.g., commercial plans, Medicaid, etc.)

Evidence for Meeting the Standard - Desktop Review Materials

- Policy/procedure and other documentation depicting the health risk tool addressing risk types and collecting risk factor information.
- Policy/procedure addressing the evidence that the HRA tool is based on and the review and approval process.
- P-MR 9(d): *LEADING* Indicator - Sample/template report provided to individual participant.
- P-MR 9(e): *LEADING* Indicator - The biometric screening tests or other screening results captured in the HRA tool.
- P-MR 9(f): *LEADING* Indicator - Sample of suggested actions for consumers to use to manage their personal health.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Meeting minutes showing of approval of HRA tool by clinical oversight body.
- Consumer HRA participation reports.
- Participating provider and/or consumer feedback regarding the HRA, if any.

Bright Ideas

- A clinical oversight committee may include and may benefit from the participation of health care professionals and content experts such as certified health educators, respiratory therapists, nutritionists, nurses, mental *health professionals* or other specialists in addition to physician participating providers.
- Establish criteria for selection of Web-based information sources and have the clinical oversight committee review and approve them prior to making consumer referrals. Re-evaluate these sources on a regular ongoing basis to ensure their continued value and validity.
- Review the HRAT on a regular ongoing basis to ensure that it remains current and appropriate for consumers enrolled in your health plan.
- Actively solicit feedback on the HRAT from participating providers and consumers.

Related Standards

![URAC logo]

P-MR 10 - Targeted Consumer Outreach

The *organization* provides targeted communication and outreach to *consumers* as appropriate based upon demographics, health risk, claims history, or other segmentation techniques chosen by the *organization*. (Mandatory)

Interpretive Information/Commentary

- The data collection and population segmentation methods utilized are at the discretion of the organization.
- Some examples of targeted communication that would meet the intent of this standard are:
  - Advising all women above a certain age to make sure they receive a mammogram periodically;
  - Reminding consumers who have submitted claims for certain drugs about other important activities. For example, the organization might remind consumers who have submitted claims for insulin to be sure they get periodic retinal exams.
  - Reminding consumers who have submitted claims for depression treatment about the importance of follow-up.
  - Informing consumers when they are about to exhaust their financial resources (such as a health savings account).

- This standard does not require one-on-one outreach.
- Outreach communications may be made available directly by the health plan or through an intermediary such as an employer. URAC will hold the health plan accountable for assuring availability for all appropriate covered consumers.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-MR 10. For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.
- This standard requires targeted consumer support, which is needed to ultimately address health care disparities and assist in managing consumer populations.

Scope of Standards

- Population(s) as identified by the health plan for targeted outreach communications based upon demographics, health risk, claims history, or other segmentation techniques.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures that specify:
  - The methods used by the organization to identify targeted populations for outreach;
  - The manner and frequency of targeted communication; and
  - Examples of targeted communications sent to consumers (note: any information that could identify an individual consumer must be removed).

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview of staff responsible for designing and implementing consumer outreach programs.

- Documentation of outreach efforts aimed at targeted population segments, such as distribution and/or outreach effectiveness analysis reports.

- Participating provider and/or consumer feedback received, if any.

Bright Ideas

- The clinical oversight committee required by P-MR 10 can be an appropriate group for review and approval of outreach communication materials.
- Establish a cycle of regular and periodic review of outreach program materials to ensure continued value and appropriateness.
- Study changes in the population of enrollees to determine if modifications are needed in the targeted segments based on demographics, health risk, claims history, or other segmentation criteria.
- Actively solicit feedback on the outreach program materials from participating providers and consumers.

Related Standards

Quality Management

P-QM 1 - Quality Management Program

The *organization* maintains a *quality management program* that promotes objective and systematic measurement, monitoring and evaluation of services, work processes, and implements quality improvement activities based upon the outcomes. (Mandatory)

Interpretive Information/Commentary

- A viable quality management (QM) program has the requisite structures and processes in place to ensure quality services to clients and consumers.

- URAC recognizes that quality management activities will vary by organization. The standards provide flexibility for an organization to implement its own quality management program. The intent of this section is to provide the framework for a quality management program within which an organization can focus on its unique needs

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-QM1. For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.
- The QM program description addresses the needs of internal and external "customers," including the organization's various internal departments, clients and consumers.
- Organizations monitor clinical and non-clinical services as applicable to their books of business.

Scope of Standards

- P-QM 1 applies to the quality management program that oversees the program coming under accreditation.
- The QM program for a health plan should be organization-wide and not specific to a department.

Evidence for Meeting the Standard - Desktop Review Materials

- Program description and plan or written policies and/or documented procedures addressing QM oversight of the program.

- Job descriptions for staff with QM responsibilities for the program coming under accreditation. For programs with less than one FTE dedicated to QM, the job description must indicate what percentage of the person's overall responsibilities is dedicated to QM. If all program staff is responsible for quality, then their scope of responsibilities pertaining to this area needs to be made clear in the job description and QM documentation.
- Written description of the Quality Improvement Program addressing oversight, members, scope and objectives.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Committee minutes from the last two to three years (based on accreditation cycle). Initial applicants can provide minutes for meetings occurring after the submittal date for the application for accreditation, but can go further back if they want to. Minutes are reviewed to verify program implementation and should be flagged to refer to those areas identified in the onsite agenda.

- Interviews with staff responsible for QM program.

Bright Ideas

- In the annual evaluation of the quality management program, include a section that covers "evaluation of resources" that addresses issues including computer resources, internal staffing, external consultants, independent survey firms, and financial resources.

- Publish a yearly Quality Management calendar for the organization so that all personnel are aware of QM efforts and timetables.

Related Standards

P-QM 2 - Quality Management Program Resources

The *organization* employs *staff* and/or provides the resources necessary to support the day-to-day operations of the *quality management program.* (3)

Interpretive Information/Commentary

- A viable quality management (QM) program has the requisite structures and processes in place to be able to evaluate and ensure quality services to clients and consumers.
- URAC recognizes that actual quality management activities will vary by organization, and URAC wishes to provide flexibility for an organization to implement its own quality management program. The intent of this section is to provide the framework for a quality management program within which an organization can focus on its unique needs.
- This standard does not imply that a specific quality management department must be created.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-QM2. For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.
- Temporary consultants cannot fulfill the role of "QM staff" for purposes of this application for accreditation

Scope of Standards

- P-QM 2 applies to the quality management program that oversees the program coming under accreditation.
- The QM program for a health plan should be organization-wide and not specific to a department.

Evidence for Meeting the Standard - Desktop Review Materials

- Program description and plan or written policies and/or documented procedures addressing QM oversight of the program.

- Job descriptions for staff with QM responsibilities including oversight of the program. For programs with less than one FTE dedicated to QM, the job description must indicate what percentage of the person's overall responsibilities is dedicated to QM. If all program staff are responsible for quality, then their scope of responsibilities pertaining to this area needs to be made clear in the job description and QM documentation.
- Written description of the Quality Improvement Program addressing oversight, members, scope and objectives.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Committee minutes from the last two to three years (based on accreditation cycle). Initial applicants can provide minutes for meetings occurring after the submittal date for the application for accreditation, but can go further back if they want to. Minutes are reviewed to verify program implementation and should be flagged to refer to those areas identified in the onsite agenda.
- Interview(s) with staff responsible for QM activities.

Bright Ideas

- Develop a QI committee meeting template that includes standing and periodic agenda items to ensure documentation that supports meeting the intent of the standards.

Related Standards

P-QM 3 - Quality Management Program Requirements

The *organization* has a written description for its *quality management program* that: (No Weight)

(a) Is approved by the *organization's* appropriate oversight authority; (2)

(b) Defines the scope, objectives, activities, and structure of the *quality management program*; (2)

(c) Is reviewed and updated by the Quality management Committee at least *annually*; (2)

(d) Defines the roles and responsibilities of the Quality Management Committee; (2)

(e) Designates a member of senior management with the authority and responsibility for the overall operation of the *quality management program* and who serves on the Quality Management Committee; (3)

(f) Describes how the *organization* measures, analyzes, and improves its performance through the use of data; **and** (3)

(g) Requires performance reporting, including reporting on performance measures from any source, from delegated entities that is reviewed by the *organization's* Quality Management Committee as part of the oversight for these entities. (3)

Interpretive Information/Commentary

- A well-articulated quality management (QM) program, approved by organizational leadership, helps to assure ongoing support for the program.
- The appropriate oversight authority may be the board of directors, or an executive committee that may include board members and that has the authority to make decisions and allocate resources for the QM program. For smaller organizations not governed by a board or committee, company leadership would then approve QM program documents.
- In any case, the oversight authority may delegate responsibility for approving the quality management plan to another group within the organization. URAC will look for documentation of this delegation.
- There are numerous strategies for implementing quality within the organization. For instance, resources allocated do not have to be a single person designated with responsibility for the QM program. This responsibility may be dispersed throughout the organization as evidenced through job descriptions, the quality management program description, meeting minutes and quality improvement project documentation.
- Standard P-QM 3 is not intended to imply that a specific quality management department be created, rather that quality management is integrated into organizational processes.
- If a delegated entity is URAC-accredited under a product that includes measures, then the delegated entity will share performance measure reporting results (i.e., numerator, denominator and percentage) with the organization.
- Delegated entities for organizations (i.e., health plans) include Pharmacy Benefit Management (PBM) and Drug Therapy Management (DTM) companies, as well as those performing services such as Specialty Pharmacy, Case Management, Disease Management, etc.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-QM 3(e). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There is a table following this document that contains a complete listing of the MLR standard elements for this accreditation.
- P-QM 3 (a) and (c): There are various ways to show approval of the QM program description, plan, or written policies and/or documented procedures:
  - Individually signed/dated.
  - A signed/dated list showing approval of these documents (see Core 3).
  - Signed/dated meeting minutes documenting formal approval.

- P-QM 3(a): The "oversight authority" is often the board of directors, or an executive committee that often includes board members. For smaller organizations not governed by a board or committee, company leadership would then approve QM program documents. Include in the quality management program the definition of the organization's oversight authority.
- P-QM 3(b): The QM Program should include performance measures for ongoing monitoring and evaluation of services and process improvement.
- Standard P-QM 3 applies to delegated contractors (business entities, not contracted individuals) including those that handle time-sensitive consumer clinical information or that provide clinical care to consumers. This standard promotes the exchange of performance reporting information between accredited organizations and their delegated entities.
  - If a delegated entity is URAC-accredited under a product that includes measures, then the delegated entity will share performance measure reporting results (i.e., numerator, denominator and percentage) with the organization.
  - Delegated entities for organizations (i.e., health plans) include Pharmacy Benefit Management (PBM) and Drug Therapy Management (DTM) companies, as well as those performing services such as Specialty Pharmacy, Case Management, Disease Management, etc.

Scope of Standards

- P-QM 3 applies to the quality management program that oversees the program coming under accreditation. The program may be contained within the program department or it may be organization-wide.

Evidence for Meeting the Standard - Desktop Review Materials

- Program description and plan or written policies and/or documented procedures addressing QM oversight of the program and all elements of the standard.
- One sample performance report from each delegated entity, if applicable.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Committee minutes from the last two to three years (based on accreditation cycle). Initial applicants can provide minutes for meetings occurring after the submittal date for the application for accreditation, but can go further back if they want to. Minutes are reviewed to verify program implementation and should be flagged to refer to those areas identified in the onsite agenda.
- Interview with program management to discuss the structure of the QM program as it effects the organization's program.

Bright Ideas

- Many organizations use the following format to establish program documentation: (1) program description– focuses on the program structure, including staff, committee, and board, and relevant accountabilities, (2) annual program plan – often a table that includes dates for special projects as well as recurring activities, and (3) annual program evaluation – where the framework for establishing next year's goals is documented.
- In the annual evaluation of the quality management program, include a section that covers "evaluation of resources" that addresses program resources.
- Include the annual review of the QI program or work plan as an agenda item for departmental staff meetings.
- Obtain ideas or input from departmental staff for quality improvement projects to be presented to the QIC as part of the quality management program.

Related Standards

P-QM 4 - Quality Management Committee

The *organization* has a quality management committee that: (No Weight)

    (a) Is granted authority for quality management by the *organization's* oversight authority; (3)

    (b) Provides ongoing reporting to the *organization's* oversight authority; (3)

    (c) Meets at least quarterly; (3)

    (d) Maintains approved records of all committee meetings; (2)

    (e) If applicable, includes at least on *participating provider* or receives input from *participating providers*; (4)

    (f) Provides guidance to *staff* on quality management priorities and projects; (3)

    (g) Approves the *quality improvement projects* to undertake; (3)

    (h) Monitors progress in meeting quality improvement goals; **and** (3)

    (i) Evaluates the effectiveness of the *quality management program* at least *annually*. (3)

Interpretive Information/Commentary

- The committee specified in these standards may be named something other than "quality management committee" as long as it meets the requirements of the standard.
- For discussion on the term "oversight authority," please refer to P-QM 3.
- P-QM 4(b): In order to meet this standard element, the quality management committee must report to the organization's oversight authority at least once a year.
- The intent of QM 4(c) is for the organization to routinely hold at least four (4) meetings consistently throughout a year. Sometimes meetings must be rescheduled or scheduled around certain dates for various reasons, so if one or two of the meetings are a week or two closer or further apart from the others, then this will still meet the intent of the standard.
- P-QM 4(d): "Record of all committee meetings" should include reports, decisions, action items, meeting minutes, and attendees.
- P-QM 4(d): Organizations may demonstrate that records and minutes are approved through signatures by a competent authority (such as a committee chairman).
- P-QM 4(d): During the accreditation review, URAC will focus on committee minutes and records from the previous three years. URAC recommends that organizations consult the regulatory compliance staff for state or federal time frames for retention of records.
- P-QM 4(e) may not apply to all organizations, but does apply to organizations that maintain a network of participating providers, such as health plans.
- With respect to P-QM 4(f) and (g), URAC expects the quality management committee to focus on projects that relate to key processes and performance measures, including those related to the functions covered by the accreditation.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-QM 4(a), (b), (c), (e), (f), (g), (h), and (i). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There is a table following this document that contains a complete listing of the MLR standard elements for this accreditation.
- For QI projects initiated within the program department, the relevant "quality management" committee may be composed of at least two individuals that come from within the department. If there are additional levels of committees, then projects originating within the program department may then be reported up through the organization's committee structure as applicable.
- P-QM 4(d): The QIC meeting minutes should reflect approval of previous meeting minutes and records by the committee.
- P-QM 4(f)-(h) must be addressed in meeting minutes or a QI project description form that includes a chronological listing of events that includes committee input. One way to ensure that committee input is documented is to make "QI projects and goals" a standing agenda item that shows up periodically (i.e., quarterly) on the agenda.
- In order to meet P-QM 4(i), an annual QM program evaluation may be submitted as evidence for meeting the standard. Otherwise, QM committee minutes may be used to document program evaluation.

Scope of Standards

- P-QM 4 applies to a committee that oversees the organization's QM program.
- Should be organization-wide and not contained in a single department.

Evidence for Meeting the Standard - Desktop Review Materials

- Program description and plan or written policies and/or documented procedures addressing QM oversight of the program.
- QM program evaluation or sample meeting minutes reflecting evaluation of program effectiveness.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Committee minutes from the last two to three years (based on accreditation cycle). Initial applicants can provide minutes for meetings occurring after the submittal date for the application for accreditation, but can go further back if they want to. Minutes are reviewed to verify program implementation and should be flagged to refer to those areas identified in the onsite agenda.
- QM committee minutes/agenda/attendance roster (include name, credentials, and affiliation) that demonstrates committee discussion, guidance, and approval of quality improvement projects, and progress toward quality improvement goals, and effectiveness of the overall QM program.
- Most recent QM program evaluation or sample meeting minutes will be reviewed to verify evaluation of QM program effectiveness.

Bright Ideas

- Construct a 5 year strategic analysis and quality management plan to assist in year to year goal setting with an eye to corporate mission, growth and other long-term strategic planning initiatives. Development of a five year, long term strategic quality management plan also ensures oversight authority (Board of Directors) involvement and oversight.
- Establish a meeting calendar for the year and distribute the meeting dates and time for the year to committee participants.

Related Standards

P-QM 5 - Quality Improvement Process

The *organization*, as part of its *quality management program*, provides written documentation of targeted quality improvement activities initiated in response to analysis of measured performance outcomes that include: (No Weight)

(a) Measurement of process, satisfaction or outcome trend performed using valid and accurate measurement methods; (Mandatory)

(b) Analysis of process, satisfaction or outcome trend that is directly related and relevant to quality of services realized by the consumer; (Mandatory)

(c) The implementation of action plans to improve or correct identified problems or meet acceptable levels of performance on measures; (Mandatory)

(d) The mechanisms to communicate to relevant *staff*: (No Weight)

    (i) The results of such activities; **and** (3)

    (ii) The sharing and integration of best practices; (3)

(e) The mechanism to communicate the results of such activities to the quality management committee; **and** (3)

(f) Once an acceptable level of performance is met (as defined by the *organization*), periodically re-measure level of performance to ensure sustained improvement. (3)

Interpretive Information/Commentary

- Successful quality management programs communicate activities to staff and organizational leadership.
- In order to proactively manage problems, organizations need to track and trend data related to consumer and client services.
- The intent of this standard is integral to the organization understanding the quality management process and the monitoring of compliance with the URAC Standards for which the organization is accredited. This standard provides guidance to the organization on how to establish performance measures on activities within the program, the monitoring of these measures, and efforts to improve when these measures are not met.
- URAC will focus on an organization's ability to demonstrate efforts to improve services when performance goals are not met. Organizations can still meet the intent of this standard even when measures are not met as long as they can show that they are taking action to improve. The process is as follows:
  - Identify performance measures for the program's operations;
  - Track and trend performance against these measures; and
  - If performance measures are not met, then develop an action plan to meet them.

- For example: A new client requires that the program's telephone abandonment rate must average 5% or less per month and the organization meets this goal from July through December 2007. In January 2008, the organization accepts several new clients and the abandonment rate climbs to an average of 10% in January and February. The organization develops an action plan to address the abandonment rate that includes hiring new staff and the abandonment rate decreases to an average of 5% by April 2008.
- The organization may decide to develop a QIP based on this process.
- For standard element QM 5(c), organizations are encouraged to employ current quality management practices when developing their performance improvement plan (e.g., LEAN, six sigma, ISO, Kaizen, Juran, Deming, Shewhart, Feigenbaum, and Donabedian, etc.)

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-QM 5(a), (b), (c). (d)(i), (d)(ii), (e), and (f). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.
- The Patient Protection and Affordable Care Act 2010 (PPACA), Section 1311(g)(1)-(3) requires periodic reporting on a health plan's implementation of strategies to address areas of focus for quality improvement (QI). Please reference URAC's Health Plan measures related to some of these areas (e.g., Measures HP-5, HP-6, HP-7, HP-8 & HP-9). Note: The Health Plan measures are found at the end of this publication.
- Some of the areas identified for quality improvement in the PPACA include those covered by the broad categories of the Medical Loss Ratio (MLR) quality improvement (QI) activities (columns 1-5), among others:
    - Improve health outcomes;
    - Prevent hospital readmissions;
    - Improve patient safety and reduce medical errors;
    - Sustain or improve the general health of health plan membership through the implementation of wellness and health promotion activies;
    - Use health information technology (HIT) for health care quality improvement; and
    - Reduce health and health care disparities.
- P-QM 5(a): Performance measures may include, but are not limited to compliance with URAC Standards, access to services, complaints, and client and consumer satisfaction with program services.
- P-QM 5(b): If ongoing monitoring and measurement reveals that there is a problem, then the organization should take actions to correct it (P-QM 5(c)).
- P-QM 5(c): Examples of the types of problems that might be identified include: A staff member generates duplicate cases within the information system, causing confusion related to the status of various cases. Other examples would be the need to improve telephone access and abandonment rates, or satisfaction rates falling below established performance measures.
- For standard element QM 5(c), organizations are encouraged to employ current quality management practices when developing their performance improvement plan (e.g., LEAN, six sigma, ISO, Kaizen, Juran, Deming, Shewhart, Feigenbaum, and Donabedian, etc.)
- P-QM 5(d) and (e): Reports should include quantifiable baseline measures and re-measures at least annually.

Scope of Standards

- P-QM 5 applies to the quality management program that oversees the organization's program coming under accreditation.
- Should be organization-wide and not contained in a single department.
- Documentation of monitoring and evaluation must include the activities of the requisite program department or operational units.
- Identification and analysis of performance measures (i.e., key indicators) must include those related to the program coming under accreditation and address issues related to both clients and consumers as appropriate.

Evidence for Meeting the Standard - Desktop Review Materials

- Program description and plan or written policies and/or documented procedures addressing QM oversight of the organization's program that describes the mechanisms used to identify and track/trend performance measures, as well as the means used to communicate with staff and management.
- Summary reports (1-2) summarizing the identification and tracking/trending of program performance data within the scope of the accreditation (please send written summary analyzing the data rather than data printouts). Reports should include quantifiable baseline measures, and re-measures (at least annually.)
- Sample action plan (1) related to the program within the past two to three years (based on accreditation cycle or, for initial applicants, minutes from the date of the application for accreditation), reviewed to verify program implementation and flagged for easy reference. Refer to onsite agenda for areas to be flagged.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Summary reports demonstrating ongoing monitoring and tracking/trending of data (related to performance measures) and printouts of the data analyzed for the reports: these may or may not be the same reports submitted with the desktop review materials.
- Recent samples (within the past two to three years) of mechanisms communicating the outcome of action plans with program staff and management, which may include meeting minutes, email, newsletters, etc.
- Interview program management staff related to QM activities.

Bright Ideas

- Include as a standing agenda item for the QI Committee meetings, reports regarding the identified performance measures, and selected program metrics.

- Create a "Quality Newsletter" to communicate with staff about the QM program, QI projects, and customer satisfaction.

Related Standards

P-QM 6 - Selection and Prioritization of Quality Improvement Projects

The *organization* implements *criteria* to guide in the selection and prioritization of *quality improvement projects*, resulting in activities designed to: (No Weight)

(a) Support the overall quality management strategy approved by clinical leadership; (3)

(b) Generate a measurable impact, which includes attaining measure performance levels; **and** (3)

(c) Provide improvement on *consumer* health outcomes or internal work processes based on various factors (e.g., number of *consumers* affected, reduced morbidity, and improved health outcomes with or without cost savings, etc.) (3)

Interpretive Information/Commentary

- This standard promotes the primary principles used to guide the selection and prioritization of quality improvement activities.
- Selection of quality improvement projects in which to invest the organization's resources should include consideration of the potential for achievement of a significant improvement.
- Selection criteria for performance improvement projects should include important criteria consistent with the overall quality management strategy approved by clinical leadership such as number of consumers affected, reduced morbidity, and/or potential impact on health outcomes. These criteria should be spelled out in policies and procedures or other documents, such as the Quality Improvement Plan.
- Organizations should strive to actually attain the performance levels established in improvement projects.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-QM 6(b) and (c). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.
- Examples of criteria selection for quality improvement projects include degree (high/ low) and nature (positive/ negative) of consumer impact, financial considerations, ease of execution, likelihood of success, etc. Project selection entails giving priority to high impact/ low effort projects over other potential projects.

Scope of Standards

- P-QM 6 applies to the quality management program that oversees the program coming under accreditation.
- Should be organization-wide and not contained in a single department.

Evidence for Meeting the Standard - Desktop Review Materials

- Quality management program description and plan or written policies and/or documented procedures that show evidence of quality improvement selection criteria.
- Minutes or other documentation showing approval of quality management strategies by clinical leadership.
- QI Project descriptions, including rationale for selection.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Documentation of QIP performance improvement results.
- QI staff presentation providing an update on the QIPs.
- Interview with management to discuss the QIPs.

Bright Ideas

- Establish a "quality improvement project form" that addresses URAC standards' requirements and other information needed by the organization in order to manage each project. Include the rationale for selection stating which of your approved criteria it meets. Estimate the impact to be achieved when the stated performance level is attained. On an ongoing basis, chronologically append the document with significant activities related to the project, such as:
  ○ Progress toward stated goal performance level;
  ○ Analysis of insufficient progress;
  ○ Identification of interventions planned to reach the stated goal performance level.

- When approving QIPS, include in the QI Committee meeting minutes discussion of each QIP, its rationale for selection, resources or degree of effort needed, and estimate of impact.
- On an ongoing basis, include in the QI Committee meeting minutes discussion of progress being made toward target performance level(s), planned interventions, and time frames for achievement of significant results.

Related Standards

P-QM 7 - Three (3) Clinical Quality Improvement Projects for Health Plans

The *organization* establishes *quality improvement projects* that address opportunities for *error* reduction or performance improvement related to the services covered by the accreditation, whereby: (No Weight)

(a) At any given time, the *organization* is underway (i.e., implementation has started) with no less than three (3) *quality improvement projects*; (Mandatory)

(b) All three (3) *quality improvement projects* must focus on clinical quality; **and** (Mandatory)

(c) At least one (1) of the three (3) clinical *quality improvement projects* must address consumer safety for the population served. (Mandatory)

Interpretive Information/Commentary

- This standard addresses elements of health care reform (e.g. PPACA and MLR).
- P-QM 7 requires the applicant health plan organization to maintain at least three quality improvement projects (QIP) per accreditation program.
- A single QIP can be submitted for two accreditations if it addresses the functions covered by both accreditations.
- Quality improvement projects (QIP) promote continuous quality improvement, supporting organizational efforts to maintain and refine consumer and client services.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-QM 7(a), (b) and (c). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.
- The following resources may be helpful in identifying patient safety/error reduction quality improvement projects:
    - The Leapfrog Group, www.leapfroggroup.org
    - Agency for Healthcare Research and Quality, www.ahrq.gov
    - Pennsylvania Patient Safety Reporting System, (PA-PSRS), www.psa.state.pa.us
    - Institute of Medicine (www.iom.edu)
    - National Patient Safety Foundation (NPSF) (www.npsf.org)
    - NQF – National Quality Forum (www.qualityforum.org)
    - NTOCC – National Transitions of Care Coalition (www.ntocc.org)
    - Talking quality.gov

- Note: In order for a quality management project to count as one of the three projects required by the standards, the organization must show that it has started to implement the improvement strategy at least by the time of the onsite review. If the project was completed within the past twelve months – back from the date that URAC receives the organization's application for accreditation or reaccreditation – then the project will count towards one of the required three.

- Organizations may have several improvement projects in progress at any given time. The intent of this standard is for organizations to submit three projects to URAC that meet all elements of standards P-QM 5, 6, 8 and 9.

Scope of Standards

- Health Plan QIPs must focus on clinical improvements and the documentation for those projects must include the elements in P-QM 8 and 9.
- At least one QIP must address a consumer safety issue per P-QM 7(c).

Evidence for Meeting the Standard - Desktop Review Materials

- Quality management program description and plan or written policies and/or documented procedures that describe the mechanisms for conducting quality improvements projects.
- QI project descriptions for three (3) different projects related to the organization's program under accreditation. If more than 3 QIPs are submitted, then applicant organizations must identify the 3 projects that are the focus of the review.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Documentation of QIP performance improvement interventions.
- QI staff presentation providing an update on the QIPs.
- Interview with management to discuss the QIPs.

Bright Ideas

- Establish a "quality improvement project form" that addresses URAC standards' requirements and other information needed by the organization in order to manage each project. On an ongoing basis, chronologically append the document with significant activities related to the project, such as:
    - Document when implementation of improvement strategies was started;
    - Summarize and comment on periodic progress measurements and cross-reference with committee meeting minutes that show when these measurements were presented and discussed;
    - Record changes in implementation strategy and briefly describe why they were changed;
    - Note the project end date;
    - Address whether or not the organization chooses to periodically measure performance after project completion, etc.

- Using this form in this way, new staff members, committee members, and board members can quickly be brought up to date on the scope and progress of each of the organization's improvement projects. In addition, the quality improvement project form will provide a complete history of each project, past and present.

- Utilize satisfaction survey results, outcome results, accessibility surveys and other operational reports to identify opportunities for quality improvement projects.

Related Standards

P-QM 8 - Data Management

The *organization*: (No Weight)

(a) Selects, collects, analyzes, and ensures data integrity prior to integrating data that is used to manage key work processes; **and** (3)

(b) Benchmarks own performance against: (No Weight)

(i) The *organization's* own performance; (3)

(ii) Customer data; **and** (3)

(iii) Comparative data. (Leading Indicator)

Interpretive Information/Commentary

- Data management is a key component of a quality management program.
- Selection of data to collect and data collection methods should include consideration of validity. See the definition of "statistically valid."
- Sample sizes should be sufficient to draw valid conclusions.
- Data collection and analysis methodologies should be consistent over time. Adjustments should be documented and explained.
- P-QM 8 allows for benchmarking an organization's performance against its own performance (i.e., baseline), comparative data (when available) and customer data.
- Data integrity is a defined term meaning "The quality or condition of being accurate, complete and valid, and not altered or destroyed in an unauthorized manner".
- Benchmarks should be used to set goals and target performance levels.
- Ongoing measurements should be compared to selected benchmarks.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-QM 8(a), (b)(i) and (b)(ii). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.

- Examples of methods to provide for data integrity include (but are not limited to):
  - Monitoring data entry personnel for accuracy;
  - Cross-checking databases for consistency;
  - Using unique identifiers for consumer data; and
  - Prevention of and checking for duplicate entries.

- P-MR 8(b)(iii) is a leading indicator. Leading indicators [L] are non-weighted, *optional* elements highlighting effective practices not yet widely adopted in health care. They may not be designated as "not applicable" since they are optional. Leading indicators are not reported to URAC's Accreditation or Executive Committees and are not considered when making an accreditation level determination. For more information, please see the scoring information included in the introductory section of this guide.

Scope of Standards

- P-QM 8 applies to all data collection required by URAC standards, including access, satisfaction and complaints, key work processes, and other performance data collected for quality management.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures that describe how the health plan selects, collects and analyzes data.
- Written policies and/or documented procedures that describe how the health plan ensures data integrity.
- Three sample data reports with evidence of benchmarking.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Staff presentation of data management methods used in quality management.
- Staff interview discussion regarding integrating data that is used to manage key work processes (KWP).

Bright Ideas

- Use a 2-year history rolling analysis of internal performance data as a benchmark.
- Establish sample size criteria based on the size of the potential sample size if 100% were included.
- Consider using Access databases and/or Excel spreadsheets for data analysis.

Related Standards

P-QM 9 - Quality Improvement Project Requirements

For each *quality improvement project*, the *organization* will: (No Weight)

(a) Establish measurable goals for quality improvement; (3)

(b) Design and implement strategies to improve performance; (3)

(c) Establish projected time frames and specific interventions for meeting goals for quality improvement; (3)

(d) Use leading indicators to evaluate the level of performance improvement throughout the projected time frame for meeting quality improvement goals; (3)

(e) Document changes or improvements relative to the baseline measurement; (3)

(f) Conduct an analysis if the performance goals are not met; (3)

(g) Once an acceptable level of performance is met (as defined by the organization), periodically re-measure level of performance to ensure sustained improvement; **and** (3)

(h) Use performance review findings along with comparative and competitive data (where available) to project future performance and drive innovation. (1)

Interpretive Information/Commentary

- Measurable goals and outcomes are essential to verify improvement. Health plans must strive to attain significant improvements.
- Measures for quality improvement projects will vary by the type of project, but must comply with P-QM 9.
- Improvement strategies will vary by the type of project. The strategy should have a reasonable expectation of producing the desired improvement.
- Incremental performance measurement periods are defined by the organization based on projected time frames for achievement of goals.
- Documentation of QIPs should include the following either on a QIP form or in the quality management meeting minutes:
  - Project approval date(s);
  - Project start date;
  - Identified quantifiable baseline measure(s) for the indicator and relevance to the consumers served;
  - Evaluation of project significance and estimated impact.
  - Quantifiable goals associated with the measure;
  - Improvement strategies and dates these were implemented;
  - Periodic progress measurements and documented discussions;
  - Any changes in improvement strategy and brief description of changes; and
  - Project end date.

- URAC recognizes HEDIS® studies as meeting the intent of URAC's Quality Management (QM) standards requiring Quality Improvement Projects (QIPs). The Healthcare Effectiveness Data and Information Set (HEDIS)® is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans.
- Health plan quality improvement projects must be clinical.
- Note: In order for a quality management project to count as one of the three projects required by the standards, the organization must show that it has started to implement the improvement strategy at least by the time of the onsite review. If the project was completed within the past twelve months – back from the date that URAC receives the organization's application for accreditation or reaccreditation – then the project may count towards the two that are required.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-QM 9(a), (b), (c), (d), (e) and (f). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.
- P-QM 9(a): Measurable means numerical measurements.
- In P-QM 9(b), 'strategies' refer to interventions used to impact the desired changes.
- For P-QM 9(c), each QIP must include established time frames for meeting quality improvement goals. The designation of "ongoing" does not qualify as a projected time frame; it must be a specific date.
- P-QM 9(d): As part of addressing defects in order to improve performance, organizations will develop strategies and implement the resulting interventions based on root cause analysis activities.
- As referenced in P-QM 9(a) and (e), each QIP must contain quantifiable/measurable outcomes relative to the baseline measurement.
- Baseline measures required in P-QM 9(e) can be used as a starting point for defining quality improvement goals.
- P-QM 9(f) requires that organizations document an analysis of any barriers affecting the progress of the QIP.
- Baseline and goal measures must be in the same unit of measure (i.e., percentages, ratios, or whole numbers).
- Refer to the "Quality Improvement Project Description Form" provided with the application materials for a sample that you can use and modify as needed. You may also use your own project form, just be sure that it addresses the elements in P-QM 9.

Scope of Standards

- Health plan QIPs must focus on clinical improvements and the documentation for those projects must include the elements in P-QM 8 and 9.
- At least one QIP must address a consumer safety issue.

Evidence for Meeting the Standard - Desktop Review Materials

- Three QI project descriptions coming under the scope of the accreditation. Label where P-QM 9(a)-(f) elements are identified.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Documentation of QIP performance improvement interventions.
- QI staff presentation providing an update on the QIPs.
- QI meeting minutes reflecting monitoring of the QIPs.
- Interview with program management to discuss QIPs.

Bright Ideas

- Pre-populate quality management meeting agendas for the next year with project reporting. Document the committee's comments on project progress and any recommended changes in project implementation in committee meeting minutes. Be sure to record the rationale behind any recommendations.
- Survey the staff to identify any patient safety issue/s that the staff sees as a priority.
- Display QI project information and progress in a highly visible place for all disease management staff to follow. Include staff in discussions of barrier analysis.
- Develop a power point presentation that addresses all of the requirements of P-QM 6-9 to present at the onsite visit and other meetings focused on quality initiatives.

Related Standards

Health Plan Operations

P-OPS 1 - General Telephone Access to Customer Service

The communications plan provides that consumers have access to the *organization* by toll-free access, including TTY, at least 40 hour/week and at a minimum from 9:00 a.m. to 4:00 p.m. each business day in each time zone that includes a portion of the geographic area served by the *organization*. (4)

Interpretive Information/Commentary

- Organizations must have a mechanism to respond telephonically to questions from consumers during normal business hours.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-OPS 1. For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.
- TTY stands for "Text Telephone" and is also sometimes called a TDD or "Telecommunication Device for the Deaf."

- Organizations with service areas that span more than one or two time zones may find that their hours of service easily exceed 40 per week. Assure that the time zones of the service areas are included in the phone coverage schedule.
- The URAC reviewer will look for evidence that the establishment and maintenance of this toll-free line is explicitly described in the written communications plan.

Scope of Standards

- This standard applies to every time zone in which the organization operates as delineated in the documentation submitted for P-NM 1 identifying the scope of the organization's services.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures addressing general telephone access to the organization by the consumer.
- Toll-free telephone number(s), including information as to which region to which they apply, if access to such numbers is limited.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview customer service management team to assess training and management of customer service representatives.
- Calls to toll-free number within times required by this standard to assess availability requirement.

Bright Ideas

- Provide a quick reference guide for obtaining after-hours /emergency services in the new member enrollee information packet.
- Include important phone numbers on the back of the member identification card. Provide access to other types of quick reference guides for phone numbers (e.g., develop a pocket/wallet quick reference guide or "refrigerator magnet" for important phone numbers such as after-hours call centers, medical management, customer services, etc.)
- If using a phone message center, include the information about hours of operation and how to access the after-hours call center as one of the first prompt options.
- Evaluate the utilization of automated call management systems that provide information regarding phone accessibility.
- As part of the new group implementation plan, include an evaluation of the demographics of the new membership to assure phone coverage for all time zones.
- Conduct quality checks of toll-free phone lines to evaluate phone accessibility during business hours and after-hours.

Related Standards

P-OPS 2 - Urgent Telephone Access to Customer Service

Access to services (required under Core 34) provides that *consumers* and their *treating providers* have 24 hour a day, 7 day a week access to an *organization* representative by toll-free telephone for urgent health care issues. (4)

Interpretive Information/Commentary

- The organization representative can be the primary care physician. In addition to telephone access during business hours, organizations must also have the ability to respond to after-hours calls regarding urgent health care issues.
- The organization may provide this access directly, or it may delegate after-hours telephone coverage. If the organization does delegate after-hours phone coverage, the delegate must have the authority to act as a representative of the organization. In other words, the information given by the delegate must be upheld by the organization.
- For example, if the after-hours phone representative instructs a consumer to seek emergency care from the closest health care facility, the organization may not retrospectively deny benefits because the consumer failed to seek care at a participating facility.
- Some organizations choose to play a recording after hours to direct its consumers to the appropriate health service.
- If the after-hours message indicates calling the primary care physician, then this standard has been met.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-OPS 2. For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.
- The communications plan describes the mechanism by which members can access the health plan for assistance after hours.
- The communications plan should describe the mechanism that the health plan has actually implemented.

Scope of Standards

- This standard applies to all health benefit plans included within the scope of the organization's application for accreditation.
- This standard applies to all consumers who may need to access the health plan for care at any hour of the day.

Evidence for Meeting the Standard - Desktop Review Materials

- Toll-free telephone number the health plan uses for after-hours phone coverage.
- Communications plan describing urgent telephone access for the consumer.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview managers in charge of implementing this aspect of the communications plan.
- Testing of the system by calling during off-hour periods.

Bright Ideas

- If utilizing an automated phone call messaging system for after-hours calls, have the initial message prompt to call to the urgent phone line or access emergency services such as "911" for immediate access.
- Establish an after-hours toll free number that is a dedicated line for provider inquiries and care coordination.
- Conduct a follow up call regarding access and satisfaction regarding after hours urgent care. If utilizing a delegated entity for management of an after-hours call center, review after hours call center line utilization.
- Routinely conduct QI testing by conducting after hours calls to assure the call messaging systems provide information regarding access to care after hours. Contact primary care provider offices after hours to verify members are receiving appropriate information regarding how to access care after business hours.

Related Standards

P-OPS 3 - One-on-One Customer Service

The *organization* maintains adequate resources and processes so that: (No Weight)

(a) *Consumers* have reasonable access to one-on-one support (e.g., telephonic, e-mail, online chat, etc.); **and** (4)

(b) Customer service representatives have access to records of *consumers'* previous interactions with the *organization* when providing one-on-one support. (2)

Interpretive Information/Commentary

- In assessing this standard, URAC reviewers will look for a process by which the organization defines access standards and measures performance against those standards.
- P-OPS 3(b): "One-on-one" means that at some point during contact with the organization, the consumer can reach a live person either through an online system or telephonically.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-OPS 3(a) and (b). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There is a table following this document that contains a complete listing of the MLR standard elements for this accreditation.
- P-OPS 3(a): Organizations with service areas that span more than one or two time zones must periodically evaluate staffing to provide adequate access to one-to-one support by telephone or email.
- P-OPS 3(b): All employees providing consumer/customer services should have detailed training programs regarding benefits plans, operations and phone/customer service training. The training should include training on all information systems used to access the consumer information needed to field customer service calls.

Scope of Standards

- This standard applies to all health benefit plans included within the scope of the organization's application for accreditation.
- This standard applies to consumers post-enrollment.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures for providing consumers access to one-on-one support.
- A description of the systems in place that allow customer service representatives to access consumer information, including records of previous interactions between the organization and the consumer.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview customer relations staff.

- Review of complaint logs.
- Observe interactions between consumers and customer relations representatives.

Bright Ideas

- Review telephone reports on a daily, weekly or monthly basis for accessibility to include average wait times, abandonment rates, average speed of answer, average length of calls, and area codes of incoming calls.
- Review the call volume reports and abandonment rates by day and the number received each hour during the day.

Related Standards

P-OPS 4 - Scope of Customer Service

At a minimum, customer service available under P-OPS 1-3 includes: (No Weight)

(a) Answers to questions regarding benefits verification and eligibility; (4)

(b) Assistance with selecting *participating providers*; (4)

(c) Answers to *claims questions*; **and** (2)

(d) Acceptance of *complaints* (see standard Core 35). (Mandatory)

Interpretive Information/Commentary

- In order to meet the intent of P-OPS 4, the organization needs to provide documentation of consumer requests and a record of the resolutions for those requests.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-OPS 4(a), (b), (c), and (d). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.

- To provide the best documentation for this standard, organizations will need to secure:
  - A comprehensive log of all consumer calls
  - For each call, a record of the type of call or call category (as described in the standard)
  - Documentation of the resolution to the consumer call

- The communication plan should describe the scope of the activities/services provided by the customer services department.

- Complaints should be documented even if the customer/member services representatives are able to resolve the complaint during the call.

- All employees providing consumer/customer services should have detailed training programs regarding the plans programs, benefit plans, plan operations and phone/customer service training.

Scope of Standards

- This standard applies to all health benefit plans included within the scope of the organization's application for accreditation.
- This standard covers all consumer calls taken by the toll-free line described in the standard.

Evidence for Meeting the Standard - Desktop Review Materials

- Communications plan.

- Toll-free number.
- Written policies and/or documented procedures.
- Training records for customer service representatives, including training agenda and attendance logs.
- Sample from log of consumer calls, showing the categories of calls described by this standard.
- Samples of types of written correspondence that may be used by the customer services department.
- Sample telephone logs/telephone statistics.
- Add customer service screen shot showing categories of calls.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interviews and observation of customer service representatives taking consumer calls to examine how calls and resolution of such calls are handled and recorded.

Bright Ideas

- As part of the training programs for customer services representatives, provide opportunities to role play utilizing the scenarios representing the various types of calls received in the customer call center.
- Use reporting information to identify the highest volume of calls based on type of call. Develop phone scripts to be used for orientation and ongoing training and development of customer service representatives for these types of calls.
- As part of the ongoing quality management program, review a sample of all types of calls for each customer service representative on a monthly or quarterly basis. Utilizes these reviews to identify opportunities for improvement and ongoing training/educational opportunities.
- Include in the orientation and training programs for member/customer service representatives, training for conflict management/resolution.
- Establish an interdepartmental e-newsletter to include organizational changes, benefit revisions and network updates.
- Provide ongoing professional development training programs for call management and documentation; establish a list of standardized abbreviations to be utilized during call documentation.

Related Standards

P-OPS 5 - Provider Directory Updates

The *organization* updates all of its provider directories such that: (No Weight)

(a) Within 45 calendar days of the date that both the credentialing and contracting processes are completed, a *provider* initially approved for network participation is: (No Weight)

(i) Displayed in online *provider* directories; **and** (4)

(ii) Flagged for inclusion in subsequent hard copy versions of the *provider* directory; (4)

(b) Once it is determined that a *participating provider* has not recredentialed for any reason or no longer meets the credentialing requirements in the *organization's* credentialing plan, then the *provider* is temporarily removed from the requisite online directories within five (5) business days of the date of that determination; (4)

(c) There are written policies and/or documented procedures for updating all provider directories that include a time frame for: (No Weight)

(i) Adding a *participating provider* previously removed from *provider* directories back into those directories; (4)

(ii) Updating a *participating provider's* contact information once the *organization* receives notification that this information has changed; (4)

(iii) Updating a *participating provider's* credentials as needed after they have been verified per the *organization's* credentialing plan; **and** (4)

(d) Within 45 calendar days of determining that a *participating provider* is no longer participating in its network, the *provider* is: (No Weight)

(i) Removed from electronic versions of the *provider* directory; **and** (4)

(ii) Flagged for removal from subsequent hard copy versions of the *provider* directory. (4)

Interpretive Information/Commentary

- Consumer complaints reveal that health plans need to update provider directories in a timely manner.

Points to Remember

- P-OPS 5(a) refers to calendar days.
- P-OPS 5(b) refers to business days.
- The health plan establishes time frames for P-OPS 5(c).

- P-OPS 5(d) refers to calendar days.

Scope of Standards

- This standard applies to all health benefit plans included within the scope of the organization's application for accreditation.
- This standard applies to both electronic and printed provider directories.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures for maintaining a current provider directory.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Review of timeliness reports for provider directory changes (e.g., following initial credentialing/contracting, changes in credentialing status, changes in network participation, updates to provider contact or credentials information, etc.)
- Interview with staff responsible for coordinating credentialing actions and provider directory maintenance.

Bright Ideas

- Create an updated electronic and hard copy version of the provider directory following credentialing committee meetings.

Related Standards

P-OPS 6 - Consumer Notification Regarding PCP Status

If the *organization* has determined or was otherwise notified that a PCP is no longer participating in its network then: (No Weight)

(a) Notification is sent to *consumers* within 45 calendar days of the date of that determination or notification; (4)

(b) *Consumers* receiving the notification referenced in (a) are those who have: (No Weight)

(i) Designated the provider as a PCP; **or** (4)

(ii) Had a *claim* with the PCP within at least the past 18 months; **and** (4)

(c) Notification includes information on how *consumers* can access customer support for assistance in selecting a new PCP. (4)

Interpretive Information/Commentary

- Analysis of consumer complaints for denied claims and an inability to get referrals from a PCP reveals that this is often the result of not being notified when a PCP is no longer participating in the network.
- This standard may be not applicable if the plan does not require the member to designate a PCP.

Points to Remember

- P-OPS 6(a) refers to calendar days.

- P-OPS 6(b)(ii) refers to claims within the past 18 months, to the month (i.e., not the day). For example, the organization determined or was otherwise notified that a PCP was no longer participating in its network some time in September 2011; therefore, consumers who are still enrolled with the health plan organization as of September 2011 and had a claim submitted for payment during March 2010 through September 2011 (organizations have 45 days to notify per P-OPS 6(a)) would receive notice.

Scope of Standards

- This standard applies to all health benefit plans included within the scope of the organization's application for accreditation.
- This standard applies to notification of consumers, currently enrolled with the health plan organization, who have designated a PCP.

- This standard does not apply to a health benefit plan included within the scope of the organization's application for accreditation if the plan does not require its members to designate a PCP.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures for notification of affected consumers when PCPs no longer are participating providers.
- Sample notification to consumers.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Review of timeliness reports for consumer notification following changes in PCP participation status.
- Interview with staff responsible for coordinating credentialing actions/participation status and consumer notifications.

Bright Ideas

- Post changes in PCP provider participation status on the consumer pages of the health plan's web site.

Related Standards

P-OPS 7 - Care Coordination Regarding Medication Safety

The *organization* demonstrates support for health care activities that promote medication safety for those consumers "at risk" for medication safety issues as determined by the *organization*, including: (No Weight)

(a) *Medication reconciliation* at transitions of care; (Mandatory)

(b) *Consumer* and/or caregiver knowledge of medication; **and** (3)

(c) Medication adherence. (4)

Interpretive Information/Commentary

- The health plan identifies mechanisms, policies, and/or procedures to support medication safety at transitions of care, including mediation reconciliation.
- The health plan implements methods to provide at risk consumers with medication information.
- An organization may determine that all members or enrollees of a particular health benefit plan (e.g., Medicare, Medicaid, etc.) would benefit from health care activities promoting medication safety and adherence. Otherwise, the organization will need to document the selection criteria it uses to determine those consumers "at risk" for medication safety and/or adherence issues.
- Examples of criteria for defining "at risk" individuals includes those who are on numerous medications (i.e., polypharmacy), have multiple comorbidities managed by multiple providers, have limited physical or cognitive ability, lack of caregiver, etc.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-OPS 7(a)-(c). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.

- Methods of promoting medication safety may involve pharmacy benefit management (PBM), disease management, case management or wellness programs.
- This standard does not require an assessment in order to support consumer / care giver medication knowledge or adherence.

Scope of Standards

- This standard applies to all health benefit plans included within the scope of the organization's application for accreditation.
- This standard applies to consumers who meet the "at risk" criteria defined by the health plan.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures for promotion of care coordination through medication reconciliation.

- Written policies and/or documented procedures defining health plan criteria for identification of at risk consumers who would benefit from health care activities promoting medication safety.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview of staff involved in care coordination of medication safety.
- Review of medication safety and adherence information provided to at risk consumers.

Bright Ideas

- Organizations may employ a variety of avenues to show active support of care coordination activities related to medication safety, including its discharge processes, health care management programs, reimbursement mechanisms and/or other incentives or initiatives. For instance, an organization could:
  - Implement a "patient centered health care home" program (also known as "medical home") [P-OPS 7(a), (b) & C)]
  - Reimburse for medication reconciliation services [P-OPS 7(a)]
  - Address consumer/caregiver knowledge of medication as a component of its disease management program [P-OPS 7(b)]
  - Over time (a minimum of a year or more is recommended), track performance on medication possession ratios through medication adherence reports provided by a Pharmacy Benefit Management (PBM) contractor [P-OPS 7(c)]

Related Standards

P-OPS 8 - P&T Formulary Development

The *organization* has a process to ensure that it promotes clinically appropriate, safe, and cost-effective drug therapy, which shall include: (No Weight)

> (a) Pharmacy & Therapeutics (P&T) Committee; (Mandatory)
>
> (b) Clearly defined formulary management that includes: (No Weight)
>
>> (i) Consideration of drug and drug class therapeutic appropriateness (safety and efficacy) when developing formularies; **and** (Mandatory)
>>
>> (ii) Established and documented procedures to assure appropriate drug class review and inclusion; **and** (Mandatory)
>
> (c) Process for regular evaluation and review. (Mandatory)

Interpretive Information/Commentary

- Organizations must have active oversight of their pharmacy and therapeutics program, including formulary development and management. The P&T Committee is instituted in order to provide clinical oversight to formulary development and management.
- Note that all standard elements are mandatory.
- P&T Committee meetings should be held no less than annually.
- "Regular evaluation and review" must occur no less than annually.
- Please see URAC's definition of "annually."

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-MR 8(b)(i)-(ii) and P-MR 8(c). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.
- Formularies may be electronic or printed and must be available to enrollees per mandatory standard P-MR 7(c)(iii). If electronic, the organization must have the ability to print copies for consumers without Internet access.

Scope of Standards

- This standard applies to all health benefit plans included within the scope of the organization's application for accreditation.
- This standard defines the formulary oversight management functions of the Pharmacy and Therapeutics Committee.
- If delegated to a PBM, then the P-OPS P&T-related standards still apply and the organization must demonstrate compliance oversight in this area per the requisite Core standards on delegation.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures for formulary management by the Pharmacy and Therapeutics Committee.
- Sample minutes of a Pharmacy and Therapeutics Committee meeting.
- Documentation of the most recent formulary evaluation and review.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview of staff managing the P&T Committee.
- Review of P&T Committee minutes documenting oversight of formulary evaluation and review, which occurs no less than annually.

Bright Ideas

Related Standards

P-OPS 9 - P&T Committee Membership

Members of the Pharmacy and Therapeutics Committee include: (No Weight)

(a) Various clinical specialties that represent the needs of the plan's *consumers*; (3)

(b) Representation of, or consultation with appropriate specialists; (3)

(c) A majority must be practicing physicians, practicing pharmacists, or both: (3)

    (i) At least one practicing physician and one practicing pharmacist who are experts regarding care of elderly or disabled individuals; **and** (3)

    (ii) The physicians and pharmacists must have appropriate credentials as stated in the URAC Core standard for Clinical Staff Credentialing; **and** (Mandatory)

(d) At least 50% of the practicing pharmacists and practicing physicians are independent and free of conflict (health plan and pharmaceutical manufacturers) and are not employed with the *organization*. (3)

Interpretive Information/Commentary

- Clinical specialties represented on the P&T Committee should reflect those types most commonly found in the provider directory.
- Committee members must be qualified to provide clinical oversight to formulary development and management.
- Consultation with appropriate other specialists does not require membership on the committee or attendance at P&T Committee meetings, but should be documented as a matter of record in meeting minutes.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-OPS 9(a), (b), (c), (c)(i) and (c)(ii). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.
- A committee is two or more members.

Scope of Standards

- This standard applies to all health benefit plans included within the scope of the organization's application for accreditation.
- This standard refers to the membership of the health plan's Pharmacy and Therapeutics Committee.
- If delegated to a PBM, then the P-OPS P&T-related standards still apply and the organization must demonstrate compliance oversight in this area per the requisite Core standards on delegation.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures for the Pharmacy and Therapeutics Committee membership and participation.
- List of P&T Committee members and qualifications.
- Sample minutes of a Pharmacy and Therapeutics Committee meeting, redacted as needed.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview of staff managing the P&T Committee.

Bright Ideas

Related Standards

P-OPS 10 - Economic Formulary Considerations

Economic considerations include (when available), but are not limited, to the following; (No Weight)

> (a) Basing formulary system decisions on cost factors only after the safety, efficacy, side effect profile, and therapeutic need have been established; **and** (Mandatory)
>
> (b) Evaluating equivalent alternative drug products and therapies in terms of their impact on health care costs. (4)

Interpretive Information/Commentary

- Formulary inclusions and exclusions must first take into consideration the safety, efficacy, side effect profile of drug products and therapies.
- Formulary inclusions and exclusions should be approved by the P&T Committee.
- The P&T Committee should consider approval of equivalent alternative drug products and therapies based on their evaluation of cost and effectiveness.
- Cost evaluation results should be documented no less frequently than annually.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-OPS 10(a). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.
- This standard does not require any specific cost evaluation method.

Scope of Standards

- This standard applies to all health benefit plans included within the scope of the organization's application for accreditation.
- This standard applies to the documented evidence of balanced formulary inclusions and exclusions.
- If delegated to a PBM, then the P-OPS P&T-related standards still apply and the organization must demonstrate compliance oversight in this area per the requisite Core standards on delegation.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures for economic formulary considerations by the P&T Committee.
- Sample documentation showing cost evaluation results, including at least one alternative drug or therapy choice.
- Sample P&T Committee minutes documenting approval of formulary inclusions and exclusions, redacted as needed.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview of staff managing the P&T Committee.
- Review of P&T Committee minutes documenting discussion of cost evaluation results at least annually.

Bright Ideas

Related Standards

P-OPS 11 - Oversight of Automated Review of Pharmacy Non-Certifications

Organizations must have written policies and/or documented procedures in place to provide oversight of the *automated review* process used for drug management and its linkage to the *appeals* process by a: (No Weight)

    (a) Senior c*linical staff* person or equivalent designate; **and** (Mandatory)

    (b) *P&T Committee*; **or** (Mandatory)

    (c) Other equivalent *clinical oversight body*. (Mandatory)

Interpretive Information/Commentary

- Organizations must have active oversight of their pharmacy and therapeutics program, including automated review of prescription requests.
- Evaluation of the link between appeals and non-certifications must be documented.
- This standard does not require any specific method of evaluation.

Points to Remember

- P-OPS 11 (a) and (b) are both mandatory standard elements. Both the senior clinical staff person or designate and the P&T Committee must review and evaluate the link between appeals and automated non-certifications.
- Evaluation of the link between appeals and automated non-certifications must be conducted no less frequently than annually.
- The designate of the senior clinical staff person must be similarly and appropriately qualified to evaluate the link between appeals and automated non-certifications.

Scope of Standards

- This standard is applicable when an automated drug review process is used to issue certifications and non-certifications of prescription requests.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures that provide for oversight of the automated review process used for drug management.
- Written description of the evaluation methodology.
- Job description of senior clinical staff person or assigned designate.
- Written policies and/or documented procedures stating the oversight responsibilities of the P&T Committee or other equivalent oversight body.
- Minutes of the P&T Committee or other equivalent oversight body documenting analysis and discussion of the automated review process and its linkage to appeals.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview of senior clinical staff person or designate.
- Interview of staff for P&T Committee.

- Review of annual evaluation documentation.

Bright Ideas

Related Standards

P-OPS 12 - Breach Notification and Management

Upon notification or discovery of a potential breach, the *organization* will: (No Weight)

(a) Record the date that the suspected breach was known, or should have reasonably been known, to the organization (i.e., date of knowledge); (Mandatory)

(b) Notify its privacy and security official; (Mandatory)

(c) Determine if an actual breach occurred; **and** (Mandatory)

(d) If a breach occurred: (No Weight)

    (i) Record the date the breach occurred; (Mandatory)

    (ii) To the extent practicable, mitigate the cause of the breach; (Mandatory)

    (iii) If the organization is acting as a business associate, notify the covered entity as soon as possible, but no later than the time frame stipulated in the applicable business associate agreement, which cannot be more than the 60 calendar days from the date of knowledge as required by federal law; (Mandatory)

    (iv) Provide notice, as required by federal law, to the individuals affected by the breach; (Mandatory)

    (v) Provide notice, as required by federal law, to the Department of Health and Human Services; **and** (Mandatory)

    (vi) Conduct post-breach evaluation and remediation. (Mandatory)

Interpretive Information/Commentary

- Organizations must have written policies and documented procedures describing how they will carry out the notification process. URAC expects that the applicant organization's written policies will address all aspects of the standard. Onsite review will include examination of more detailed procedural documentation and interviews with staff to verify implementation.
- The policy must require that the organization develop and maintain documentary evidence of the notification process.
- Element (a): the time period for breach notification begins when the incident is first known, or should have reasonably been known, not when the risk assessment of the incident is complete, even if it is initially unclear whether the incident constitutes a breach. Therefore per standard element (a), the organization must document when the breach first became known to the organization.
  - "Reasonable" in this context is related to the controls put in place.

- Element (d)(ii): once it is determined that the incident constitutes an actual breach, the organization must evaluate various aspects of the breach in order to mitigate the cause of the breach to the extent practicable.
- Element (d)(iii): if an organization is acting as a business associate and the business associate agreement (BAA) is in "business days," URAC will evaluate any incident where notification to the covered entity taking longer than the 60 calendar days as non-compliant with the standard.
  - Organizations must consider all applicable regulations when determining all parties to be notified of a breach. As part of the accreditation, URAC will verify that the covered entity was notified.

- The time frame needs to consider the time needed by the covered entity to complete its part of notification process. The time allotted to the business associate and the covered entity cannot exceed 60 calendar days.

Points to Remember

- Written policy must address the standard elements, which are based upon HIPAA requirements.
- For the onsite review, URAC reviewers will examine more detailed process documents, including detailed descriptions of any actual breach and follow-up actions.

Scope of Standards

- This standard applies to all situations where it is known that a breach might have occurred.
- This standard applies to the health plan program(s) seeking accreditation, which are typically covered entities, but could be covered entities acting like business associates as well.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures addressing the identification and reporting of privacy breach events, mitigation of cause(s), evaluation and remediation.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Review of privacy breach events log
- Review of documentation of any actual breach event and follow-up actions
- Interview the senior clinical staff person, compliance officer, privacy officer and supervisory personnel
- Interview staff in customer service, utilization management, and quality management

Bright Ideas

Related Standards

Compliance Program

P-CP 1 - Compliance Program: Internal Controls

To effectively monitor adherence to applicable statutes and regulations, the *organization* implements internal controls including: (No Weight)

(a) Designating a compliance officer; (4)

(b) Pursuant to the *organization's* policy, periodic review and update of the compliance program in the *organization's* training and education; (2)

(c) Pursuant to the *organization's* policy, periodic internal monitoring and auditing; (2)

(d) Pursuant to the *organization's* policy: (No Weight)

(i) Periodic review and analysis to determine if there are any changes in its benefits, policies and procedures, and utilization management protocols that impact compliance; **and** (2)

(ii) Communication to delegated contractors regarding changes impacting compliance, including parity of health care services such as mental health and/or substance use disorder parity (MHPAEI), as applicable; **and** (2)

(e) Performance of a thorough review of state and federal laws and regulations related to: (No Weight)

(i) Privacy and security, including the HIPAA; (Mandatory)

(ii) Parity of health care services such as mental health and/or substance use disorder parity, including the MHPAEA, as applicable; **and** (Mandatory)

(iii) Fraud, waste and abuse. (Mandatory)

Interpretive Information/Commentary

- Duties of the compliance officer may be incorporated into an existing position along with other duties and responsibilities. This standard does not require that compliance officer duties constitute a full-time job; however, large organizations may choose to assign a full time Compliance Officer position.
- Written policies and/or documented procedures and/or a compliance program description establish the organization's internal controls and support the compliance program.
- The organization defines in policies and/or documented procedures and/or a compliance program description the time frames for periodic review and updates of the compliance program.

- The organization defines in policies and/or documented procedures and/or a compliance program description the appropriate oversight body for the compliance program. The designated oversight body approves the compliance plan and any revisions thereof.
- The compliance program plan includes periodic internal monitoring and auditing. Reports of findings are made to the designated oversight body.
- Written policies and/or documented procedures and/or a compliance program description document methods and accountabilities for periodic review, analysis and communication of compliance-driven changes in benefits, policies or procedures or protocols.
- Written policies and/or documented procedures and/or a compliance program description document methods and accountabilities for an ongoing thorough review of state and federal laws and regulations related to HIPAA, health care services parity, fraud, waste, and abuse.

Points to Remember

- This standard complements CORE 4 - Regulatory Compliance as well as Core 27 - Staff Training Program; efforts and assignments should be collaborative and coordinated.
- Note that standard elements P-CP 1(e)(i), (ii) and (iii) are mandatory.

Scope of Standards

- This standard applies to all health benefit plans included within the scope of the organization's application for accreditation.
- This standard delineates needed regulatory compliance internal control processes, procedures and accountabilities for health plan accreditation applicants.

Evidence for Meeting the Standard - Desktop Review Materials

- Job description for Compliance Officer.
- Written policies and/or documented procedures and/or a compliance program description related to the regulatory compliance internal controls methods, processes, procedures and accountabilities.
- Minutes of the designated oversight committee documenting approval of the compliance plan.
- Sample training and education materials related to compliance.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview with the Compliance Officer.

- Internal monitoring and auditing reports.

Bright Ideas

Related Standards

Mental Health Parity

P-MHP 1 - Analysis of Compliance with Mental Health Parity Law

For each *health benefit plan* product that provides mental health and/or substance use disorder (MH/SUD) services that is included in its application for this accreditation, the *organization* will provide written documentation of one of the following: (No Weight)

(a) An affirmative declaration, signed by a principal of the organization, indicating that the identified product is in "exempt status" with regards to the applicable federal and/or state law or regulation and any binding regulatory or sub-regulatory guidance related thereto, including the statutory/regulatory basis for the exempt status; **or** (4)

(b) If not exempt, a detailed analysis of the identified product documenting its compliance with the applicable federal and/or state law or regulation and any binding regulatory or sub-regulatory guidance related thereto, demonstrating that for the MD/SUD services provided, including applicable pharmacy benefits, the *organization* does not have more restrictive: (No Weight)

(i) Financial requirements; (4)

(ii) Quantitative treatment limitations; **and** (4)

(iii) Nonquantitative treatment limitations. (4)

Interpretive Information/Commentary

- The requirement for a detailed, documented analysis of an organization's compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) is an essential first step towards complying with this Act. URAC will not pass judgment as to whether the conclusions are valid; however, a reasoned analysis of the applicable health benefit plan is necessary to meet the intent of the standard.
- As part of that reasoned analysis, if there is medical or scientific evidence and/or clinical practice guidelines (often collectively referred to as "standard of care") permitting a difference between mental health/substance use disorder treatment or service benefits and those for medical/surgical, then the organization needs to include that evidence/standard of care as part of its reasoned analysis. A declaration that there is medical or scientific evidence to that effect will not suffice.
- Pharmacy benefits are a benefit classification under the interim final rules for MHPAEA. As such, they must be compliant with the parity rules. Formulary structure and the management thereof should also be in compliance with the Interim Final Rules (IFR) rules respecting financial, quantitative and non-quantitative treatment limitations applicable to the pharmacy benefit. The validation thereof is documentation that a compliance analysis was performed with a clear rationale supporting the conclusions.

Points to Remember

- If an organization provides MH/SUD services through other than mental health providers, such as a PCP, then the MHPAEA applies, even if MH/SUD benefits are not provided as part of the health benefit plan.

- P-MHP 1(b)(iii): Examples of nonquantitative treatment limitations from the CMS.gov website: "Nonquantitative treatment limitations include but are not limited to medical management, step therapy and pre-authorization. There is an illustrative list of nonquantitative treatment limitations in the regulation. A group health plan or coverage cannot impose a nonquantitative treatment limitation with respect to MH/SUD benefits in any classification unless, under the terms of the plan (or coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification. The final regulation eliminated an exception that allowed for different nonquantitative treatment limitations "to the extent that recognized clinically appropriate standards of care may permit a difference."
  - Source: CMS.gov website. Select "Private Insurance" tab at the top of the opening page, under "CCIIO" in the left-hand navigator list select "Other Insurance Protections" under the "Programs and Initiatives" heading. Select MHPAEA then select "Fact Sheets" and scroll down to #3 under "Regulation."

Scope of Standards

- This standard applies to all health benefit plans included within the scope of the organization's application for accreditation.
- Pharmacy benefits are included within the scope of the analysis required by this standard when they are included as a component of a health benefit plan covered by this accreditation.

Evidence for Meeting the Standard - Desktop Review Materials

- Exempt status attestation, if applicable.
- Copy of product analysis report or executive summary.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview with Compliance Officer.
- Interview with Senior Clinical Staff Person.

Bright Ideas

Related Standards

P-MHP 2 - UM Protocols Applied to MH/SUD Benefits

For all of the *utilization management* protocols applied to mental health and/or substance use disorder (MH/SUD) benefits, the *organization* will provide a detailed analysis demonstrating that these *utilization management* protocols do not have more restrictive nonquantitative treatment limitations. (4)

Interpretive Information/Commentary

- The requirement for a detailed, documented analysis of an organization's compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) is an essential first step towards complying with this Act. URAC will not pass judgment as to whether the conclusions are valid; however, a reasoned analysis of the utilization management protocols is necessary to meet the intent of the standard.
- UM protocols are by definition non-quantitative treatment limitations ("NQTLs"); therefore, UM protocols must be comparable to, and applied no more stringently than, those used for medical/surgical benefits. Since there are no "bright line" rules here, the organization must present its analysis supporting its conclusions one way or another. As previously mentioned, a URAC reviewer cannot opine on the validity, but can review to see that a compliance analysis was done; therefore, a one-sentence declaration that the organization is in compliance with the MHPAEA is not acceptable as evidence.
- Note that the final MHPAEA regulation eliminated an exception that allowed for different nonquantitative treatment limitations "to the extent that recognized clinically appropriate standards of care may permit a difference."

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-MHP 2. For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.

Scope of Standards

- This standard applies to all UM protocols used for health benefit plans included within the scope of the organization's application for accreditation.
- The term "protocol" includes "…any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation to mental health or substance use disorder benefits…" [Federal Register, Vol. 75, No. 21, page 5416, 45 CFR Part 146, IFR under the HCPAEA]

Evidence for Meeting the Standard - Desktop Review Materials

- Copy of the report or executive summary of parity analysis of HUM protocols for MH/SUD benefits.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview with Compliance Officer.
- Interview with Senior Clinical Staff Person.

Bright Ideas

Related Standards

P-MHP 3 - MH/SUD Parity Addressed in Contractor Written Agreements

The *organization* enters into *written agreements* with *contractors* providing mental health and/or substance use disorder (MH/SUD) health care services that: (No Weight)

(a) Meet the requirements set forth in standards P-NM 8-10; **and** (4)

(b) Specify that the *contractor* shall comply with, and maintain parity between the MH/SUD benefits it administers and the *organization's* medical/surgical benefits pursuant to the applicable federal and/or state law or regulation and any binding regulatory or sub-regulatory guidance related thereto. (4)

Interpretive Information/Commentary

- Compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and any binding regulatory or sub-regulatory guidance related thereto must be addressed in contract language.

Points to Remember

- This standard is implemented on a going-forward basis, such that current compliance program written policies and/or documented procedures must be in effect at the time an organization submits its application for initial accreditation or reaccreditation under this standard. For every contract executed after that submittal date, URAC will examine client-specific documentation showing that mental health parity is addressed in the contracts between the organization and its contractors for mental health and substance use disorder health care services.

- See also standard P-CP 1(d), where it addresses communication to delegated contractors regarding changes impacting compliance.

Scope of Standards

- This standard applies to the contracts between the organization and its contractors for mental health and substance use disorder health care services.
- This standard includes delegation of pharmacy benefit management (PBM) services.

Evidence for Meeting the Standard - Desktop Review Materials

- Sample or template of agreement with contractors providing mental health and/or substance use disorder (MH/SUD) health care services.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Review of agreements with contractors providing mental health and/or substance use disorder (MH/SUD) health care services.
- Interview with Compliance Officer.
- Interview with Senior Clinical Staff Person.

Bright Ideas

Related Standards

Health Utilization Management

P-HUM 1 - Review Criteria Requirements

The *organization* utilizes explicit *clinical review criteria* or scripts that are: (No Weight)

(a) Developed with involvement from appropriate *providers* or *prescribers* with current knowledge relevant to the *criteria* or scripts under review; (3)

(b) Based on current clinical principles and processes; (3)

(c) Evaluated at least *annually* and updated if necessary by: (3)

(i) The *organization* itself; **and** (3)

(ii) Appropriate, actively practicing physicians, *pharmacists* and other *providers* with current knowledge relevant to the *criteria* or scripts under review; **and** (Mandatory)

(d) Approved by the *medical director* (or equivalent designate), *clinical director* (or equivalent designate), P&T Committee or other equivalent clinical oversight body. (Mandatory)

Interpretive Information/Commentary

- The applicant organization can develop its own criteria, purchase commercially-available criteria, or use a combination of both. Either way, annual review with the potential for updates to the criteria is required.
- If commercial clinical review criteria or scripted clinical screening are used, the organization should indicate how the criteria and scripted clinical screening tools were developed. Also include who (names and qualifications) was involved in this process and how often the criteria or scripts will be reviewed and updated.
- With commercial criteria, even if the organization does not receive yearly updates, the medical/clinical director and other physicians (including outside providers) should review the criteria and scripted clinical screening to verify their continued appropriateness.
- When disclosing the clinical review criteria and scripted clinical screening, whether they are commercial or proprietary products, a general synopsis of the criteria or scripted screening is allowed.
- The definition of an "actively practicing physician" is determined by the organization, however the definition may vary from state to state and organizations should comply with applicable regulations.

- When the Mental Health Parity and Addiction Equity Act (MHPAEA) is applicable, "…the criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) must be made available in accordance with regulations by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request (''medical necessity disclosure'')." [Federal Register, Vol. 75, No. 21, page 5428, 45 CFR Part 146, Interim Final Rule (IFR) under the MHPAEA] For health plans and the entities that provide utilization management services for them, complying with this regulation is required under standard Core 4 – Regulatory Compliance, when the MHPAEA is applicable.

Points to Remember

- This standard includes element(s) that may support Medical Loss Ratio (MLR) quality improvement activities: P-HUM 1(a), P-HUM 1(b), P-HUM 1(c), P-HUM 1(c)(i), P-HUM 1(c)(ii) and P-HUM 1(d). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There is a table following this document that contains a complete listing of the MLR standard elements for this accreditation.
- Stem of standard: Review Criteria may include proprietary or licensed criteria, scripts, clinical guidelines and or medical policies used to make review determinations.
- P-HUM 1(a) and 1(b): If the clinical review criteria and scripted clinical screening are developed by the UM organization, policy and procedure must identify who (names and qualifications) is involved in their development, the process used in their development, and when and how often they will be evaluated and updated. Also, if changes occur through a committee process, these changes should be reflected in the committee's minutes or other Documentation.
- P-HUM 1(a): If criteria are for non-physician care (e.g., chiropractor and therapist), then review of criteria may be conducted by non-physicians, subject to the discretion of the senior clinical staff person (see Core 31 and Core 32).
- P-HUM 1(c): If commercial criteria are purchased by the organization, the criteria must also be reviewed and approved.
- If utilizing commercial criteria, the organization should obtain updates from the vendor and include the review of the commercial criteria update during the annual criteria review process. Assure that your organization is utilizing the most current version of the commercial criteria.
- P-HUM 1(d): Medical or clinical director approval must be documented after each review/revision cycle. Acceptable mechanisms for documenting approval of clinical criteria are a dated attestation or through meeting minutes of an established UM or quality committee.

Scope of Standards

- P-HUM 1 applies to any clinical criteria and scripted clinical screening that the UM organization uses for utilization reviews including practice guidelines and medical policy.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures covering development, approval and evaluation of criteria and scripts
- Samples of scripts, clinical criteria or other pre-review documents

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Documentation indicating medical director or clinical director involvement with the development and approval of clinical review criteria, medical policy, medical guidelines and/or scripts
- Documentation of the annual evaluation of clinical review criteria, medical policy, medical guidelines and/or scripts
- Clinical case records illustrating initiation of the review process, pre-review screening, and initial clinical review, concurrent review and retrospective review
- Hard copy or electronic versions of scripts or algorithms used for clinical reviews
- Staff demonstration using criteria and scripts

Bright Ideas

- If your organization is using commercially developed criteria, refer to the commercial vendor's development and approval process in your organizational policies or refer to the vendor's website information related to criteria development and approval.
- Place clinical criteria and scripts on the intranet for efficient staff access, but keep a hard copy version of criteria and scripting as back-up.
- Make the annual review of clinical criteria and scripts a standing agenda item as part of the overall compliance/quality work plan.
- If using commercial criteria, obtain a copy of the vendor's policy and procedure for criteria development and updates. Identify the role and responsibility of the individual(s) within your organization who will be accountable for the receipt, review and approval and implementation of the commercial criteria revisions.
- Include in the ongoing professional development/training programs, an annual review and update of criteria revisions.
- Develop a process to review and update criteria as new scientific evidence becomes available. A designated committee may perform a formal literature search to include a review of nationally developed practice guidelines to review and approve criteria updates.

Related Standards

P-HUM 2 - Access to Review Staff

The *organization* provides *access* to its review *staff* by a toll free or collect telephone line at a minimum from 9:00 a.m. to 4:00 p.m. of each normal business day in each time zone where the *organization* conducts at least two percent of its review activities. (4)

Interpretive Information/Commentary

Refer to "Points to Remember."

Points to Remember

- The UM staff must be reasonably accessible during normal business hours.
- Access to review staff must be provided for areas in which two percent of the review activities are provided in each time zone. "Two percent of review activities" may be calculated as follows: % Reviews in time zone = Number of reviews originating in a particular time zone X 100 divided by the total number of reviews.

Scope of Standards

P-HUM 2 encompasses the UM organization including all geographical locations where reviews are conducted.

Evidence for Meeting the Standard - Desktop Review Materials

- Documentation of percentage of cases in each time zone.
- Written policies and/or documented procedures describing hours of operation including when and how UM staff may be reached.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview and observation of staff to determine hours of business and access to staff.
- Review of total number of reviews by time zone report/documentation.

Bright Ideas

- If your organization serves clients in multiple states, maintain a log or map listing the percentage of reviews conducted in each state on an ongoing basis. This will provide important information regarding the hours of operation required for UM staff access and the need for adjustments to staffing.
- Assure that web sites, newsletters, identification cards, and/or provider manuals (when applicable), provide the following information:
  - The toll free number to contact the UM department
  - The normal business hours when staff are available (note holidays)
  - Instructions for faxing or leaving a voice mail after hours; provide contact information for responses, i.e. the UM staff will respond on the next business day
- Establish implementation procedures for adding new clients/groups to your organization that includes an evaluation of geographical locations (time zones) of the new members.

- Annually conduct a geographic evaluation of the population served within the various time zones.
- As part of the annual compliance work plan, periodically call the phone numbers to evaluate the phone functionality and voice mail messaging system.
- Review telephone reports on a daily, weekly basis for accessibility to include average wait times, abandonment rates, average speed of answer, average length of calls, and area codes of incoming calls.
- Review the call volume reports and abandonment rates by day and the number received each hour during the day.
- Using phone statistical analysis, establish staffing guidelines to provide adequate phone coverage.
- Provide flexible scheduling of UM staff to provide coverage for all time zones defined in the geographical service area of the utilization management organization.
- Conducting ongoing monitoring and tracking of the number of calls received 'after hours' will provide the organization important information related to the need to adjust hours of operations for the UM program.
- If your organization has a centralized complaint reporting system, be sure to include in the internal communication as process notification regarding complaints about access to services to the appropriate staff within the UM department.

Related Standards

P-HUM 3 - Review Service Communication and Time Frames

The *organization* maintains processes to: (No Weight)

(a) Receive communications from *providers* and *patients* during the business day and after business hours; (4)

(b) Respond to communications within one business day; **and** (4)

(c) Conduct its outgoing communications related to *utilization management* during *providers'* reasonable and normal business hours, unless otherwise mutually agreed. (4)

Interpretive Information/Commentary

- "Communications" includes telephonic and electronic correspondence; the organization can define which methods it uses.
- P-HUM 3 applies to general, administrative communications, for example, when a patient calls to ask what forms need to be filled out to submit a request. P-HUM 3 does NOT apply to processes covered elsewhere in these standards, especially request for review determinations.
- Time frames for review determinations are covered in Standards P-HUM 19, 20, and 21. For example, a request for a prospective review determination is a routine request, and is covered elsewhere in these standards (see P-HUM 18 that references peer-to-peer conversations] so P-HUM 3 do not apply. However, a non-routine inquiry from a patient or provider would be covered under P-HUM 3.
- The UM staff will try to reach providers during times when they would normally be available.
- Note that Standard P-HUM 3(c) addresses outgoing communications.
- Standard P-HUM 3(b) is the only URAC HUM standard that uses business days; the rest of the standards use calendar days (consistent with the calendar days in the Department of Labor claims regulation.) URAC retained the business day standard here because 1) P-HUM 3(b) does not correspond exactly to any provision in the Department of Labor regulation, and 2) in this case, there is no number of calendar days that appeared to be a reasonable substitute for one business day.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-HUM 3(a), P-HUM 3(b) and P-HUM 3(c). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There is a table following this document that contains a complete listing of the MLR standard elements for this accreditation.
- P-HUM3b: Communication with UM staff must be convenient to callers and UM staff are to reply within one business day.
- P-HUM 3c: If an organization requests after hours notification the organization should have documentation available that documents this request (i.e., contract, email, etc).

Scope of Standards

P-HUM 3 encompasses the UM organization communication practices.

Evidence for Meeting the Standard - Desktop Review Materials

- Submit written policies and/or documented procedures addressing communication processes and when/how UM staff may be reached.
- Include in the written policies and/or documented procedures when outgoing communications will be conducted.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview and observation of staff regarding communication procedures.
- UM staff will be interviewed regarding program hours of operation and the processes for accessing UM program staff after normal business hours.
- Staff may be interviewed and observed to verify references are available to staff outlining HUM requirements and procedures.
- References may be requested during interviews with staff that need to be able to readily locate/retrieve these resources.

Bright Ideas

- If your organization serves clients in multiple states, maintain a log or map listing the percentage of reviews conducted in each state on an ongoing basis. This will provide important information regarding the hours of operation required for UM staff access and the need for adjustments to staffing.
- Conducting ongoing monitoring and tracking of the number of calls received 'after hours' will provide the organization important information related to the need to adjust hours of operations for the UM program.
- If your organization has a centralized complaint reporting system, be sure to include in the internal communications process notification regarding complaints about access to services to the appropriate staff within the UM department.
- Review the voice mail messages periodically to assure providers and members know how to obtain information after hours.
- Use an electronic facsimile program for receiving after-hours faxes while maintaining confidentiality.

Related Standards

P-HUM 4 - Review Service Disclosures

The *organization:* (No Weight)

(a) Requires *utilization management staff* to identify themselves by name, title, and *organization* name; **and** (2)

(b) Upon request, verbally informs *patient*s*, facility* personnel, the *attending physician* and other *ordering provider*s, and *health professionals* of specific *utilization management* requirements and procedures. (4)

Interpretive Information/Commentary

- Appropriate courtesy will help facilitate communication and persons needing access to health care through the UM process will receive help as needed.
- For P-HUM 4(a), clarify that first or last name or another identifier is acceptable.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-HUM 4(b). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There is a table following this document that contains a complete listing of the MLR standard elements for this accreditation.
- P-HUM4(a): If the company name is part of an introductory message for caller; this does not have to be repeated by staff.
- Staff is not required to give their last name, but must provide their job title or clinical title, such as 'Registered Nurse'.
- P-HUM 4(b): Applies to all levels of UM staff (nonclinical and clinical).
- P-HUM 4(b): Include in written documentation that UM staff will verbally inform callers of UM requirements and procedures.

Scope of Standards

P-HUM 4 includes individuals calling the UM organization for certification or notification of admission to a facility or other related matters.

Evidence for Meeting the Standard - Desktop Review Materials

Written policies and/or document procedures describing review service disclosures.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- References/written resources outlining UM requirements and procedures may be requested during interviews with staff who need to be able to readily locate/retrieve these resources.
- Interview and observe staff handling incoming calls to the UM program

Bright Ideas

- If the organization has documented their UM program procedures on a website, refer caller inquiries regarding UM processes to the specific website location.
- Develop a table of UM requirements that may vary by lines of business, state requirements or individual clients; create a link to this table of UM requirements on the intranet or within the clinical information system.
- As part of the ongoing compliance program, conduct periodic phone observations of UM staff to evaluate staff performance for following policies and/or documented procedures for answering the phone properly and providing correct information to the caller.
- As part of the orientation program, include phone service and communication activities; conduct role play exercises utilizing scenarios for providing UM information facilities, providers, patient/members, etc. This is also a way to evaluate the knowledge and understanding of the UM program requirements.
- If the organization is using an after-hours answering service for handling incoming UM calls, conduct ongoing monitoring of the answering service to verify they are handling the calls according to organizational policy and procedures.

Related Standards

P-HUM 5 - On-Site Review Requirements

For on-site review services, the *organization*: (No Weight)

    (a) Requires on-site *reviewers* to carry a picture ID with full name and the name of the *organization*; (2)

    (b) Schedules reviews at least one business day in advance, unless otherwise agreed; **and** (4)

    (c) Requires the on-site *reviewers* to follow reasonable hospital or facility procedures, including checking in with designated hospital or facility personnel. (4)

Interpretive Information/Commentary

- Onsite review will not interfere with health care facility operations.
- Routine onsite procedures may vary depending upon the facility and should be documented policies and/or documented procedures.

Points to Remember

- If the organization does not conduct any onsite review services, this standard may be not applicable. Please indicate this in the citation area found in Accreditnet.
- P-HUM 5(a): If the organization does not utilize company photo identification then the onsite reviewer may use a driver's license along with a company business card.
- P-HUM 5(b) and (c): If contractual agreements require specific onsite reviewer identification or onsite scheduling practices, this information must be available to staff conducting onsite UM activities.
- UM personnel must follow policies and/or documented procedures for appropriate safeguards for confidentiality and security of any information gathered during the onsite review.

Scope of Standards

P-HUM 5 applies to reviews performed in hospitals or other facilities where patient care is provided.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures covering general on-site review procedures that address the elements of this standard.
- Documentation of procedures for those facilities that require specific on-site reviewer scheduling and identification processes.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Facility-specific agreements or contracts addressing on-site review procedures.
- On-site review staff may be interviewed regarding the review services that they perform.
- Supervisor interview to verify the process for onsite review.

Bright Ideas

- Include in training materials a section regarding the policies and procedures for onsite reviewers.
- Include in the UM Program Description document a reference to whether or not the organization conducts onsite UM review activities as a part of the service delivery model component.
- Include in the information management policies and/or documented procedures the guidelines for confidentiality and security of data collected during an onsite review.
- Develop policies and procedures for off-site use of portable electronic devices, such as personal computers, to provide for confidentiality, security and proper storage, maintenance and destruction of review information.
- As part of the compliance program, conduct periodic satisfaction surveys for facilities where onsite reviews are performed.

Related Standards

P-HUM 6 - N/A

This standard number is reserved to synchronize with URAC's Workers' Compensation Utilization Management Standards. There is no standard P-HUM 6. (No Weight)

Interpretive Information/Commentary

Related Standards

P-HUM 7 - Limitations in Use of Non-Clinical Staff

For *initial screening*, the *organization* limits use of *non-clinical administrative staff* to: (No Weight)

    (a) Performance of *review of service request* for completeness of information; (2)

    (b) Collection and transfer of non-clinical data; (2)

    (c) Acquisition of *structured clinical data*; **and** (2)

    (d) Activities that do not require evaluation or interpretation of clinical information. (Mandatory)

Interpretive Information/Commentary

- "Initial screening" was formerly referred to as "scripted clinical screening" and "structured clinical data" in Health Utilization Management Standards, version 3.0 and "pre-review screening" in version 4.0. The term "initial screening" takes into account that many organizations are transitioning to automated systems (web-enabled and telephonic) that may not involve staff interaction.

Points to Remember

- The standards in the "Initial Screening" section only apply to organizations that use the initial screening process.
- Note: In addition to paper-based processes, the organization may use automated or semi-automated processes to collect data and conduct screening of cases to issue certifications. These processes can include scripted clinical screening, intake screening, web-enabled certification request processes, and other techniques. Collectively, these standards refer to such processes as initial screening.
- P-HUM 7(a): Non-clinical staff may inform callers of a list of procedure codes that do not require pre-certification.
- P-HUM 7(b): Examples of non-clinical data may include demographic information, employer name, insurance information, date of surgery, physician name, facility name, etc.
- P-HUM 7(c): Structured clinical data is collected using explicit scripts or algorithms.
- P-HUM 7(d): Non-clinical staff may not conduct any activities that require interpretation of clinical information, including but not limited to, the choosing of a set of criteria to use for handling a request for healthcare services or treatments.

Scope of Standards

P-HUM 7 applies to review processes, regardless of the level of automation, that do not require clinical judgment and that do not result in non-certification determinations.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures clearly defining the scope of the non-clinical administrative staff role in the UM process.
- Job descriptions for non-clinical administrative staff.

- Samples of scripts and/or algorithms used for pre-review screening.
- Orientation content/outline related to non-clinical staff roles and responsibilities.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Clinical case records illustrating initiation of the review process, pre-review screening, and initial clinical review.
- Scripts or algorithms used for pre-review screening (P-HUM 1).
- Non-clinical staff will be randomly selected for interviews and observation.
- If the organization utilizes a system that has automated algorithms, the Accreditation Reviewer will need a demonstration of system utilized for initial screening.

Bright Ideas

- Clarify in the non-clinical staff job description that non-clinical staff are not responsible for conducting any UM review activities that require interpretation of clinical information.
- Include in staff training curriculum specific information regarding the working relationship between clinical and non-clinical staff.
- Use role play scenarios as part of the orientation and training program for non-clinical staff.
- Develop a web based guide for documentation guidelines to include terminology and standardized abbreviations to be used by all staff, non-clinical and clinical.
- Provide ongoing training/professional development for non-clinical staff to include subjects such as call management, customer service, time management, medical coding, etc.

Related Standards

P-HUM 8 - Pre-Review Screening Staff Oversight

The *organization* ensures that *licensed health professionals* are available to *non-clinical administrative staff* while performing *initial screening*. (Mandatory)

Interpretive Information/Commentary

- Standard P-HUM 8 does not require face-to-face availability; however, immediate availability via a real-time communication mechanism is required. In web-based screening, contact information must be provided to facilitate additional communication telephonically.

Points to Remember

- The supervisor of the non-clinical staff does not have to be a clinical person; however, there should be a process in place for availability of clinical reviewers for oversight and follow up for clinical related questions or issues.
- Job descriptions and written policies and/or documented procedures must reflect that licensed health professions are available and indicate process for the oversight.

Scope of Standards

- P-HUM 8 applies to review processes, regardless of the level of automation, that do not require clinical judgment and that do not result in non-certification determinations.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures clearly defining the scope of the non-clinical administrative staff role in the UM process, and clinical oversight of the screening process.
- Job descriptions for non-clinical administrative staff.
- Organizational chart of UM department indicating reporting relationships.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview with non-clinical and supervisory staff to verify oversight of initial screening functions.
- Demonstration of automated initial screening process will be required.

Bright Ideas

- Clarify in the relevant health care professional job description the responsibility for conducting ongoing availability, monitoring and oversight of non-clinical staff activities.
- Include in staff training curriculum specific information regarding the working relationship between clinical and non-clinical staff.
- Conduct periodic reviews of non-clinical staff job performance activities for compliance with pre-review screening and documentation; review activities may include phone observations and written documentation (case file reviews).
- For ongoing compliance programs, establish a schedule to review and test any web based/automated algorithms on a regular basis.

- Schedule an annual review of the web based algorithms to coincide with the annual review/revisions of the UM criteria and policies and/or documented procedures.

Related Standards

P-HUM 9 - Preview-Review Screening Non-Certifications

The *organization* does not issue *non-certifications* based on *initial screening.* (Mandatory)

Interpretive Information/Commentary

- Refer to the section "Points to Remember."

Points to Remember

- Non-clinical staff may not conduct any activities that require interpretation of clinical information to include the choosing of a set of criteria to use for handling a request for health care services or treatment.
- Non-clinical staff may inform callers of a list of procedure codes that do not require pre-certification.
- Note: In addition to paper-based processes, the organization may use automated or semi-automated processes to collect data and conduct screening of cases to issue certifications. (These processes can include scripted clinical screening, intake screening, web-enabled certification request processes, and other techniques. Collectively, these standards refer to such processes as initial screening.)
- The standards in the "Initial Screening" section only apply to organizations that use the initial screening process.
- All medical necessity non-certifications must be done by a peer reviewer.

Scope of Standards

- P-HUM 9 applies to review processes, regardless of the level of automation, that do not require clinical judgment and that do not result in non-certification determinations.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures clearly defining the scope of the non-clinical administrative staff role in the UM process and their role in the non-certification process.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Clinical case records illustrating initiation of the review process, pre-review screening, and initial clinical review and non-certification process.
- Scripts or algorithms used for pre-review screening (P-HUM 1).
- Non-clinical staff will be randomly selected for interviews and observation.

Bright Ideas

- Clarify in the non-clinical staff job description that non-clinical staff is not responsible for conducting any UM review activities that require interpretation of clinical information including non-certification of requests.
- Develop job aids (workflows) that include the specific tasks for conducting an initial screening that includes the review process, to include how to manage pre-review screenings that do not meet criteria for certification.

- Supplement the job description by developing a policy and procedure or document that describes more detailed job performance expectations for all levels of staff.
- Identify the most frequently asked questions received during the pre-screening process; develop a table of the most frequently asked questions to include appropriate responses or appropriate actions(to refer to clinical reviewer or other departments). Post this table on the intranet or include this information in the call document tracking or clinical information system.
- When using an electronic clinical information system, configure the web based algorithms that do not pass the pre-review screening for auto approval, to pend to a clinical reviewer's work queue.

Related Standards

P-HUM 10 - Initial Clinical Reviewer Qualifications

Individuals who conduct *initial clinical review* possess an active, professional *license or certification:* (No Weight)

> (a) To practice as a *health professional* in a state or territory of the United States; **and** (Mandatory)

> (b) With a scope of practice that is relevant to the clinical area(s) addressed in the *initial clinical review*. (Mandatory)

Interpretive Information/Commentary

- It is URAC's policy that initial clinical reviewers must hold a U.S. license or certification; however, unlike peer reviewers conducting peer clinical review and appeals, initial clinical reviewers can be located outside of the United States or its territories when performing initial clinical review. Please see standards P-HUM 14 and P-HUM 35, which address peer reviewer qualifications.
- Initial clinical reviewers may assist in the notification process for non-certifications.
- For drug utilization management review, adequately trained pharmacy technicians are acceptable for conducting initial clinical review provided they work under the supervision of a pharmacist or are acting within the scope of algorithms.
    - Please reference standard P-HUM 15(a)(i)-(ii) for more information.
    - Pharmacy technicians are individuals who are either certified/ licensed or who have been adequately trained. "Adequately trained" means that the individual has been part of an extensive training program and/or has had significant experience at a dispensing site.
    - If pharmacy technicians are conducting reviews, they must be certified/ licensed in accordance with the state where they are practicing if the state requires it.
    - Adequately trained pharmacy technicians are acceptable for conducting a review provided they work under the supervision of a pharmacist or are acting withing the scope of algorithms.
    - For non-automated review, pharmacy technicians may not issue clinical non-certifications.

Points to Remember

- P-HUM 10(a): Clinical review staff must have an active license when performing review activities; organizations must implement a mechanism for tracking licensure expiration dates.
- P-HUM 10(a): Review the scope of the nurse practice act and/or licensure requirements for clinical reviewers for all states in which the organization may provide UM services.
- P-HUM 10(a): An LPN/LVN meets the URAC definition of health professional and this licensure category may conduct initial clinical review.
- HUM 10(a): A certified genetic counselor meets the definition of health professional and individual practitioners with this certification can conduct initial clinical review. Certified genetic counselors may also conduct peer clinical review; for more information, see the supporting guide language for standard HUM 14.
- P-HUM 10(b): Initial clinical reviewers must have the appropriate clinical background in order to render decisions requiring clinical judgment and experience.
- "Health professionals" is a defined term; please refer to the glossary.

- For information pertaining to mutual recognition model of nurse licensure and the status of legislation for Nurse Licensure Compact for your state, refer to the National Council State Board of Nursing web site at www.NCSBN.org.

Scope of Standards

- P-HUM 10 through P-HUM 12 cover the initial clinical review staff and processes.

Evidence for Meeting the Standard - Desktop Review Materials

- Job description for initial clinical reviewers that includes requirements for licensure and professional education and experience.
- Written policies and/or documented procedures describing who conducts initial clinical review.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Clinical case records illustrating initiation of the review process, pre-review screening, and initial clinical review, concurrent review and retrospective review.
- Review of personnel files to include clinical staff credentialing.
- Record of primary source verification of licensure for all clinical reviewers.

Bright Ideas

- In order to avoid changes in licensure status (e.g., restrictions or revocations) occurring without the company's knowledge, develop a policy to require licensed personnel to notify their supervisor immediately of any changes in licensure status. Review this policy at the time of hire and annually when conducting the performance appraisal.
- Ongoing monitoring of staff licensure through licensure board websites will alert the organization to changes in credentialing status. Electronically track using an 'alert' function when staff licensure or certification is due for renewal will assure timely notification of renewal requirements.
- To assure timely notification of renewal requirements, develop a credentialing database that includes the licensure review date and expiration date for each clinical staff member for all states where licensed; assign an individual(s) to monitor this data base on a monthly basis.
- Develop an attestation statement regarding licensure status. Have the individual review and sign the attestation annually at the time the performance appraisal is conducted.

Related Standards

P-HUM 11 - Initial Clinical Reviewer Resources

Individuals who conduct *initial clinical review* have *access* to consultation with a: (3)

(a) *Licensed* doctor of medicine or doctor of osteopathic medicine; **or** (No Weight)

(b) *Licensed health professional* in the same licensure category as the *ordering provider*, **or** (No Weight)

(c) *Health professional* with the same clinical education as the *ordering provider* in clinical specialties where *licensure* is not issued. (No Weight)

Interpretive Information/Commentary

- Initial clinical reviewers may assist in the notification process for non-certifications.
- For standard P-HUM 11, a licensed health professional in the same licensure category does not require the health professional to be of the same specialty as the ordering provider.

Points to Remember

- Initial clinical reviewers must have appropriate clinical support and do not issue non-certifications.
- Initial clinical reviewers must have the appropriate clinical background in order to render decisions requiring clinical judgment and experience.
- Policies and/or documented procedures will describe staffing and accessibility of the peer clinical reviewer.
- In some organizations, the senior clinical staff's (Medical Director) job description may include the role and responsibilities of the peer clinical reviewer.
- Clinical peer reviewers may also be independent contractors (consultants) and not employees of the UM organization.
- All initial clinical peer reviewer resources, employees and consultants should have completed credentialing procedures for clinical staff upon hire and thereafter no less than every 3 years.

Scope of Standards

- P-HUM 10 through P-HUM 12 cover initial clinical review staff and processes.

Evidence for Meeting the Standard - Desktop Review Materials

- Job description of the licensed doctor of medicine, doctor of osteopathic medicine or health professional who is responsible for providing consultation to initial clinical review staff.
- Written policies and/or documented procedures that describe staffing and accessibility of the peer clinical reviewer.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Clinical case records illustrating initiation of the review processes: pre-review screening, initial clinical review, concurrent review and retrospective reviews.

- Consultative physician's or clinical practitioner's personnel file will be examined for licensure, qualifications and past work experience.

Bright Ideas

- In order to avoid changes in licensure status (e.g., restrictions or revocations) occurring without the company's knowledge, develop a policy or, ask licensed staff to sign upon hire and annually an agreement that they will notify their supervisor immediately of any changes in licensure status.
- Ongoing monitoring of staff licensure through licensure board websites will alert the organization to changes in credentialing status. Plus, electronic tracking with an 'alert' function when staff licensure or certification is due for renewal will assure timely notification of renewal requirements.
- Develop a staffing schedule of the medical director or peer clinical reviewer who is available to the UM staff.
- Post the schedule (and contact information) of the medical director or peer clinical reviewer on the organization's Intranet.

Related Standards

P-HUM 12 - Initial Clinical Reviewer Non-Certifications

The *organization* does not issue *non-certifications* based on *initial clinical review.* (Mandatory)

Interpretive Information/Commentary

- Initial clinical reviewers may assist in the notification process for non-certifications.

Points to Remember

- Initial clinical reviewers must have appropriate clinical support and do not issue Medical necessity non-certifications.

Scope of Standards

- P-HUM 10 through P-HUM 12 cover initial clinical review staff and processes.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures prohibiting the issuance of non-certifications based on initial clinical review.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Clinical case records illustrating initiation of the review process, pre-review screening, and initial clinical review, concurrent review and retrospective review.
- Interview and observation of initial clinical reviewer to verify compliance with the process.

Bright Ideas

- Develop work flows/job aids that provide information specific to the referral of potential non-certification cases to peer clinical reviewers.
- Develop job performance standards that include the scope of responsibilities related to initial clinical review and non-certifications.
- As part the quality management program, conduct evaluations such as inter-rater reliability audits for proper application of criteria and compliance with review procedures for non-certifications.

Related Standards

P-HUM 13 - Peer Clinical Review Cases

The *organization* conducts *peer clinical reviews* for all *cases* where a *certification* is not issued through *initial clinical review* or *initial screening.* (Mandatory)

Interpretive Information/Commentary

- All P-HUM standards are applicable for all clinical reviews conducted for the evaluation of medical necessity of health care services, procedures and facilities under the provision of the applicable benefit plan.

Points to Remember

- Peer clinical review will be conducted for all cases where a clinical determination to certify cannot be made by an initial clinical reviewer.
- If any portion of requested services is not approved, the organization will provide a peer clinical review.
- All peer clinical reviews must be documented and include the specific reasons for the decision. Documentation of "not medically necessary" is not sufficient for documentation of the peer clinical review decision.
- Case review documentation must be legible, including the identity and credentials of the peer clinical reviewer.

Scope of Standards

- P-HUM 13 applies to peer clinical review staff and processes for all reviews conducted for medical necessity determinations.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures covering the initial clinical review process and the peer review process.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Clinical case records illustrating peer clinical review.

Bright Ideas

- Periodic 'Grand Rounds' and interesting case discussion between UM staff and peer reviewers will provide ongoing communication regarding problematic case types.
- To assure comprehensive knowledge of peer reviewers, develop a formal peer reviewer staff orientation and training curriculum or self-training packet related to specific peer reviewer responsibilities.
- As part of the quality management program, conduct ongoing reviews of peer clinical review decisions for consistency of decision making and documentation.
- Develop an electronic template to assist the initial clinical review staff to provide sufficient information to the peer clinical reviewer.

- Develop a written or electronic template for the peer clinical reviewer to document the outcomes of the peer clinical review. The template should include a section to document the principal reason and clinical rationale for the decision, the name and credentials of the peer clinical reviewer, date and time the review was completed.

Related Standards

P-HUM 14 - Peer Clinical Reviewer Qualifications

Individuals who conduct *peer clinical review* are *clinical peers* who: (No Weight)

(a) Hold an active, unrestricted *license* or *certification* to practice medicine or a *health profession* in a state or territory of the United States; (Mandatory)

(b) Unless expressly allowed by state or federal law or regulation, are located in a state or territory of the United States when conducting a *peer clinical review*; (Mandatory)

(c) Are qualified, as determined by the *medical director* or *clinical director*, to render a clinical opinion about the medical *condition*, procedures, and treatment under review; **and** (Mandatory)

(d) Hold a current and valid *license*: (Mandatory)

    (i) In the same licensure category as the *ordering provider*; **or** (No Weight)

    (ii) As a doctor of medicine or doctor of osteopathic medicine. (No Weight)

Interpretive Information/Commentary

- Under URAC standards policy, any level of review requiring a peer reviewer (i.e., peer clinical review, appeal or external review), the reviewer must hold a U.S. license (or certification) as minimally required to engage in clinical practice and conduct the review within the United States or one of its territories.
  - As a point of clarification, peer clinical review, appeal or external review cannot be conducted on a U.S. military base, vessel, or embassy located outside of the U.S. or its territories.
  - Note that with the exception of drug utilization review, initial clinical review (P-HUM 10-12) can be conducted outside of the U.S. or its territories.
  - Note that peer clinical reviewer qualifications (HUM 14) and appeal peer reviewer qualifications (HUM 35) are covered in the following URAC accreditations: the P-HUM section of Health Plan, Health Utilization Management, Workers' Compensation Utilization Management, and Independent Review Organization (IRO) accreditation (internal review); whereas, external review (i.e., state-mandated review) is addressed in the P-HUM section of Health Plan (P-HUM 42) as well as URAC's IRO accreditation.

- M.D.s and D.O.s may review care recommended by any type of practitioner, but only M.D.s and D.O.s may review other M.D.s and D.O.s. For example, a psychiatrist may review a psychologist's plan of care (or another psychiatrist's). A psychologist may only review other psychologists.
- The requirement for "similar specialty match" applies to the appeal level of review; please refer for standard HUM 35 - Appeal Peer Review Qualifications, for more information.

- Organizations must apply state utilization management (UM) laws and regulations as well as review state scope of practice acts as they apply to all levels of review (including appeals) and for all types of reviewers (physician and non-physician). This is required under Core 4 – Regulatory Compliance.
    - Bear in mind that there are states that require licensure to be in the same state where the patient resides.
    - In addition, there are some states that limit rendering non-certification determinations to a physician (i.e., MD or DO).

- **Therapists Conducting Review (physical medicine & behavioral health)****
- **Under URAC standards policy, some non-physician providers can conduct various levels of review under specific circumstances unless prohibited by state UM law and/or state scope of practice act. For instance, a physician will often order therapy with an order to "evaluate and treat," whereby the therapist must develop and determine the progression of the treatment plan based on initial and subsequent evaluations of the patient. Under these circumstances, a physical medicine therapist (i.e., PT, OT or ST) and behavioral health therapist (i.e., psychologist) are allowed to:
    - Conduct initial clinical review (where only certification is allowed).
    - Make a peer clinical review decision (approval or non-certification) regarding:
        1. The initial treatment plan, and
        2. Progression of the treatment plan under the established goal(s) for that particular treatment plan.

- Physical medicine therapist (i.e., PT, OT or ST) and behavioral health therapist (i.e., psychologist) are not allowed to conduct first-level internal appeal considerations regarding the treatment plan unless permitted by state appeal laws.

- With regard to peer clinical review, a physical medicine therapist (i.e., PT, OT or ST) or behavioral health therapist (i.e., psychologist) is <u>not permitted</u> to conduct peer clinical review when the:
  - Ordering provider and/or patient requests that a physician conduct the review, or
  - The patient's response to treatment requires physician intervention as indicated by *medical or scientific evidence* or *clinical practice guidelines* in circumstances that require the involvement of a physician, such as when a patient:
    - Has an adverse reaction to the treatment, or
    - Is not responding to treatment (failure to progress), or
    - Regresses to an earlier level of functioning or disease state (i.e., morbidity increases).

  - A physical medicine therapist (i.e., PT, OT or ST) or behavioral health therapist (i.e., psychologist) is <u>not permitted</u> to conduct a first level internal appeal or an external review (i.e., appeal) unless part of a panel that includes as least one physician that meets the qualifications to conduct the appeal, including that the physician is in the appropriate clinical specialty for the review.
  - In those states that allow direct access to a therapist:
    - If a member has obtained services directly from a therapist without a medical physician referral, then a therapist may conduct peer clinical review; however,
    - If a member has obtained services from a therapist upon referral from a medical physician, then the reviewer must be a physician (i.e., MD or DO).
- A certified genetic counselor meets the definition of health professional and individual practitioners with this certification may conduct initial clinical review [HUM 10] as well as peer clinical review. Certified genetic counselors are not permitted to conduct a first level internal appeal or an external review (i.e., appeal) unless part of a panel that includes at least one physician that meets the qualifications to conduct the appeal, including that the physician is in the appropriate clinical specialty for the review. Note: External review is addressed in URAC's Independent Review Organization (IRO) standards.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: HUM 14(c) and HUM 14(d). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There is a table following this document that contains a complete listing of the MLR standard elements for this accreditation.
- HUM 14(a): Personnel hired by the UMO to provide peer clinical review services are properly qualified and credentialed to provide a clinical opinion about the medical condition, procedures, and treatment under review.
- HUM 14(a): Peer clinical review staff must have an active license when performing review activities; organizations must implement a mechanism for tracking licensure expiration dates (see Core 30).
- HUM 14(c): Medical director/clinical director approval decisions of peer clinical reviewer qualifications may be reflected in UM or QM meeting minutes.

- Some state regulatory requirements include a "same state licensure "requirement for all peer reviews. For example, if the review was being conducted in the state of Mississippi, the UMO would need to access a peer reviewer who is licensed within the state of Mississippi to conduct the peer review and render a decision.
- HUM 14(d): If the URO is a specialty review organization, then the reviewer could be of that specialty. For example, for a chiropractic UMO, a chiropractor would meet the peer clinical reviewer qualifications.

Scope of Standards

- P-HUM 14 applies to peer clinical review staff and processes.

Evidence for Meeting the Standard - Desktop Review Materials

- Job description/contracts for individuals who conduct peer clinical review.
- Written policies and/or documented procedures describing the peer review process.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Contracted and employee physician's and clinical practitioner's personnel files will be examined for licensure, qualifications and past work experience. Past experience can be obtained from a CV, job application or resume.

Bright Ideas

- To assure comprehensive knowledge of clinical peer reviewers, develop a formal orientation and training curriculum or self-training packet related to specific peer reviewer responsibilities for both clinical peer reviewer employees and contracted clinical peer reviewers. Include training in the URAC Core and UM standards as part of the curriculum for all peer clinical reviewers.
- If using independent contracted clinical peer reviewers, assure that the contract requires the appropriate credentials as required by the standard, and includes peer clinical reviewer roles and responsibilities.
- Conduct inter-rater reliability reviews of all clinical peer reviewer decisions, including independent contracted clinical peer reviewers.
- Conduct an annual review of written policies and documented procedures, medical review policies and/or documented procedures and criteria revisions for all clinical peer reviewers.
- Provide ongoing training via Webinars regarding changes in medical review criteria, medical polices and related departmental policies and/or documented procedures.
- Develop a newsletter for peer clinical reviewers regarding updates to accreditation standards, changes in policies, review criteria, clinical practice guidelines, etc.

Related Standards

P-HUM 15 - Drug Utilization Management Reviewer Qualifications

When conducting *drug utilization review*: (No Weight)

(a) In addition to the initial clinical *reviewers* described in HUM 10, *certifications* (only) can be rendered by pharmacy technicians who: (No Weight)

(i) Follow HUM 1 established *criteria*; **and** (Mandatory)

(ii) If required by state law, possess an active professional relevant *license* in good standing; **and** (Mandatory)

(b) In addition to the *clinical peers* described in HUM 14, *non-certifications* (as well as *certifications*) can be rendered by *pharmacists* who: (No Weight)

(i) Hold an active, unrestricted *license* or *certification* to practice pharmacy in a state or territory of the United States; (Mandatory)

(ii) Unless expressly allowed by state or federal law or regulation, are located in a state or territory of the United States when conducting *drug utilization review*; (Mandatory)

(iii) May not conduct *peer clinical review non-certifications* for *drug utilization management* if prohibited by state *utilization management* laws; **and** (Mandatory)

(iv) May not conduct *peer clinical review non-certifications* for *drug utilization management* if the requesting party specifically requests a *clinical peer*. (Mandatory)

Interpretive Information/Commentary

- HUM 15(a): Pharmacy technicians are individuals who are either licensed or certified in accordance with the state where they are practicing, or they have been adequately trained. "Adequately trained" means that the individual has been part of an extensive training program and/or has had significant experience at a dispensing site.
  - Adequately trained pharmacy technicians are acceptable for conducting the review provided they work under the supervision of a pharmacist or are limited to the use of algorithms.

- HUM 15(b): This standard ensures that appropriately licensed pharmacists render non-certifications (i.e., clinical denials) for pharmacy services when conducting drug utilization review.

Points to Remember

- All elements in this standard are mandatory.

- HUM 15(a): The pharmacy technician works within the confines of algorithms, which do not permit independent decision making. The pharmacy technician has access to a pharmacist when assistance is required with the application of the algorithm.
- HUM 15(a)(i) and 15(b)(i): The organization's regulatory compliance program has a method to ensure that for all of the states in which it conducts drug utilization management, the organization knows the specific clinical license or certification required for staff. Additionally, the organization can demonstrate verification of current active licensure or certification for clinical staff that conducts drug utilization review.

Scope of Standards

- All drug utilization review conducted by the applicant organization.

Evidence for Meeting the Standard - Desktop Review Materials

- Job descriptions for the prior authorization staff inclusive of required licensure, certification, education and professional competencies
- Policy and procedure stipulating requirements for algorithms and pharmacy technicians
- Policy and procedure indicating that non-certifications/clinical denials for drug utilization reviews are rendered by a licensed pharmacist or physician/clinical peer
- State specific regulatory compliance documentation of staff requirements for drug utilization management reviews
- Staff training plan for prior authorization functions
- Template audit tool used to audit prior authorization documentation for compliance with the standards

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview prior authorization staff at their work station
- Review authorization requests as they appear on staff's information management system to verify use of algorithms and non-automated requests
- Selected prior authorization case records

Related Standards

P-HUM 16 - Prospective, Concurrent and Retrospective Drug Utilization Management

The *organization* ensures *drug utilization management* mechanisms using the available information and data addressing the following, where appropriate: (Mandatory)

(a) Therapeutic appropriateness; (No Weight)

(b) Over and underutilization; (No Weight)

(c) Generic use; (No Weight)

(d) *Therapeutic interchange*; (No Weight)

(e) Duplication; (No Weight)

(f) Drug-disease contraindications; (No Weight)

(g) Drug-drug or drug-allergy interactions; (No Weight)

(h) Drug dosage; (No Weight)

(i) Duration of treatment; (No Weight)

(j) Clinical abuse or misuse; (No Weight)

(k) Drug-age precautions; (No Weight)

(l) Drug-gender precautions; (No Weight)

(m) Drug-pregnancy precautions; (No Weight)

(n) Regulatory limitations; **and** (No Weight)

(o) Benefit design. (No Weight)

Interpretive Information/Commentary

- The elements of standard P-HUM 16 are reviewed <u>as appropriate</u> for any given utilization review; it is not the intent of this standard for organizations to address all elements of this standard for every review. The organization determines the key elements of the review based on its clinical criteria and review policies, taking into account the information available to conduct the review.
- **Pharmacists Conducting Review**
- A doctor of pharmacy (PharmD) is the current entry level degree into the pharmacy profession. In order to practice pharmacy, after obtaining a doctor of pharmacy degree, an individual has to become state licensed, designated as a "registered pharmacist" and abbreviated "RPh."

- Registered pharmacists (RPh) ("pharmacists") can conduct initial clinical review (the level of utilization management (UM) review where only certification is permitted). In addition, pharmacists are permitted – on subsequent review and within their scope of licensure – to render an approval or non-certification, which is in line with their scope of licensure.
- Keep in mind that there are some states that require licensure to be in the same state where the patient resides. In addition, there are some states that limit rendering non-certification determinations to a physician (i.e., MD or DO).
- With regard to peer clinical review, under URAC standards policy a pharmacist is <u>not permitted</u> to conduct peer clinical review when:
  - State UM law prohibits pharmacists from rendering non-certifications as part of the utilization management process, or
  - The ordering provider and/or patient request that a physician conduct the review, or
  - A patient's response to treatment requires physician intervention as indicated by *medical* or *scientific evidence* or *clinical practice guidelines* in circumstances that require the involvement of a physician, such as when a patient:
    - Has an adverse reaction to the treatment, or
    - Is not responding to treatment (failure to progress), or
    - Regresses to an earlier level of functioning or disease state (i.e., morbidity increases).

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-HUM 16(a)-(m). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There is a table following this document that contains a complete listing of the MLR standard elements for this accreditation.
- This standard is mandatory; standard elements apply as appropriate to the case under review (see first bullet under "Interpretive Information/Commentary" for more information).
- Organizations analyze submitted information from sources such as claims data, live callers, or fax requests, as well as the organization's existing available data. Analysis can occur or be prompted by functionality electronically embedded in claims software, clinical decision support tools, and/or clinical review tools, including alerts for program staff to take action per the organization's policies and procedures.
- The clinical decision support tools identify when outbound communication is warranted with the prescriber, consumer, and/or dispensing pharmacy for potential consumer safety events.

Scope of Standards

- Prospective, concurrent, and retrospective drug authorization requests.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policy and documented procedures that identify the program's specific mechanism(s) for all elements of this standard
- Screen shots of electronic programs/tools used to analyze data and/or alert program staff

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview with clinical review staff
- Selected prospective, concurrent, and retrospective reviews with application of clinical decision support tools for alerts pertaining to the elements in this standard

Related Standards

P-HUM 17 - Peer-to-Peer Conversation Availability

*Health professional*s that conduct *peer clinical review* are available to discuss review determinations with *attending physicians* or other *ordering provider*s. (4)

Interpretive Information/Commentary

- Peer clinical review can occur by telephone, in person, or electronically.
- The goal of the peer-to-peer conversation is to allow the treating provider a chance to discuss a UM determination before the initiation of the appeal process. It is hoped that some disagreements can be worked out without the need for a formal and often-adversarial appeal process.
- Previous versions of the URAC UM standards referred to "peer-to-peer conversation" as "reconsideration."

Points to Remember

- The peer-to-peer discussion shall be timely and the UM organization must have a back-up procedure for situations where the original peer reviewer is not available, then another clinical peer is available within one business day.
- Some states have regulatory requirements that require access to a peer-to–peer reviewer of a same or similar specialty. Refer to the state regulatory requirements for requirements for peer-to–peer reviewers.
- If the peer-to-peer conversation occurs before the issuance of the UM determination, there would NOT be an extension to the time frames specified in P-HUM 19 through P-HUM 21. The only likely exception to this is when the organization makes repeated attempts and the treating physician is not available. That would be "an event outside the organization's control" and would entitle the organization to an extension (see P-HUM 19 through P-HUM 21).
- The "peer-to-peer conversation" required by these standards is not an "appeal" and as such is considered outside the scope of the appeal process for both URAC and the DOL. In addition to a "peer-to-peer" policy and procedure, organizations must also submit a policy and procedure on urgent or expedited appeals. Please note that the peer reviewer requirements for a peer-to-peer conversation and an appeal review are different. Appeal peer reviewers must always be someone other than the peer reviewer who made the initial non-certification determination; whereas for a peer-to-peer conversation, the peer reviewer may be the same peer reviewer who made the initial non-certification determination. In addition, the appeal peer reviewer must be in the same or similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate. (See P-HUM 35)

Scope of Standards

- P-HUM 17 and P-HUM 18 apply to the prospective and concurrent review processes where the request for certification is non-certified by a clinical peer reviewer.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures describing the peer-to-peer process, including the mechanism used to make providers aware that they have this option.

- Job description/contracts for individuals who conduct peer clinical review.
- Sample template of written notification of non-certification informing providers of their option for a peer-to-peer conversation if not conducted prior to the non-certification.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Clinical case records illustrating peer clinical review and peer-to-peer conversations.
- Interview with medical director and utilization management staff to verify compliance with the peer to peer process.

Bright Ideas

- Scheduling a formal appointment between the requesting provider and the peer reviewer will support timely case discussion.
- If your organization offers a peer-to-peer conversation prior to a non-certification, provide structured 'scripting' for initial clinical reviewers and peer reviewers to use when verbally informing the provider of the potential for a non-certification. This will assure consistent communication of the mechanism for requesting a peer-to-peer conversation and timely resolution to some disagreements.
- Add a section for peer to peer contact within the peer reviewers' clinical review documentation (written or electronic) to document the attempts made to contact the attending or ordering provider; include the date, time, method of communication and outcome of the interaction.
- Clearly define in the policy and procedure the documentation requirements (for documented attempts) to contact to attending/ordering provider.
- Include in the voice mail messaging for the peer clinical reviewer, the availability of times the peer clinical reviewer is available for a discussion with the ordering provider.
- Establish an "instant messaging" process to notify the peer clinical reviewer by e-mail that a provider is awaiting a phone call or contact.

Related Standards

P-HUM 18 - Peer-to-Peer Conversation Alternate

When a determination is made to issue a *non-certification* and no *peer-to-peer conversation* has occurred: (No Weight)

(a) The *organization* provides, within one business day of a request by the *attending physician* or *ordering provider*, the opportunity to discuss the *non-certification* decision: (4)

(i) With the *clinical peer reviewer* making the initial determination; **or** (No Weight)

(ii) With a different *clinical peer*, if the original *clinical peer reviewer* cannot be available within one business day; **and** (No Weight)

(b) If a *peer-to-peer conversation* or review of additional information does not result in a *certification*, the *organization* informs the *provider* and *consumer* of the right to initiate an *appeal* and the procedure to do so. (4)

Interpretive Information/Commentary

- Peer clinical review can occur by telephone, in person, or electronically.

- The goal of the peer-to-peer conversation is to allow the treating provider a chance to discuss a UM determination before the initiation of the appeal process. It is hoped that some disagreements can be worked out without the need for a formal and often-adversarial appeal process.

- Previous versions of the URAC HUM standards referred to "peer-to-peer conversation" as "reconsideration."

- A peer-to-peer conversation has to be offered at some point in the process – this offer can occur before or after a non-certification is issued (at the organization's option). However, regardless of when it was offered, if a peer-to-peer conversation did not occur before the non-certification determination was rendered, the intent of the standard is for the attending physician or ordering provider to have the option to request one afterward.
  - If it is the organization's policy to only conduct peer-to-peer conversations prior to issuing a non-certification decision, the applicant organization does not meet the intent of element (a) and will lose 4 points.

- If a non-certification or 'partial approval' occurs then a non-certification notice must be issued and P-HUM 24 must be followed in the notification process.

- The organization needs to have a mechanism to make providers aware that they have the option of a peer-to-peer conversation. Mechanisms may vary by type of organization. Examples include, but are not limited to, the following:
  - A phone call to the treating provider;
  - Language in the non-certification letter; or
  - Language in the contract/ provider manual for contracted providers.

- A peer-to-peer conversation is not an appeal.

Points to Remember

- This standard requires that when a peer-to-peer conversation did not occur prior to when a non-certification decision is made, a peer-to-peer conversation is available to a requesting provider afterward.
    - If a peer-to-peer conversation did occur before a non-certification determination was made, the organization is not required by this standard to make another one available afterwards.
    - If the organization chooses to make another peer-to-peer conversation available, the URAC standards do not prohibit another one from being offered or occurring.
    - If it is the organization's policy not to allow a peer-to-peer conversation to occur after a non-certification determination has been rendered regardless of whether one occurred, the organization would lose 4 points for missing element (a).
- P-HUM 18(a): The opportunity for a peer-to-peer discussion must be available to the treating provider within one business day of the request.
- P-HUM 18(a)(i): The peer to peer conversation may be conducted by the physician who made the initial denial.
- P-HUM 18(a)(ii): If the initial peer reviewer is not available then the organization must make another clinical peer reviewer available within the one business day.
- P-HUM 18(a): If it is the UM organization's policy to have the peer reviewer attempt to speak with the provider prior to rendering a non-certification decision, a peer-to-peer procedure should be in place to cover those instances where the peer reviewer is unable to reach the attending physician or provider. If the peer-to-peer conversation occurs before the issuance of the UM determination, there would NOT be an extension to the time frame specified in P-HUM 19 through P-HUM 21. The only likely exception to this is when the organization makes repeated attempts and the treating physician is not available. That would be "an event outside the organization's control" and would entitle the organization to an extension (see P-HUM 19 through P-HUM 21).
- The "peer-to-peer conversation" required by these standards is not an "appeal" and as such is considered outside the scope of the appeal process for both URAC and the Department of Labor (DoL). In addition to a "peer-to-peer" policy and procedure, organizations must also submit a policy and procedure on urgent or expedited appeals.
- Please note that the peer reviewer requirements for a peer-to-peer conversation and an appeal review are different. Appeal peer reviewers must always be someone other than the peer reviewer who made the initial non-certification determination; whereas for a peer-to-peer conversation, the peer reviewer may be the same peer reviewer who made the initial non-certification determination. In addition, the appeal peer reviewer must be in the same or similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate. (See P-HUM 35)
- P-HUM 18(a): Some states have regulatory requirements that require access to a peer-to-peer reviewer of a same or similar specialty. Refer to the state regulatory requirements for requirements for peer-to-peer reviewers.
- P-HUM 18(b): Documentation of the peer to peer process with notification of appeal rights should the discussion not result in a certification must be found in the written policy and/or documented procedures.

Scope of Standards

- P-HUM 15 and P-HUM 16 apply to the prospective and concurrent review processes where the request for certification is non-certified by a clinical peer reviewer.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures describing this process, including the mechanism used to make providers aware that they have this option.
- Job description/contracts for individuals who conduct peer clinical review.
- Sample template of written notification of non-certification informing providers of their option for a peer-to-peer conversation if not conducted prior to the non-certification.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Clinical case records illustrating peer clinical review and peer-to-peer conversations.
- Interview with medical director and utilization management staff to verify compliance with the peer to peer process.

Bright Ideas

- Scheduling a formal appointment between the requesting provider and the peer reviewer will support timely case discussion.
- If your organization offers a peer-to-peer conversation prior to a non-certification, provide structured 'scripting' for initial clinical reviewers and peer reviewers to use when verbally informing the provider of the potential for a non-certification. This will assure consistent communication of the mechanism for requesting a peer-to-peer conversation and timely resolution to some disagreements.
- When communicating with the attending/ordering provider regarding the opportunity for a peer to peer discussion, provide information on how to contact the peer clinical reviewer, for example, provide a specific phone number, email address for the reviewer and suggested times for contacting the peer clinical reviewer.
- If using an ACD phone systems, with a "call triage" system, provide an option for the ordering physician to be connected to the peer clinical reviewer.
- Include in the orientation and training of all administrative, non-clinical and clinical staff, the procedures (may include a script) for providing instructions to the attending/ordering physician (or physician's office staff) regarding the availability of a peer-to-peer discussion.

Related Standards

URAC

P-HUM 19 - Prospective Review Time Frames

For *prospective review*, the *organization* issues a determination: (No Weight)

(a) As soon as possible based on the clinical situation, but in no *case* later than 72 hours of the receipt of request for a *utilization management* determination, if it is a *case involving urgent care*; **or** (4)

(b) Within 15 calendar days of the receipt of request for a *utilization management* determination, if it is a non-urgent *case*; **and** (4)

(c) For non-urgent *cases*, this period may be extended one time by the *organization* for up to 15 calendar days: (No Weight)

(i) Provided that the *organization* determines that an extension is necessary because of matters beyond the control of the *organization*; **and** (4)

(ii) Notifies the *patient*, prior to the expiration of the initial 15 calendar day period, of the circumstances requiring the extension and the date when the plan expects to make a decision; **and** (4)

(iii) If a *patient* fails to submit necessary information to decide the *case*, the notice of extension must specifically describe the required information and the *patient* must be given at least 45 calendar days from receipt of notice to respond to the plan request for more information. (4)

Interpretive Information/Commentary

- These time frames are intended to closely follow the time frames specified in the Department of Labor (DoL) claims regulation.
- P-HUM 19(a) remains 72 hours based upon amendments to the "External Review Interim Final Rule" published in the Federal Register on June 24, 2011, addressing "Expedited Notification of Benefit Determinations Involving Urgent Care (Paragraph (b)(2)(ii)(B) of the July 2010 Regulations).
- In cases where there is an extension to the process that is permitted under the Department of Labor regulation – for example, to obtain additional information to consider the case – URAC will consider the URAC time frames suspended during the extension. The organization must document the reasons for the extension in the case file as well as the dates the extension started and ended.
- See the definitions section of this document for the definition of "case involving urgent care." It is recommended that organizations provide a definition of urgent care in their policies and procedures. Important: The application of this definition to determine whether a case is urgent is left to the organization, unless a "physician with knowledge of the consumer's medical condition" expresses the opinion that following non-urgent time frames "would jeopardize the health of the consumer."

- The time frames provided in these standards are inclusive of the entire UM process, from the receipt of the request for a UM decision to the issuance of the decision, including the sending of the written notification (but not necessarily receipt of the decision by the patient or provider, as the mail can take several days). (In cases that result in non-certification, this means the issuance of the written determination required by P-HUM 24.)
- If a peer-to-peer conversation (see P-HUM 18) occurs before the issuance of the UM determination, there would NOT be an extension to the time frames specified in P-HUM 19-21. The only likely exception to this is when the organization makes repeated attempts and the treating physician is not available. That would be "an event outside of the organization's control" and would entitle the organization to an extension.
- For purposes of administering and demonstrating compliance with these standards, it is important that the organization has a mechanism to identify the date on which a case was received.
- Updated 1/27/2015: Element (a): urgent prospective review applies to at least the following outpatient review scenarios, whether it is an initial request for outpatient services or they have already started (i.e., an extension or continuation of the care plan). An organization may have additional criteria used to classify a review as an urgent, outpatient review. The criteria presented here are based on URAC's definition of "case involving urgent care," which is based on the DoL definition of the same.

  The provider and/or patient can request an urgent outpatient review, which would be conducted within 72 hours of the request for review. An urgent review of initial or ongoing outpatient services would be conducted if the review case scenario meets one of the following criteria:
    - Interruption or delay of services will impact the life or health of the consumer (e.g., a need for continued home health services given inadequate support and self-care)
    - The request is part of a transition of care (e.g., leaving the hospital or rehab facility to go home)
    - Interruption or delay of services will impact the ability of the consumer to regain maximum function (e.g., a request for a wheelchair, the order for a passive motion device/ special equipment, and the need for continued services such as home care, and physical therapy or respiratory therapy)
    - Interruption or delay of services will subject the consumer to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case

Points to Remember

- See also the definition of "case involving urgent care," which does not indicate that all hospital stays are considered urgent.
- Some states may have a tighter time frame than 15 days for non-urgent prospective review.

- When a state or federal government entity such as CMS provides consumers (i.e., enrollees, members, or patients) with the right to extend the timeline for an initial review or appeal, the applicant organization does not need to submit to URAC a request for a regulatory variance. Even though the time frame within which to complete the review or appeal is extended, this type of law or regulation enhances consumer rights and as such is not viewed as reducing the requirements of the standard and results in a matter outside of the organization's control.
  - For more information on related CMS guidance, reference the Medicare Managed Care Manual, Chapter 13, Section 40.1 (utilization review), Section 50.4 (expedited utilization review), Section 70.7.1 (standard appeal), and Section 80.1 (expedited appeal).

- Do not confuse the term "urgent care" with "emergency care." These are separate and distinct concepts. An organization may not be required to pre-authorize emergency room visits; however, this is different from an urgent care pre-authorization request.
- Some state regulatory agencies may also have specific definitions of "urgent and emergent care."
- P-HUM 19(a): Organizations may refer to urgent care cases as "expedited" cases. Organizations are not required to change their terminology for purposes of meeting URAC Standards.
- The time frames in P-HUM 19(a), (b) and (c) should be monitored on an on-going basis as part of the UM organization's quality management program. Time frames are calculated based on receipt of the UM request by the organization, not on receipt of clinical information.
- These time frames are intended to maintain consistency with the DoL regulations. If your organization has stricter turnaround time frames, you are encouraged to maintain the stricter performance turnaround time.
- Should your organization's policies and/or documented procedures contain stricter time frame guidelines, URAC will review the case files for compliance with the organization's defined time frames.
- Some state regulatory agencies may have specific time frames for review that are more restrictive than DoL regulations. Review the statue regulatory time frames of all states in which you conduct UM reviews.
- The time frames are inclusive of denial notification (refer to P-HUM 24).
- P-HUM 19(b): The organizations policy and/or written procedure must state calendar days with the clock starting at the initial request for service. The 15 calendar day requirement is inclusive of the notification process.
- P-HUM 19(c): if the organization never extends time frames for non-urgent cases please reflect that in the policies and/or written procedure.

Scope of Standards

- Updated 1/27/2015: HUM 19 applies to utilization review conducted prior to rendering services and includes all outpatient review, initial or ongoing.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures covering urgent and non-urgent prospective reviews including time frames for review completion.
- Sample of a template of a written notice of extension to patient and ordering physician.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Review of clinical case records illustrating the prospective review process.

Bright Ideas

- Develop and provide templates or guidelines to clinical providers and facilities that outline the required routine clinical information needed to support acquiring the appropriate clinical review information in a timely manner.
- If the UM review process is supported on an electronic platform, build time frame requirements into the system to alert reviewers of impending reviews.
- Develop a template that includes any specific time frames for state-specific regulatory requirements for utilization review; place this document on the intranet or integrate this template within the clinical information system based on the zip code or state abbreviation of the consumer's record.
- As part of the quality management program and monitoring activities, include an element in the case file review audit tool that is specific to adherence to review time frames for all types of reviews.
- Establish a policy and procedure to assign a staff member to review the work queues of authorizations pending review at the beginning and ending of each work day.

Related Standards

P-HUM 20 - Retrospective Review Time Frames

For *retrospective review*, the *organization* issues a determination: (No Weight)

> (a) Within 30 calendar days of the receipt of request for a *utilization management* determination; **and** (3)

> (b) This period may be extended one time by the *organization* for up to 15 calendar days: (No Weight)

>> (i) Provided that the *organization* determines that an extension is necessary because of matters beyond the control of the *organization*; **and** (4)

>> (ii) Notifies the *patient*, prior to the expiration of the initial 30 calendar day period, of the circumstances requiring the extension and the date when the plan expects to make a decision; **and** (4)

>> (iii) If a *patient* fails to submit necessary information to decide the case, the notice of extension must specifically describe the required information and the *patient* must be given at least 45 calendar days from receipt of notice to respond to the plan request for more information. (4)

Interpretive Information/Commentary

- These time frames are intended to closely follow the time frames specified in the Department of Labor claims regulation.
- In cases where there is an extension to the process that is permitted under the Department of Labor regulation – for example, to obtain additional information to consider the case – URAC will consider the URAC time frames suspended during the extension. The organization must document the reasons for the extension in the case file as well as the dates the extension started and ended.
- The extension permitted under P-HUM 20 for "matters beyond the control of the organization" is based directly on the Department of Labor claims regulation.
- The time frames provided in these standards are inclusive of the entire UM process, from the receipt of the request for a UM decision to the issuance of the decision, including the sending of the written notification (but not necessarily receipt of the decision by the patient or provider, as the mail can take several days). (In cases that result in non-certification, this means the issuance of the written determination required by P-HUM 24.)
- If a peer-to-peer conversation (see P-HUM 18) occurs before the issuance of the UM determination, there would NOT be an extension to the time frames specified in P-HUM 19-21. The only likely exception to this is when the organization makes repeated attempts and the treating physician is not available. That would be "an event outside the organization's control" and would entitle the organization to an extension.
- For purposes of administering and demonstrating compliance with these standards, it is important that the organization has a mechanism to identify the date on which a case was received.

Points to Remember

- P-HUM 20(a): The thirty calendar day time frame should be monitored on an on-going basis as part of the UM organization's quality management program. Time frames are calculated based on receipt of the UM request by the organization, not on receipt of clinical information.
- These time frames are intended to maintain consistency with the DoL regulations. If your organization has stricter turnaround time frames, you are encouraged to maintain the stricter performance turnaround time.
- When a state or federal government entity such as CMS provides consumers (i.e., enrollees, members, or patients) with the right to extend the timeline for an initial review or appeal, the applicant organization does not need to submit to URAC a request for a regulatory variance. Even though the time frame within which to complete the review or appeal is extended, this type of law or regulation enhances consumer rights and as such is not viewed as reducing the requirements of the standard and results in a matter outside of the organization's control.
  - For more information on related CMS guidance, reference the Medicare Managed Care Manual, Chapter 13, Section 40.1 (utilization review), Section 50.4 (expedited utilization review), Section 70.7.1 (standard appeal), and Section 80.1 (expedited appeal).

- The organization's case file reviews will be evaluated based on the time frames specified in the organization's written policies and/or documented procedures.
- Time frames for written requests are reviewed based on the date and time the request was received by the organization (mail room), not the date and time the request was received by the UM department.
- The time frames are inclusive of denial notification.
- P-HUM 20(a)(i): If the organization never extends time frames for retrospective review cases please reflect that in the written policies and/or documented procedures.

Scope of Standards

- P-HUM 19 through P-HUM 21 apply to the initial review process (i.e., prospective, concurrent and retrospective).

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures covering retrospective reviews.
- Sample template of written notice (letter) of extension to consumer and ordering physician.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Clinical case records illustrating the retrospective review process.
- Copies or re-prints of written notifications (letters).

Bright Ideas

- Develop and provide templates or guidelines to clinical providers and facilities which outline the required routine clinical information needed to support acquiring the appropriate clinical review information in a timely manner.
- If the UM review process is supported on an electronic platform, build time frame requirements into the system to alert reviewers of impending reviews.

- Develop reports to monitor the status of receipt of retrospective reviews, documentation of correspondence and pending follow up dates.
- As part of the operations or quality management oversight, conduct periodic evaluations of written notifications/letter generation to assure the quality of the content of the letters and that letters have been mailed and responded to within the stated time frames.
- Date and time stamp all letters when received in the organization's mail room and receipt within the UM department.
- Image all correspondence received from a provider and/or patient regarding a retrospective review. Retain the imaged documents in the member's case file.
- Establish a communication tracking log for all faxes received during and after regular business hours.

Related Standards

P-HUM 21 - Concurrent Review Time Frames

For *concurrent review*, the *organization* adheres to the following time frames: (No Weight)

> (a) For reductions or terminations in a previously approved course of treatment, the *organization* issues the determination early enough to allow the *patient* to request a review and receive a decision before the reduction or termination occurs; **and** (4)

> (b) For requests to extend a current course of treatment, the *organization* issues the determination within: (No Weight)

>> (i) 24 hours of the request for a *utilization management* determination, if it is a *case involving urgent care* and the request for extension was received at least 24 hours before the expiration of the currently certified period or treatments; **or** (4)

>> (ii) 72 hours of the request for a *utilization management* determination, if it is a *case involving urgent care* and the request for extension was received less than 24 hours before the expiration of the currently certified period or treatments. (4)

Interpretive Information/Commentary

- These time frames are intended to closely follow the time frames specified in the Department of Labor (DoL) claims regulation.
- In cases where there is an extension to the process that is permitted under the Department of Labor regulation – for example, to obtain additional information to consider the case – URAC will consider the URAC time frames suspended during the extension. The organization must document the reasons for the extension in the case file as well as the dates the extension started and ended.
- See the definitions section of this document for the definition of "case involving urgent care." It is recommended that organizations provide a definition of urgent care in their policies and procedures. Important: The application of this definition to determine whether a case is urgent is left to the organization, unless a "physician with knowledge of the consumer's medical condition" expresses the opinion that following non-urgent time frames "would jeopardize the health of the consumer."
- The time frames provided in these standards are inclusive of the entire UM process, from the receipt of the request for a UM decision to the issuance of the decision, including the sending of the written notification (but not necessarily receipt of the decision by the patient or provider, as the mail can take several days). (In cases that result in non-certification, this means the issuance of the written determination required by P-HUM 24.)
- If a peer-to-peer conversation (see P-HUM 18) occurs before the issuance of the UM determination, there would NOT be an extension to the time frames specified in P-HUM 19-21. The only likely exception to this is when the organization makes repeated attempts and the treating physician is not available. That would be "an event outside the organization's control" and would entitle the organization to an extension.
- For purposes of administering and demonstrating compliance with these standards, it is important that the organization has a mechanism to identify the date on which a case was received.

- If the patient is discharged prior to approving the next course of stay then this would be treated like a retrospective review.
- For all other urgent/non-urgent requests, refer back to prospective review time frames.

Points to Remember

- P-HUM 21(a): Organization cannot reduce or terminate a course of treatment that was already approved, certified or authorized unless they give the patient time to request another review before the reduction or termination goes into effect. This is very different than a situation where a provider is requesting an extension to or continuation to the previously approved course of treatment.
- P-HUM 21(b)(i) and P-HUM 21(b)(ii): Do not confuse the term "urgent care" with "emergency care." These are separate and distinct concepts. An organization may not be required to pre-authorize emergency room visits; however, this is different from an urgent care pre-authorization request.
- Organizations may refer to urgent care cases as "expedited" cases. Organizations are not required to change their terminology for purposes of meeting URAC Standards.
- The urgent time frames should be monitored on an on-going basis as part of the UM organization's quality management program.
- These time frames are intended to maintain consistency with the DoL regulations. If your organization has stricter turnaround time frames, you are encouraged to maintain the stricter performance turnaround time.
- Some state regulatory agencies may have specific time frames for review that are more restrictive than DOL regulations. Review the statue regulatory time frames of all states in which you conduct UM reviews.
- When a state or federal government entity such as CMS provides consumers (i.e., enrollees, members, or patients) with the right to extend the timeline for an initial review or appeal, the applicant organization does not need to submit to URAC a request for a regulatory variance. Even though the time frame within which to complete the review or appeal is extended, this type of law or regulation enhances consumer rights and as such is not viewed as reducing the requirements of the standard and results in a matter outside of the organization's control.
  - For more information on related CMS guidance, reference the Medicare Managed Care Manual, Chapter 13, Section 40.1 (utilization review), Section 50.4 (expedited utilization review), Section 70.7.1 (standard appeal), and Section 80.1 (expedited appeal).

- The organization's case file reviews will be evaluated based on the time frames specified in the organization's written policies and/or documented procedures.
- Time frames are inclusive of denial notification.

- Updated 1/27/2015: To clarify the intent of the standard with regard to concurrent review time frames, given an urgent care case, if the request for an extension is:
  - Received at least 24 hours or more before certification expires, notification of the review determination occurs within 24 hours of receipt of the request.
  - Received less than 24 hours before certification expires, notification of the review determination occurs within 72 hours of receipt of the request.

Scope of Standards

- Updated 1/27/2015: HUM 21 applies to all ongoing (i.e., concurrent) inpatient reviews; whereas, outpatient reviews (both urgent and non urgent) are covered under prospective review (HUM 19).

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures covering the concurrent review process.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Clinical case records illustrating the concurrent review process.
- Randomly selected staff interview to verify compliance with the concurrent review process.

Bright Ideas

- Develop and provide templates or guidelines to clinical providers and facilities which outline the required routine clinical information needed to support acquiring the appropriate clinical review information in a timely manner.
- If the UM review process is supported on an electronic platform, build time frame requirements into the system to alert reviewers of impending reviews.
- Evaluate the feasibility of assigning specific UR staff to facilities for obtaining concurrent review information.
- If most of the concurrent reviews are conducted telephonically, then schedule a time each day with high volume facilities to obtain concurrent review information.
- Establish a process to assign an individual to conduct reminder calls on the day prior to when the information is needed for the concurrent review.

Related Standards

P-HUM 22 - Certification Decision Notice and Tracking

For *certifications*, the *organization:* (No Weight)

(a) Has a process for notification of the *attending physician* or other *ordering provider*, *facility rendering service,* and *patient;* (4)

(b) Includes tracking information (such as a reference number) in the notice of *certification*; **and** (3)

(c) Upon request from the *attending physician* or other *ordering provider*, *facility rendering service,* or *patient*, provides *written notification* of any *certification.* (4)

Interpretive Information/Commentary

- Notification of certifications will be timely and contain information pertinent to the review, including any tracking or reference number.
- If the notification is not within the scope of the contract for a delegated UM decision, then the delegate must refer the inquiry to the delegator.
- A request for written notification of a certification is provided to the individual making the request.
- The time frames associated with certification decision notice and tracking should be monitored on an ongoing basis as part of the organization's quality management program.
- The provider may be responsible for notifying the patient. An example of the process represented by standard element (a) would be if the organization or health plan makes the PCP contractually responsible for notification. This process would be formally approved in policies and procedures and would be documented as part of the case file. It should also be reflected as a participating PCP provider responsibility in the PCP/provider contract, contract attachments or addenda (such as the provider manual - if the provider manual is a binding document.)

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-HUM 22(a) and P-HUM 22(c). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.
- For P-HUM 22(a), types of notification include verbal (should be documented in case review notes), voice mail, electronic means including email and fax, or mailed letters.
- P-HUM 22(b) refers to a number or tracking identifier for the authorization that a patient or provider can use in referencing the authorization. Examples include a case number, or a system-generated authorization number for the review.
- For P-HUM 22(c), the written policies and/or documented procedures should address the process to provide written notification if requested.

Scope of Standards

- P-HUM 20 through P-HUM 21 cover notification of certification determinations, not non-certifications.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures covering prospective, concurrent, and retrospective review notifications.
- Sample template(s) of written notification letters of certifications.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Clinical review records illustrating the certification notification process.
- Copies of certification notification letters will be reviewed as part of the case file review process. If another means of notification is used, then documentation of the notification must be part of the clinical record.

Bright Ideas

- When UM organizations are conducting multiple concurrent reviews on a daily basis with clinical providers and facilities, create a log to document the concurrent reviews to include the number of extended days, next anticipated review date and total number of days or services approved.
- When using a clinical information system, generate a daily follow up report based on the next review date to ensure timely follow up on pending reviews.
- If the UM review process is supported on an electronic platform, build an electronic interface with letter generation functionality to document tracking information, number of days or services approved, extended days or units and next anticipated review date.
- Include a phone number and preferably the name of an individual within the UM department within the body of the letter for the member or provider to contact for additional information or questions.

Related Standards

P-HUM 23 - Continued Certification Decision Requirements

Confirmation of *certification* for continued hospitalization or services includes the number of extended days or units of service, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services. (3)

Interpretive Information/Commentary

- If notification is not within the scope of the contract for a delegated utilization management decision, then the delegated entity must refer the requisite party (e.g., attending physician or other ordering provider, facility rendering service, or patient) to the organization (i.e., delegator).
- The organization is required to have a process in place that ensures that all authorized individuals in the organization have access to information regarding prior authorization decisions as outlined in the standard, as well as other information pertinent to the case.

Points to Remember

- Types of notification include verbal communication (including voice mail), electronic (including email and fax), or mail (hard copy notification).

- Verbal notification must be documented in the case notes.

Scope of Standards

- P-HUM 20 through P-HUM 21 cover notification of certification determinations, not non-certifications.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures covering prospective, concurrent and retrospective review notifications.
- Sample templates of written notification used for continued stay certifications for patients, providers and facilities.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Clinical review records illustrating continued stay certification notification process.
- Certification notification letters associated with case files chosen for review.

Bright Ideas

- When UM organizations are conducting multiple concurrent reviews on a daily basis with clinical providers and facilities, create a log to document the concurrent reviews to include the number of extended days, next anticipated review date and total number of days or services approved.
- If the review process is supported by a clinical information system, establish a daily report to generate a listing of cases due for review based on the scheduled review date.
- To improve the efficiency of conducting concurrent reviews, establish primary and secondary contacts for the facilities.

- Establish a care coordination team of RNs who will conduct all concurrent reviews to identify patients for discharge planning and referral to case management and/or disease management programs.
- If the UM review process is supported on an electronic platform, build an electronic interface with letter generation functionality to document tracking information, number of days or services approved, extended days or units and next anticipated review date.

Related Standards

P-HUM 24 - Written Notice of Non-Certification Decisions and Rationale

For *non-certifications*, the *organization* issues *written notification* of the *non-certification* decision to the *patient* and *attending physician* or other *ordering provider* or *facility rendering service* that includes: (No Weight)

(a) The *principal reasons* for the determination not to certify; (4)

(b) A statement that the *clinical rationale* used in making the *non-certification* decision will be provided, in writing, upon request; **and** (4)

(c) Instructions for*:* (No Weight)

(i) Initiating an *appeal* of the *non-certification;* **and** (Mandatory)

(ii) Requesting a *clinical rationale* for the *non-certification.* (Mandatory)

Interpretive Information/Commentary

- The **principal reasons** for a non-certification determination include a clinical or non-clinical statement as to why the utilization management organization said "no" to the request. For example, "care could be provided in a less acute setting," "insufficient diagnostic work-up," and "conservative treatment not tried nor ruled out," etc., are examples of acceptable principal reasons.
   - A general, non-specific statement such as "care is not medically necessary" does not meet the intent of the principal reason requirement for P-HUM 24(a). The principal reason for a non-certification determination must explain the primary reasons why a requested service at a facility, procedure or treatment is not medically necessary.

- The **clinical rationale** provides additional clarification of the clinical basis for a non-certification decision and specific reasons why a particular patient's symptoms or clinical scenario did not meet clinical review criteria.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-HUM 24(a) and P-HUM 24(b). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There is a table following this document that contains a complete listing of the MLR standard elements for this accreditation.
- Non-certification notification will be timely, will be provided in writing and will include the information needed to provide the basis for an appeal.
- The health literacy /education level and linguistic needs of the population served should be considered when developing the non-certification letter templates to patients/members (reference Core 40).

- P-HUM 24(a): The principal reason for the non-certification determination should include a general clinical or non-clinical statement as to why the utilization management organization said "no" to the request. For example, "care could be provided in a less acute setting," "insufficient diagnostic work-up," and "conservative treatment not tried nor ruled out," etc.
- P-HUM 24(a): A general statement such as "care is not medically necessary" does not meet the intent of the principal reason requirement.
- P-HUM 24(b): If the organization provides the clinical rationale in the non-certification notification letter, then the offer for the clinical rationale in writing would not be required. Remember that the clinical rationale is the specific reason why services are not being authorized specific to the consumer.
- P-HUM 24(b): Some state regulatory requirements may require that the clinical rationale be provided in the letter. Reference the state regulatory requirements for all states in which the UMO conducts business.
- P-HUM 24(b): URAC recognizes that in certain circumstances, such as when a patient is potentially suicidal, it would not be appropriate to send the clinical rationale directly to the patient. For these exceptions, it is permissible for the utilization management organization to send the rationale to the provider and have the provider discuss the clinical rationale with the patient. Note that this exception applies only to clinical rationale and not principal reason. For this exception, the notification letter sent to the patient includes the principle reason and refers the patient to the physician or other ordering provider.
- P-HUM 24(c): The non-certification letter must include the process to request an appeal and the clinical rationale (if not provided in the letter). Some states have specific appeal language requirements and it would be prudent to check with regulatory compliance for guidance.
- For entities such as HMOs and PPOs, the patient may not be financially responsible for a procedure, treatment or service at a facility that is not certified; therefore, notification does not have to be sent to the patient. However, before implementing this policy, the organization need to discuss the situation with the entity (HMO or PPO) and review any applicable state or federal law or regulation specific to this situation.

Scope of Standards

- P-HUM 24 covers notification of non-certification determinations, not certifications.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures covering non-certifications.
- Sample template of written notification of non-certifications.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Examples of written notification (letters).
- Appeal reports (database, log). If the organization is applying for initial accreditation the report should include a list of cases received since the applicant submitted their application for accreditation. If the organization Denial is applying for re-accreditation the report must include all cases received since the last accreditation visit.
- A random selection of at least 30 denial and appeal cases will be selected to verify compliance with the requirements of the URAC standards.

- UM case records chosen for review during the onsite visit will be assessed for UM non-certification documentation and notification.

Bright Ideas

- Providing the clinical rationale for a non-certification at the time of the non-certification notification rather than waiting for a request of the clinical rationale.
- For organizations providing UM in multiple states and using an electronic platform, hyper-link the address field of letter templates to state regulations related to the issuance of non-certification notices.
- Develop a template, guideline or hyperlink that provides the written notification requirements for a particular state, line of business, or group.
- As part of the quality monitoring program, implement a process to verify that all letters generated electronically were printed and mailed within the time frames.
- Establish a process to routinely monitor the letters for accuracy of information.
- Run a daily report of letters generated by a clinical information system.
- If letter generation is outsourced to another department, establish quality monitoring procedures to monitor accuracy and timeliness of letter generation.
- To evaluate the health literacy and linguistic needs for written notifications, conduct an annual review of the demographics of the population served by the utilization management organization.

Related Standards

P-HUM 25 - Clinical Rationale for Non-Certification Requirements

Upon request from the *patient, attending physician,* or other *ordering provider* or *facility rendering service*, the *organization* provides the specific *clinical rationale* upon which the *non-certification* was based. (4)

Interpretive Information/Commentary

- The clinical rationale provides additional clarification of the clinical basis for a non-certification decision, and specific reasons why the patient's symptoms did not meet the criteria.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-HUM 25. For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.
- URAC recognizes in certain circumstances, such as a potentially suicidal patient, it may not be appropriate to send the clinical rationale directly to the patient. For these exceptions, URAC will allow the UM organization to send the rationale to the provider, and have the provider discuss the clinical rationale with the patient. Note that this exception applies to clinical rationale, not principal reason. The letter to the patient should refer him or her to the physician or other ordering provider.
- Clinical rationale provides supporting documentation specific to the patient under review, for a non-certification decision. Simply referring to clinical criteria is not sufficient to meet the standard.
- If the organization provides the clinical rationale in the non-certification letter then this standard may be non-applicable. The policy and/or written procedure should indicate that the rationale is provided.

Scope of Standards

- P-HUM 25 covers notification of non-certification determinations, not certifications.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures covering non-certifications and mechanisms for providing clinical rationale upon request.
- Sample template of written notification of non-certification letters that provide clinical rationale.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Denial and appeal reports (database report or log). If the organization is applying for initial accreditation the report should include a list of cases received since the applicant submitted their application for accreditation. If the organization is applying for re-accreditation the report must include all cases received since the last accreditation visit.

- Examples of cases where clinical rationale for a non-certification was provided upon request and/or written notification letters that provide clinical rationale.

Bright Ideas

- Consider providing the clinical rationale for a non-certification at the time of the non-certification notification rather than waiting for a request of the clinical rationale.
- For organizations conducting utilization management in multiple states and using an electronic platform, hyper-link the address field of letter templates to state regulations related to the issuance of non-certification notices.
- Develop a process for tracking requests and response for clinical rationale documentation.
- Image all hard copy correspondence and store the file electronically with the case file information (include the certification/case reference number).
- Store receipt and response dates and times, as well as clinical rationale information in the case file documentation (either electronic or hard copy files.)

Related Standards

P-HUM 26 - Prospective Review Patient Safety

To improve *patient* safety and reduce medical errors, the *organization* has implemented a mechanism to address potential safety issues identified during *prospective review* through to resolution. (Mandatory)

Interpretive Information/Commentary

- Examples of potential safety issues to screen for during prospective review include, but are not limited to:
  - Contraindicated treatment
  - Conservative treatment not addressed or ruled out
  - Adverse drug interactions
  - Inappropriate treatment

- Written policies and/or documented procedures need to clearly delineate the various possible decision points and steps in the process used to address potential or known safety issues through to resolution. The "resolution" or "last step in the process" for the organization will vary depending on what the issue is. The various possible decision points and next or final steps are listed below:
  - A potential safety issue needs to be referred to another entity or authority in order to determine if it is a safety issue.
  - A potential safety issue needs to be researched by the organization in order to determine if it is a safety issue.
  - A known safety issue is referred to another entity or authority for further action.
  - A known safety issue is referred internally within the organization for further action.

- This standard <u>does not require</u> organizations to document the presence or absence of safety issues for every prospective review conducted; documentation by exception is acceptable.
- Note that the screening for potential safety issues is based on the information received for the prospective review; this standard <u>does not require</u> organizations to secure additional information in order to determine potential safety-related problems.
- Organizations are to use the criteria required by P-HUM 1; additional criteria sets <u>are not needed</u> to implement this standard.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-HUM 26. For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.

- This standard is designed to address a process that begins with prospective review and includes the actions needed to address safety or medical error issues identified during that process. These activities are included in the Medical Loss Ratio (MLR), Column 3 – Improve Patient Safety and Reduce Medical Errors:
  - "Expenses for implementing activities to improve patient safety and reduce medical errors as defined above through prospective prescription drug Utilization Review aimed at identifying potential adverse drug interactions."

- Note that this is a mandatory standard.

- The organization will not be penalized if it does not have a potential or actual safety issue discovered during prospective review to share during the accreditation onsite review.

Scope of Standards

- This standard applies to potential or known patient safety issues identified based on the information received for a prospective review.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures delineating the various possible decision points and steps in the process used to address potential or known safety issues through to the resolution or final step in the process as determined by the organization.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Documentation of potential or known patient safety issues identified during prospective review, which includes the resolution or final step in the process as determined by the organization.
- Interview with senior clinical staff person.
- Interview with UM supervisory staff.
- Interview of UM staff involved in the prospective review process.

Bright Ideas

- Establish a log - similar to a complaint log - that documents tracking of potential or known patient safety issues from identification to resolution/ final step in the process.

- Enter a note into the case file documenting identification of potential or known patient safety issues and any related action(s) leading to resolution/ final step in the process.
- Include medication safety in your definition of a patient safety concern. Potential adverse drug interactions and/or poly-pharmacy may be identifiable in a medication reconciliation process such as is required by P-OPS 7.

Related Standards

P-HUM 27 - Reversal of Certification Determinations

The *organization* does not reverse a *certification* determination unless it receives new information that is relevant to the *certification* and that was not available at the time of the original *certification.* (4)

Interpretive Information/Commentary

- The organization must document under what circumstance it will reverse a prior certification (non-certify a case that was previously certified). If the organization does not reverse certification decisions regardless of any new information provided, then this must be indicated in a written policy statement.

Points to Remember

- Written policies and/or documented procedures that specify the organization's process for reversing (or not reversing) certification decisions.

Scope of Standards

- P-HUM 27 applies to the potential reversal of certification determinations, not non-certifications.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures addressing reversal of prior certification decisions.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Clinical case records illustrating the clinical review process.
- Review staff may be interviewed to determine what instructions they have been provided regarding the reversal of certifications

Bright Ideas

- Create workflow/job aides for UM personnel on how to complete a reversal of a certification decision.
- Create a template within the case file information to identify additional relevant information that was received to reflect the date, time and source of the information.
- Create training scenarios for initial orientation that include examples of reversal of certifications.
- Establish a database for monitoring the reversals of certification determinations to include information for provider performance patterns. This information may identify potential fraudulent practices or identify providers that need additional education regarding the review process.
- Establish internal notification procedures regarding reversals of certification determinations to other departments, such as claims and members services as applicable.

Related Standards

P-HUM 28 - Frequency of Continued Reviews

The *organization* ensures that the frequency of reviews for the extension of initial determinations is based on the severity or complexity of the *patient's condition* or on necessary treatment and *discharge planning* activity (i.e., not routinely conducted on a daily basis). (4)

Interpretive Information/Commentary

- Refer to the section "Points to Remember."

Points to Remember

- It is understood that hospital stays can be very short and as such, may require daily reviews for appropriate discharge planning. That being said, however, there are instances where daily reviews could place an undue burden on providers or patients, and may not be necessary given the severity of the patient's clinical condition. Examples include a new ventilator patient in an ICU, a rehabilitation patient recovering from extensive injuries, a complex newborn in NICU, or an acutely psychotic patient refusing to take medication.
- The utilization management organization must allow initial clinical review staff to base the frequency of concurrent reviews on the patient's condition. It is acceptable to require that each day of clinical service be included as part of the review.
- Concurrent reviews are applicable to any clinical setting, including services provided in the outpatient setting.

Scope of Standards

- P-HUM 28 applies to concurrent reviews regardless of the clinical setting.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures addressing frequency of concurrent reviews.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Clinical case records illustrating continued stay review patterns.
- Review staff may be interviewed to determine what instructions they have been provided regarding the frequency of conducting concurrent reviews.

Bright Ideas

- To improve communications with providers, furnish a guideline or list of circumstances under which the organization would require daily reviews.
- To improve review efficiencies, schedule specific appointments with the hospital or other facility staff to conduct the clinical reviews for continued stay.
- As part of the quality monitoring process, conduct periodic reviews/audits of the frequency of continued stay reviews.
- Establish continued stay review guidelines based on diagnosis and levels of care for all clinical staff.

- Provide the frequency of review guidelines on the intranet or include in a clinical information system (based on diagnosis, service codes and level of care).

Related Standards

P-HUM 29 - Scope of Review Information

The *organization*, when conducting routine *prospective review*, *concurrent review*, or *retrospective review*: (No Weight)

(a) Accepts information from any reasonably reliable source that will assist in the *certification* process; (2)

(b) Collects only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services; (2)

(c) Does not routinely require hospitals, physicians, and other *provider*s to numerically code diagnoses or procedures to be considered for *certification*, but may request such codes, if available; (4)

(d) Does not routinely request copies of all medical records on all *patient*s reviewed; (4)

(e) Requires only the section(s) of the medical record necessary in that specific *case* to certify medical necessity or appropriateness of the admission or extension of stay, frequency or duration of service, or length of anticipated inability to return to work; **and** (4)

(f) Administers a process to share all clinical and demographic information on individual *patients* among its various clinical and administrative departments that have a need to know, to avoid duplicate requests for information from enrollees or *providers*. (3)

Interpretive Information/Commentary

- Written policies and/or documented procedures should indicate that additional medical records should only be requested when there is difficulty in making a review determination.
- Patient and provider confidentiality must be protected when obtaining or sharing medical information.

Points to Remember

- P-HUM 29(a): The UM organization must accept information from any reasonably reliable source. Most organizations identify in their policies and/or documented procedures who they consider a "reasonably reliable source".
- P-HUM 29(b): The organization must collect only the information necessary to make the determination.
- P-HUM 29(c): The organization may not require that the provider numerically code diagnoses or procedures, but it may request this information and if not provided, the review process continues.
- P-HUM 29(d): The organization must collect only the information necessary to make a determination on a specific case; therefore, it is not acceptable to request copies of all medical records on all patients reviewed.
- P-HUM 29(e): The organization must collect only the information necessary to make that specific determination.

- P-HUM 29 (f): Information is shared within the utilization management organization so as to avoid repeated requests for information from patients or providers.
- Note: Utilization management organizations may take language from the URAC standards, weaving it into their written policies and/or documented procedures and evaluating it to make sure that it reflects their current way of doing business.

Scope of Standards

- P-HUM 29 applies to initial reviews (i.e., prospective, concurrent and retrospective).

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures addressing scope of review information when conducting prospective, concurrent and retrospective reviews.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Clinical case records illustrating scope of review information processes.

Bright Ideas

- If an organization's UM program is managed on an electronic platform, then create automatic alerts to other departments/ programs that need to be alerted regarding approved health care services (e.g., Case Management, Disease Management, Claims, etc.)
- Develop and provide templates or guidelines to clinical providers that outline the required routine clinical information needed to support gathering the appropriate clinical review information in a timely manner.
- Develop a workflow/job aid covering the elements required for clinical reviews.
- Develop a template for clinical staff to use to collect the appropriate data elements for a UM review.
- As part of quality and compliance monitoring activities, conduct phone observations of the clinical review process and case file review audits for documentation of clinical information.
- Develop a standard abbreviation list to for all personnel to use for case file documentation.

Related Standards

P-HUM 30 - Prospective and Concurrent Review Determinations

For *prospective review* and *concurrent review*, the *organization* bases review determinations solely on the medical information obtained by the *organization* at the time of the review determination. (4)

Interpretive Information/Commentary

- The purpose of standards P-HUM 29 and P-HUM 30 is to ensure that review decisions are based on information available at the time of the review.
- For retrospective decisions, review decisions are based on the information available to the provider at the time the medical care was provided. Examples of this include emergency room retrospective reviews where diagnostic tests may have been conducted to rule out a serious medical condition.

Points to Remember

- Prospective and concurrent reviews are applicable to inpatient and outpatient review types. Decisions must be based on the information obtained at the time of the review determination.

Scope of Standards

- P-HUM 28 applies to prospective and concurrent reviews.
- The scope of the Health Utilization Management standards is limited to medical necessity reviews conducted when certification is required.
- Non-certification for reasons that the service is experimental and/or investigational or a non-covered benefit as indicated in a certificate of coverage, are outside the scope of the URAC utilization management standards.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures addressing prospective and concurrent review.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Random selection of case files reflecting prospective and concurrent review processes.
- Records illustrating peer clinical review and peer-to-peer conversations.

Bright Ideas

- Image any/all written clinical documents (medical records, letters) that have been submitted as part of the clinical review; file the imaged documents using a unique case identification number.
- Develop case documentation guidelines and templates for the clinical reviewers to use when documenting the receipt of clinical information.

Related Standards

P-HUM 31 - Retrospective Review Determinations

For *retrospective review*, the *organization* bases review determinations solely on the medical information available to the *attending physician* or *ordering provider* at the time the medical care was provided. (4)

Interpretive Information/Commentary

- For retrospective review determinations, review decisions are made based on the information available to the provider at the time the medical care was rendered.

Points to Remember

- Retrospective reviews apply to all types of reviews, for example, inpatient and outpatient. Decisions must be based on the information available to the provider at the time care was rendered.

Scope of Standards

- P-HUM 31 applies to retrospective reviews.
- The scope of the Health Utilization Management standards is limited to medical necessity reviews conducted when certification is required.
- Non-certification for reasons that the service is experimental and/or investigational or a non-covered benefit as indicated in a certificate of coverage, are outside the scope of the URAC utilization management standards.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures addressing retrospective review.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Random selection of case files containing documentation on the retrospective review process.

- Records illustrating peer clinical review.

Bright Ideas

- Image any/all written clinical documents (medical records, letters) that have been submitted as part of a clinical review; file the imaged documents using a unique case identification number.
- Establish a tracking log or database to document the receipt, status, outcomes and written correspondence for retrospective reviews.
- Establish interdepartmental notification procedures regarding changes in the review determinations such as claims and member services, if applicable.

Related Standards

P-HUM 32 - Lack of Information Policy and Procedures

The *organization* implements policies and procedures to address situations in which it has insufficient information to conduct a review. Such policies and procedures provide for: (No Weight)

    (a) Procedural time frames that are appropriate to the clinical circumstances of the review (i.e., *prospective*, *concurrent* and *retrospective reviews*); (4)

    (b) Resolution of *cases* in which the necessary information is not provided to the *organization* within specified time frames; **and** (4)

    (c) Processes by which the *organization* issues an administrative *non-certification* due to lack of information. (4)

Interpretive Information/Commentary

- For URAC accreditation, the utilization management organization may set its own time frames under this standard. However, the Department of Labor claims regulations provide specific guidance on this issue.
- If the provider submits some clinical information and indicates to the company that this is all of the information that is available, then the request must be processed in accordance with standards P-HUM 19, 20, and 21.

Points to Remember

- The goal of this standard is to ensure that the utilization management organization has a policy and procedure in place that explains in detail how the company will resolve the situation when information essential to making a review determination is not forthcoming.

- Notification attempts to obtain additional information must be documented (e.g., phone calls are recorded in case records, copies of letters, etc.)

- The Department of Labor (DoL) claims regulation provides considerable guidance with respect to time frames and processes for requests for additional information. Please refer to the DoL regulations when developing or revising your policy and procedure.

- State regulations may also include specific requirements for time frames and processes, such as a requirement for peer-to-peer conversation, prior to issuing a review determination based on insufficient or lack of information. Refer to the appropriate regulatory requirements for the states in which the utilization management organization is licensed for UM.

Scope of Standards

- P-HUM 32 covers cases where there is insufficient information to render a utilization management decision.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures describing the processes to be followed in cases where a lack of information prevents completion of the review process.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Clinical case records illustrating the lack of information process.
- Log/report of administrative denials for lack of information.

Bright Ideas

- Many organizations label this process a "certification suspension" process rather than an "administrative denial" process to eliminate confusion between clinical and administrative non-certification decisions.

- Also, for provider networks, monitoring the rate of administrative non-certifications (along with clinical non-certifications) by provider and providing this feedback is very helpful in increasing compliance of call-backs.

- Many organizations provide a process for "reopening" a case that has been either suspended or denied for administrative reasons. Notification of the case suspension or administrative denial should include the process for requesting the case be "reopened" and what information is necessary to complete the clinical review.

- Develop correspondence that specifies what additional information is needed and any specific time frames (that may be included) for a response to an administration denial for lack of information.

- Some organizations establish a policy and procedure that identifies these types of denials as "lack of information" denials and will conduct retrospective reviews if additional information is submitted within a specific time frame.

Related Standards

P-HUM 33 - Non-Certification Appeals Process

The *organization* maintains a formal process to consider *appeals* of *non-certifications* that includes: (No Weight)

> (a) The availability of a *standard appeal* for non-urgent *cases* and *expedited appeal* for *cases involving urgent care*; **and** (Mandatory)

> (b) Written *appeal* policies and procedures that: (No Weight)

>> (i) Clearly describe the *appeal* process, including the right to *appeal* of the *patient, provider,* or *facility rendering service*; (Mandatory)

>> (ii) Provide for explicit time frames for each stage of the *appeal* resolution process; **and** (Mandatory)

>> (iii) Are available, upon request, to any *patient, provider,* or *facility rendering service*. (Mandatory)

Interpretive Information/Commentary

- The appeal process is written and communicated to the stakeholders in the process. These appeal processes and time frames closely follow those specified in the Department of Labor (DoL) claims regulation.
- It is acceptable for organizations to make available a written description or summary of the policies and procedures on appeals.
- The member, patient, provider or facility may request an appeal either verbally or in writing.

Points to Remember

- P-HUM 33(a): The written policy and/or documented procedure must include an expedited and standard appeal process.
- P-HUM 33(a): To gain an understanding of the intent of this standard, please review the definitions for the defined terms found in standard element P-HUM 33(a):
    - Standard Appeal
    - Expedited Appeal
    - Cases Involving Urgent Care

- P-HUM 33(b): This standard element encompasses the right of the consumer, provider, or facility rendering service to request an appeal verbally or in writing. It is acceptable to have appeal policies and/or documented procedures that apply exclusively to patients, separate from the ones that apply to providers and facilities rendering service. Organizations are required to identify the time frame in which the provider or facility may submit an appeal. If the utilization management organization uses the term "provider" to include facilities, then this needs to be documented in the appeals policy.

- P-HUM 33(b): Some states have regulatory requirements specific to the appeals process. It may be related to terms and definitions, time frames, peer clinical reviewer requirements, using an external review organization, notification requirements, etc. Reference the state regulatory requirements for all states in which the utilization management organization conducts business.
- P-HUM 33(b)(i): Correspondence with the members/patients should be in plain language that is applicable to the health literacy and linguistic needs of the population(s) served by the utilization management organization.
- Delegation: If appeals processes are delegated to a non-URAC accredited utilization management vendor, then the organization should establish a policy and procedure to address the oversight and accountability of the appeals process of the delegated entity.

Scope of Standards

- P-HUM 33 applies to medical necessity appeals of non-certification determinations.
- Appeals of non-coverage determinations are not considered medical necessity appeal determinations and are not included in the scope of these UM standards.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures covering expedited and standard appeals.
- Sample template of correspondence related to appeals.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Clinical case records illustrating implementation of the appeals process.
- Appeal reports (database, log). If the organization is applying for initial accreditation the report should include a list of cases received since the applicant submitted their application for accreditation. If the organization is applying for re-accreditation the report must include all cases received since the last accreditation visit.
- A random selection of at least 30 denial and appeal cases will be selected to verify compliance with the requirements of the URAC standards.
- UM case records chosen for review during the onsite visit will be assessed for UM appeal processing inclusive of the notification process.
- Staff coordinating the appeals process may be interviewed to ensure an understanding of the appeals process, including time frames.
- URAC reviewers will interview staff responsible for notifying consumers and providers of appeal processes.
- Senior clinical staff person interview to verify understanding of the organizations appeal processes.

Bright Ideas

- Create an appeal tracking mechanism (log or database) that includes the types of the appeals, date received, date referred to the clinical peer reviewer, clinical peer reviewer name and qualifications, outcomes and dates of notifications.
- As part of the ongoing quality management program, analyze the appeals data on a monthly or quarterly basis to identify trends or opportunities for process improvement.
- Establish "appeals reporting" as a standing agenda item for the QI Committee meeting.

- For easy access to the organization's appeal process, establish a consumer portal and provider portal on the Internet.
- Develop templates or guidelines that can be inserted into letters to address the variations in appeals time frames due to state regulatory requirements.
- Develop a table that contains the various appeal types, time frames and notification requirements based on lines of business, state requirements or peer clinical reviewer qualifications. Make this table available on the organization's intranet or as a hyperlink in an electronic clinical information system.

Related Standards

P-HUM 34 - Appeals Process

As part of the *appeals* process: (No Weight)

    (a) The *organization* provides the *patient, provider,* or *facility rendering service* the opportunity to submit written comments, documents, records, and other information relating to the *case*; (Mandatory)

    (b) Takes all such information into account during the *appeals* process without regard as to whether such information was submitted or considered in the initial consideration of the *case*; **and** (Mandatory)

    (c) In the instance of a first level *appeal,* the *organization* implements the decision of the first level clinical *appeal* if it overturns the initial denial. (Mandatory)

Interpretive Information/Commentary

- The appeals process allows for additional information to be submitted, all of which is to be taken into consideration when making an appeal determination.
- The organization has the option to pay for a claim even if the first level clinical appeal upholds the initial non-certification.

Points to Remember

- P-HUM 34(a): The organization's written policies and/or documented procedures must address the right of the provider, consumer, and facility rendering service to submit information related to a request under review.
- P-HUM 34(b): The organization's written policies and/or documented procedures must address that all information will be considered during the appeal process regardless of whether it was reviewed during the initial review.
- P-HUM 34(c): The organization's written policies and/or documented procedures must require that the organization implement the appeal reviewer's determination if it reverses a prior non-certification.
- In addition to the internal appeals processes required by these standards, federal law as well as many state laws requires an external appeal process that is outside the scope of this review.

Scope of Standards

- P-HUM 34 applies to medical necessity appeals of non-certification determinations.
- Appeals of non-coverage determinations are not considered medical necessity appeal determinations and are not included in the scope of these UM standards.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures covering medical necessity standard and expedited appeals.
- Sample template of correspondence related to appeals.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Appeal reports (database, log). If an organization is applying for initial accreditation, then report should include a list of cases received since the applicant submitted its application for accreditation. If an organization is applying for re-accreditation, then the report must include all cases received since the last accreditation visit.
- A random selection of at least 30 denial and appeal cases will be selected to verify compliance with the requirements of the URAC standards.
- UM case records chosen for review during the onsite visit will be assessed for UM appeal processing inclusive of the notification process.
- Interview with senior clinical staff person or medical director responsible for the appeal process to verify understanding of standard requirements.

Bright Ideas

- If some clients retain the appeals process within their organization, make it a part of your written agreement with them that they report back to you on any appeal outcomes. It is one way to obtain feedback on initial non-certification decisions and facilitate communication with your clients.
- If your UM program is on an electronic platform and you are performing UM in multiple states, hyperlink to the state Web site information related to external appeals process requirements.
- Identify the individual(s) within the utilization management organization who will be responsible for coordination of the appeals process. This coordination includes documentation of the receipt of an appeal, facilitation and completion of the appeal process, and proper notification of an appeal outcome.
- As part of the ongoing quality management program, periodically conduct reviews of the appeals files for compliance with all policies and/or documented procedures and regulatory requirements.
- Establish a template that outlines the various state requirements related to appeals such as requirements for an external peer review process.
- As part of the regulatory compliance program work plan, conduct a periodic review of appeals process requirements.
- Develop a workflow (job aid) for all types of appeal processes (i.e., standard and expedited).
- Develop a report from an appeals tracking database to monitor the current status and time frames for appeals processing.

Related Standards

P-HUM 35 - Appeal Peer Reviewer Qualifications

Individuals who conduct *appeal consideration*s are *clinical peers* who: (No Weight)

(a) Hold an active, unrestricted *license* or *certification* to practice medicine or a *health profession* in a state or territory of the United States; (Mandatory)

(b) Unless expressly allowed by state or federal law or regulation, are located in a state or territory of the United States when conducting a*ppeal considerations*; (Mandatory)

(c) Are in the same profession and in a similar specialty as typically manages the medical *condition*, procedure, or treatment as mutually deemed appropriate; (Mandatory)

(d) Are neither the individual who made the original *non-certification*, nor the subordinate of such an individual; **and** (Mandatory)

(e) Are *board-certified* (if applicable).
(3)

Interpretive Information/Commentary

- For any level of review requiring a peer reviewer (i.e., peer clinical review, appeal or external review), the reviewer must hold a U.S. license (or certification) as minimally required to engage in clinical practice and conduct the review within the United States or one of its territories.
  - ❍ Note that peer clinical reviewer qualifications (P-HUM 14) and appeal peer reviewer qualifications (P-HUM 35) are covered in the following URAC accreditations: the P-HUM section of Health Plan, Health Utilization Management and Workers' Compensation Utilization Management; whereas, external review (i.e., state-mandated review) is addressed in URAC's "Independent Review Organization" (IRO) accreditation.

- "Subordinate" in P-HUM 35(d) means someone who reports directly to the individual who made the original non-certification. This standard element aligns with a Department of Labor regulation.
  - ❍ The prohibition in P-HUM 35(d) would apply in situations where an associate medical director as an employee of the UM organization, is asked to consider an appeal of a decision made by the medical director.

- Element (e): URAC recognizes the following board certifications for physicians (MD and DO):
  - ❍ A specialty board approved by the *American Board of Medical Specialties* (doctors of medicine); and
  - ❍ The Advisory Board of Osteopathic Specialists from the major areas of clinical services (doctors of osteopathic medicine); and
  - ❍ Physician board certifications that are formally accepted by a federal program or state medical Board. The applicant organization must have documentation of this recognition from the requisite federal program or state agency. This extended URAC recognition permits these physicians to make or oversee decisions and provide clinical leadership for the federal program or within the state that formally recognized the board certification.

- Element (e): this element is applicable to organizations conducting appeals for dental care.
  - URAC will verify that the applicant organization's credentialing plan identifies the specific dental boards that it will recognize and use to primary source verify (PSV) board certification.
  - If the applicant does not conduct dental appeals, this is documented in its application for accreditation and URAC will consider these appeals outside the scope of the applicant's UM program.
  - URAC recognizes that most dentists are not board certified, so for this standard element only, if the requesting provider is board certified, the appeal reviewer must also be board certified. Conversely, if the requesting provider is not board certified, the appeal reviewer does not have to be board certified either.
    - If the applicant organization conducts dental appeals, in addition to a policy, it needs to be prepared to pull appeal case files demonstrating compliance, which means for each appeal, it needs to know and <u>record in the appeal case file</u> whether or not the requesting dentist is board certified.
    - If the applicant organization has never had a board-certified dentist of any type request an appeal, it needs to show this in a tracking report to URAC.

- Element (e): this element is applicable to organizations conducting appeals for podiatric care.
  - URAC will verify that the applicant organization's credentialing plan identifies the specific podiatric boards that it will recognize and use to primary source verify (PSV) board certification.
  - If the applicant does not conduct podiatric appeals, this is documented in its application for accreditation and URAC will consider these appeals outside the scope of the applicant's UM program
  - Please note that the former "American Board of Podiatric Orthopedics and Primary Podiatric Medicine" (ABPOPPM) is now called the "American Board of Podiatric Medicine" (ABPM) as listed in the standard. The American Board of Podiatric Surgery (ABPS) and the ABPM are the only podiatric boards formally recognized by the American Podiatric Medical Association (APMA) through delegated authority actually conducted by the Joint Committee on the Recognition of Specialty Boards (JCRSP), which is an arm of the Council on Podiatric Medical Education (the Council or CPME).

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-HUM 35(c) and P-HUM 35(e). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.
- The applicant must have written policies and/or documented procedures identifying appeal peer reviewer qualifications. It must include at least all of the mandatory requirements found in the standard. Italicized requirements are defined terms found in the program guide glossary.
- P-HUM 35(a): The organization must have a process to verify that the appeal reviewer has an active and unrestricted license. Primary source verification is required. Organizations must implement a mechanism for tracking licensure expiration dates (see Core 31).

- P-HUM 35(c): Appeal policy must include that appeal reviews are to be made by a specialist or sub-specialist as indicated by the case under review. Ideally the policy would indicate who is responsible for selecting the requisite specialist.
  - The types of specialist reviewers available should cover the types of reviews the UM organization performs. For example, if the UM organization performs behavioral health reviews either exclusively, or as part of general health and welfare reviews, a psychiatrist should be on the panel of advisors/reviewers.
  - An example of appropriate clinical peer selection would be having either a board certified surgeon specializing in cardio-thoracic surgery or a board certified cardiologist conduct the appeal for an aortic valve replacement inpatient stay.

- P-HUM 35(d): The organization's written policies and/or documented procedures must include that the appeal reviewer may not be the same peer reviewer who made the initial determination or report to the that individual.
- P-HUM 35(e): Board certification must be verified via primary source.
- Some state regulatory requirements include a request for a "same state licensure" and/or board certification for the peer clinical reviewer for appeals.
- Refer to the frequently asked questions (FAQs) section of the URAC website (www.urac.org) for examples of appropriate appeal reviewer specialty matching.
- Appeal case review documentation must be legible, including the identity of the appeal peer reviewer.

Scope of Standards

- P-HUM 35 applies to medical necessity appeals of non-certification determinations.
- Appeals of non-coverage determinations are not considered medical necessity appeal determinations and are not included in the scope of these UM standards.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures covering appeal peer reviewer qualifications

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Appeal reports (database, log) - If an organization is applying for initial accreditation, then the report should include a list of cases received since the applicant submitted their application for accreditation - If an organization is applying for re-accreditation, then the report must include all cases received since the last accreditation visit
- A random selection of at least 30 denial and appeal cases will be selected to verify compliance with the requirements of the URAC standards
- UM case records chosen for review during the onsite visit will be assessed for appeal peer reviewer qualifications and credentials verification
- Interview with senior clinical staff person or medical director responsible for the appeal process to verify understanding of standard requirements
- List of names and specialties of peer reviewers performing initial peer review and appeals so the requirements under P-HUM 35 can be verified

Bright Ideas

- If using a contracted specialist panel to conduct appeal reviews, obtain an annual attestation from the contracted vendor verifying that specialist credentials are current and unrestricted.
- Conducting periodic audits of 'specialty matching' will alert the organization to any trends in failure to conduct appeals using appropriate specialists and provide indications for the need to expand the depth of the specialty panel.
- Develop written policies and/or documented procedures that include the guidelines for selection of the clinical peer reviewer for appeal reviews.
- Specify the roles and responsibilities of the individual(s) who will be responsible for referring an appeal to a clinical peer reviewer.
- As part of the quality management program, evaluate all complaints related to appeals outcomes.
- Develop a peer review template for the documentation of an appeal to a peer clinical reviewers; include the name and credentials of the specialist who performed the review.

Related Standards

P-HUM 36 - Drug Utilization Management Appeals: Reviewer Qualifications

In addition to the *clinical peers* described in standard HUM 35, individuals who conduct *drug utilization management appeal considerations* include *pharmacists* who: (No Weight)

   (a) Hold an active, unrestricted *license* or *certification* to practice pharmacy in a state or territory of the United States; (Mandatory)

   (b) Unless expressly allowed by state or federal law or regulation, are located in a state or territory of the United States when conducting *appeal considerations*; (Mandatory)

   (c) Are neither the individual who made the original *non-certification*, nor the subordinate of such an individual; **and** (Mandatory)

   (d) May not conduct *drug utilization management appeal considerations* if: (No Weight)

      (i) Prohibited by state *appeal* laws; **or** (Mandatory)

      (ii) The requesting party specifically requests a *clinical peer*. (Mandatory)

Interpretive Information/Commentary

- One of the goals of this standard is to ensure that the health professionals rendering appeal decisions are capable of conducting an informed dialogue with providers. This is accomplished by requiring that reviewers are knowledgeable and up-to-date in the clinical area under review as shown by their experience, licensure, and requisite board certifications.
- A pharmacist is <u>not permitted</u> to conduct drug utilization management appeal considerations when:
  - State UM law prohibits pharmacists from rendering non-certifications as part of the utilization management process, or
  - The ordering provider and/or patient request that a physician conduct the review.

Points to Remember

- Element (a): The organization has a mechanism to verify active licensure for the individuals conducting appeal considerations.
- "Subordinate" in element (c) means someone who directly reports to the individual who made the original non-certification. This requirement aligns with a Department of Labor regulation.
- Note: External reviews are covered under URAC's Independent Review Organization (IRO) standards. A pharmacist cannot conduct an external review (i.e., external appeal) unless part of a panel that includes at least one physician that meets the qualifications to conduct the appeal, including that the physician is in the appropriate clinical specialty for the review.

Scope of Standards

- This standard applies to drug utilization management appeal considerations.

Evidence for Meeting the Standard - Desktop Review Materials

- Job description of health professional that conduct appeals
- Appeal policy and procedure
- Sample template of correspondence related to appeals

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- 30 appeal files will be selected from the appeal log
- Clinical case records illustrating implementation of the appeals process
- Appeal tracking database or log of appeal reviewer assigned and outcome of the appeal determination
- List of names and specialties of appeal reviewers with licensure and board certification

Related Standards

P-HUM 37 - Reviewer Attestation Regarding Credentials and Knowledge

For each *appeal case* they accept, *reviewers* attest to:
(No Weight)

> (a) Having a scope of *licensure* or *certification* that typically manages the medical *condition*, procedure, treatment, or issue under review; **and** (4)

> (b) Current, relevant experience and/or knowledge to render a determination for the *case* under review. (4)

Interpretive Information/Commentary

- The goal of this standard is to ensure that a reviewer accepting an appeal case believes that s/he has the requisite scope of licensure or certification and experience and/or knowledge to conduct the review.

Points to Remember

- Methods of documenting reviewer attestation include: electronic signature, wet signature, electronic or wet mark in a checkbox where the identity of the reviewer can be determined by name or using a unique identifier assigned to an individual reviewer.
- To demonstrate compliance with this standard, URAC expects a case by case act of attestation by the peer reviewer. Thus, if the statement at the top of the screen requires some active affirmation (such as a check box) by the peer reviewer, then it would be in compliance with HUM 37. If the statement at the top of the page does not require validation by the peer reviewer, then the attestation is passive and not in compliance with HUM 37.

Scope of Standards

- P-HUM 37 focuses on peer reviewer experience and knowledge and pertains to those individuals who accept an assignment to perform review of a specific appeal case.

- P-HUM 37 does not include peer clinical review (P-HUM 13-14).

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures that address reviewer experience and knowledge required for individual cases.
- Attestation template.
- Reviewer training on experience and knowledge requirements, attestation and the process to recuse themselves.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Signed reviewer attestations will be verified as part of the case file review.

Bright Ideas

Related Standards

P-HUM 38 - Expedited Appeal Process Time Frame

Expedited appeals are completed with verbal notification of determination to the requesting party within 72 hours of the request followed by a written confirmation of the notification within 3 calendar days to the *patient* and *attending physician* or other *ordering provider* or *facility rendering service.* (Mandatory)

Interpretive Information/Commentary

- Types of notification include verbal (should be documented in case review notes), voice mail, electronic means including email and fax, or mailed letter. The term "appeals" includes both expedited and standard appeals.
- Appeals notification will be timely, will be provided in writing as well as other acceptable means, and will include the information needed to provide the basis for any additional level of appeal as available.
- **Written notification is to be sent within three (3) calendar days of verbal notification.**

Points to Remember

- "Initiation of the appeal process" means that the patient, attending provider, or facility rendering service has requested an appeal. See P-HUM 33, which does not specify how requests are made (by telephone or written). Written requests can be transmitted by mail, facsimile, or electronic medium.
- Since a non-certification medical necessity determination has already been rendered, it is acceptable for these entities to request an appeal and not submit any additional information; however, it is incumbent upon the utilization management organization to determine whether any additional information will be submitted. This should be documented in the appeal case notes.
- When a state or federal government entity such as CMS provides consumers (i.e., enrollees, members, or patients) with the right to extend the timeline for an initial review or appeal, the applicant organization does not need to submit to URAC a request for a regulatory variance. Even though the time frame within which to complete the review or appeal is extended, this type of law or regulation enhances consumer rights and as such is not viewed as reducing the requirements of the standard and results in a matter outside of the organization's control.
    - For more information on related CMS guidance, reference the Medicare Managed Care Manual, Chapter 13, Section 40.1 (utilization review), Section 50.4 (expedited utilization review), Section 70.7.1 (standard appeal), and Section 80.1 (expedited appeal).

- The appeal time frame starts with the organization's receipt of the appeal request. For verbal requests, it is the date the call came in; for written requests, it is the date the written request arrived at the organization's mailroom (or reception area if mail is received there).
- *If there is a delay delivering the medical necessity appeal documentation to the UM department, then "delay days" count as part of the allotted time frame for the appeal and are not considered "outside of the organization's control." For instance, there was a problem delivering the mail from the mailroom, or the organization chooses to scan the documents prior to sending them to the UM department, or the patient chart was sent in with a claim and thus was routed through the claims department first.

- Regardless of where in the organization the appeal request was received, routed, or delayed, the time frame for the appeal starts when it arrives at the organization; the time it takes to get it into the hands of those who will process the medical necessity appeal once it has arrived at the organization counts as part of the allotted time to conduct the appeal.
- Appeals for cases involving urgent care (organizations may also use the term "expedited") and standard appeals shall be conducted:
  - Within time frames that are appropriate and reasonable for the type of appeal; and
  - Within time frames that protect the interests of the parties involved.
  - The time frames specified should be monitored on an ongoing basis as part of the utilization management organization's quality management program.
  - Definitions of appeals may vary based on state and federal regulatory requirements.

- State and federal programs have specific requirements regarding consumer notification and various time frames.
- Please note that verbal notification of the determination of an expedited appeal must be documented in the case file notes.

Scope of Standards

- P-HUM 38 applies to medical necessity appeals of non-certification determinations.
- Appeals of non-coverage determinations (i.e., a non-covered benefit as per the certificate of group coverage) are not considered medical necessity appeal determinations and are not included within the scope of URAC's Health UM Standards. Please note, however, that the Department of Labor's (DoL) term "claims" is broader in scope than medical necessity decisions and includes benefit and coverage decisions.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures covering expedited appeals.
- Sample template of correspondence related to expedited appeals.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Appeal reports (database, log). If tan organization is applying for initial accreditation, then the report should include a list of cases received since the applicant submitted their application for accreditation. If an organization is applying for re-accreditation, then the report must include all cases received since the last accreditation visit.
- A random selection of at least 30 denial and appeal cases will be selected to verify compliance with the requirements of the URAC standards.
- UM case records chosen for review during the onsite visit will be assessed for UM appeal processing inclusive of the notification process
- Interview with senior clinical staff person or medical director responsible for the appeal process to verify understanding of standard requirements.

Bright Ideas

- Tracking the number of cases upheld and overturned on appeal by diagnosis may be helpful information to know when updating your clinical criteria or medical policies.

- In your non-certification notice, give a specific address to route appeal requests to a designated area within the UM department versus a general organizational address.
- Routing appeal requests to the designated staff who conduct appeals request activities will reduce the risk of appeal determinations being delayed within the organization.
- If your UM program operates on an electronic platform, create automatic alerts to notify staff of impending deadlines for determinations of submitted appeals.
- Include in the appeals policy and procedure definitions of various appeals types and/or levels; include this information on the intranet and/or provider Web sites.
- Assign an individual(s) as an appeal coordinator to document the receipt of all appeals and manage the entire appeals process to include notification of outcomes.
- Develop a template or guideline within the clinical information system to document all appeal-related activities to include receipt of request, documents received, date referred to clinical peer reviewer, peer reviewer clinical documentation and credentials, appeals outcome (upheld or overturned) and documentation of notification.
- Conduct additional training programs for supporting departments such as mail services, member/customer services, and claims regarding the appeals process and required time frames.
- Establish an appeal file for each appeal (by member or case identification) to include all documents received, documentation of the appeals process and copies of all correspondence. Image all documents received for the appeal review process (refer to P-HUM 41).

Related Standards

P-HUM 39 - Standard Appeal Process Time Frame

Standard appeals are completed, and *written notification* of the *appeal* decision issued, within 30 calendar days of the receipt of the request for *appeal* to the *patient* and *attending physician* or other *ordering provider* or *facility rendering service.* (Mandatory)

Interpretive Information/Commentary

- Types of notification include verbal (should be documented in case review notes), voice mail, electronic means including email and fax, or mailed letter. The term "appeals" includes both expedited and standard appeals.
- Appeals notification will be timely, will be provided in writing as well as other acceptable means, and will include the information needed to provide the basis for any additional level of appeal as available.

Points to Remember

- "Initiation of the appeal process" means that the patient, attending provider, or facility rendering service has requested an appeal. See P-HUM 33, which does not specify how requests are made (by telephone or written) Written requests can be transmitted by mail, facsimile, or electronic medium.
- Since a non-certification medical necessity determination has already been rendered, it is acceptable for these entities to request an appeal and not submit any additional information; however, it is incumbent upon the UM organization to determine whether any additional information will be submitted. This should be documented in the appeal case notes.
- When a state or federal government entity such as CMS provides consumers (i.e., enrollees, members, or patients) with the right to extend the timeline for an initial review or appeal, the applicant organization does not need to submit to URAC a request for a regulatory variance. Even though the time frame within which to complete the review or appeal is extended, this type of law or regulation enhances consumer rights and as such is not viewed as reducing the requirements of the standard and results in a matter outside of the organization's control.
  - For more information on related CMS guidance, reference the Medicare Managed Care Manual, Chapter 13, Section 40.1 (utilization review), Section 50.4 (expedited utilization review), Section 70.7.1 (standard appeal), and Section 80.1 (expedited appeal).

- The appeal time frame starts with the organization's receipt of the appeal request. For verbal requests, it is the date the call came in; for written requests, it is the date the written request arrived at the organization's mailroom (or reception area if mail is received there).*
- *If there is a delay delivering the medical necessity appeal documentation to the UM department, then "delay days" count as part of the allotted time frame for the appeal and are not considered "outside of the organization's control." For instance, there was a problem delivering the mail from the mailroom, or the organization chooses to scan the documents prior to sending them to the UM department, or the patient chart was sent in with a claim and thus was routed through the claims department first. Regardless of where in the organization the appeal request was received, routed, or delayed, the time frame for the appeal starts when it arrives at the organization; the time it takes to get it into the hands of those who will process the medical necessity appeal once it has arrived at the organization counts as part of the allotted time to conduct the appeal.

- Appeals for cases involving urgent care (organizations may also use the term "expedited") and standard appeals shall be conducted:
  - Within time frames that are appropriate and reasonable for the type of appeal; and
  - Within time frames that protect the interests of the parties involved.

- The time frames specified should be monitored on an on-going basis as part of the utilization management organization's quality management program.
- Notice to the patient is required except in situations where the patient bears no financial responsibility.
- Written policies and/or documented procedures must clearly document when the patient will be notified of a determination and include any exceptions to the policy.
- Assure that all communications are in compliance with the health literacy policies and/or documented procedures to address the health literacy requirements of the population served.

Scope of Standards

- P-HUM 39 applies to medical necessity appeals of non-certification determinations.
- Appeals of non-coverage determinations (i.e., a non-covered benefit as per the certificate of group coverage) are not considered medical necessity appeal determinations and are not included within the scope of URAC's Health UM Standards. Please note, however, that the DoL's term "claims" is broader in scope than medical necessity decisions, and includes benefit and coverage decisions.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures covering standard appeals.
- Sample template of correspondence related to appeals.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Appeal reports (database, log). If an organization is applying for initial accreditation, then the report should include a list of cases received since the applicant submitted their application for accreditation. If an organization is applying for re-accreditation, then the report must include all cases received since the last accreditation visit.
- A random selection of at least 30 denial and appeal cases will be selected to verify compliance with the requirements of the URAC standards.
- UM case records chosen for review during the onsite visit will be assessed for UM appeal processing inclusive of the notification process.
- Interview with senior clinical staff person or medical director responsible for the appeal process to verify understanding of standard requirements.

Bright Ideas

- Tracking the number of cases upheld and overturned on appeal by diagnosis may be helpful information to know when updating your clinical criteria or medical policies.

- In the non-certification notice, give a specific address to route appeal requests to a designated area within the UM department versus a general organizational address. Routing appeal requests to the designated staff who conduct appeals request activities will reduce the risk of appeal determinations being delayed within the organization.
- If your UM program operates on an electronic platform, create automatic alerts to notify staff of impending deadlines for determinations of submitted appeals.
- Establish a separate mailbox or address for submission of appeals.
- Assign an individual(s) as an appeal coordinator to document the receipt of all appeals and manage the entire appeals process to include notification of outcomes.
- As part of the quality monitoring program, establish a process to verify that the appeals written notifications were mailed and/or received. Document all returned mail and establish processes for follow up.
- Develop a template or guideline within the clinical information system to document all appeals related activities to include receipt of request, documents received, date referred to clinical peer reviewer date reviewed,, peer reviewer clinical documentation and credentials, appeals outcome (upheld or overturned) and documentation of notification.
- Establish an appeal file for each appeal (by member or case identification) to include all documents received, documentation of the appeals process and copies of all correspondence. Image all documents received for the appeals review process. Refer to P-HUM 41.
- Include a note in the case file for claims processing regarding the outcome of the appeals review as applicable to changes in the status of the authorization for claims payment and processing.

Related Standards

P-HUM 40 - Written Notice of Upheld Non-Certifications

For *appeal* determinations, the *organization* issues *written notification* of the adverse *appeal* decision to the *patient* and *attending physician* or other *ordering provider* or *facility rendering service* that includes: (No Weight)

    (a) The *principal reason*s for the determination to uphold the *non-certification*; (4)

    (b) A statement that the *clinical rationale* used in making the *appeal* decision will be provided, in writing, upon request; **and** (4)

    (c) Information about additional *appeal* mechanisms available, if any. (4)

Interpretive Information/Commentary

- Types of notification include verbal (should be documented in case review notes), voice mail, electronic means including email and fax, or mailed letter. The term "appeals" includes both expedited and standard appeals.
- Appeals notification will be timely, will be provided in writing as well as other acceptable means, and will include the information needed to provide the basis for any additional level of appeal as available.
- For P-HUM 40(c), it is not necessary to list the specific appeal mechanisms. Alternatively, the organization may list contact information as to where patients may get more information about their appeal rights.
- The additional appeal mechanisms under P-HUM 40(c) may be internal mechanisms, external mechanisms available through the health plan or plan sponsor, or mechanisms administered by the State.
- When the Mental Health Parity and Addiction Equity Act (MHPAEA) is applicable, the "… MHPAEA also requires the reason for any denial under a group health plan (or health insurance coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary must be made available upon request or as otherwise required by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations (''claims denial notice'')." [Federal Register, Vol. 75, No. 21, page 5428, 45 CFR Part 146, Interim Final Rule (IFR) under the MHPAEA] For health plans and the entities that provide utilization management services for them, complying with this regulation is required under standard Core 4 – Regulatory Compliance, when the MHPAEA is applicable.

Points to Remember

- "Initiation of the appeal process" means that the patient, attending provider, or facility rendering service has requested an appeal. See P-HUM 33, which does not specify how requests are made (e.g., by telephone, written, etc.) Written requests can be transmitted by mail, facsimile, or electronic medium.
- P-HUM 40(a): A general statement such as "care is not medically necessary" does not meet the intent of the principal reason requirement.
- The non-certification notice should provide sufficient information to the provider and/or member to understand the reason for the denial and how to appeal a decision.

- The health literacy /education level and linguistic needs of the population served should be considered when developing the non-certification letter templates to patients/members (see Core 40).
- Some state regulatory requirements may require that the clinical rationale be provided in the letter. Reference the state regulatory requirements for all states in which the UMO conducts business.

Scope of Standards

- Appeals of non-coverage determinations (i.e., a non-covered benefit as per the certificate of group coverage) are not considered medical necessity appeal determinations and are not included within the scope of URAC's Health UM Standards. Please note, however, that the Department of Labor's (DoL) term "claims" is broader in scope than medical necessity decisions, and includes benefit and coverage decisions.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures covering standard appeals.
- Sample template of correspondence related to appeals.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Appeal reports (database, log). If an organization is applying for initial accreditation, then the report should include a list of cases received since the applicant submitted their application for accreditation. If an organization is applying for re-accreditation, then the report must include all cases received since the last accreditation visit.
- A random selection of at least 30 denial and appeal cases will be selected to verify compliance with the requirements of the URAC standards.
- UM case records chosen for review during the onsite visit will be assessed for UM appeal processing inclusive of the notification process.
- Interview with senior clinical staff person or medical director responsible for the appeal process to verify understanding of standard requirements.

Bright Ideas

- Tracking the number of cases upheld and overturned on appeal by diagnosis may be helpful information to know when updating your clinical criteria or medical policies.
- In your non-certification notice, give a specific address to route appeal requests to a designated area within the UM department versus a general organizational address.
- Routing appeal requests to the designated staff who conduct appeals request activities will reduce the risk of appeal determinations being delayed within the organization.
- If your UM program is supported on an electronic platform, create automatic alerts to notify staff of impending deadlines for determinations of submitted appeals.
- Conduct an annual review of all appeals letters for evaluation of health literacy requirements and compliance with regulatory requirements of the demographics of the population served.
- Assign an individual(s) to review all appeals notifications (letters) for accuracy and completeness (prior to mailing).

- Establish monitoring processes to assure notifications (letters) were mailed in a timely manner and to follow up on any returned/undeliverable mailings.

Related Standards

P-HUM 41 - Appeal Record Documentation

The *organization* maintains records for each *appeal* that includes: (No Weight)

    (a) The name of the *patient, provider,* and/or *facility rendering service*; (3)

    (b) Copies of all correspondence from the *patient, provider,* or *facility rendering service* and the *organization* regarding the *appeal*; (3)

    (c) Dates of *appeal* reviews, documentation of actions taken, and final resolution; (3)

    (d) Minutes or transcripts of *appeal* proceedings (if any); **and** (3)

    (e) Name and credentials of the *clinical peer* that meets the qualifications in standard HUM 35. (3)

Interpretive Information/Commentary

- For purposes of risk management, liability, and quality management, the organization must keep complete appeal records.
- The records do not need to be all in one location (file) but they need to be readily accessible.
- Storage mechanisms will vary from organization to organization, and will often include hard copy, electronic, or a combination of both. "Copies" can be generated in any reliable format in order to meet P-HUM 41(b).
- Credentials for the clinical peer referenced in P-HUM 41(e) include the attestation of credentials and knowledge (P-HUM 37) and must be included in the appeal record.

Points to Remember

- As part of the accreditation verification process, these appeal files will be surveyed during an onsite review by URAC. The accreditation reviewer may examine hard copies of the files or review them online. If online, then a UM organization staff member will need to be available to help navigate the system throughout this part of the accreditation onsite review process.

Scope of Standards

- P-HUM 41 applies to medical necessity appeals of non-certification determinations.
- Appeals of non-coverage determinations are not considered medical necessity appeal determinations and are not included in the scope of these UM standards.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures covering maintenance of appeal file records.

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Appeal reports (database, log). If an organization is applying for initial accreditation, then the report should include a list of cases received since the applicant submitted their application for accreditation. If an organization is applying for re-accreditation, then the report must include all cases received since the last accreditation visit.
- A random selection of at least 30 denial and appeal cases will be selected to verify compliance with the requirements of the URAC standards.
- UM case records chosen for review during the onsite visit will be assessed for UM appeal processing inclusive of the notification process and file maintenance.
- Interview with senior clinical staff person or medical director responsible for the appeal process to verify understanding of standard requirements.

Bright Ideas

- Organizations are not required to maintain copies of denial or appeals letter if these can be system generated/re-produced upon request. However, if the computer system cannot retain the "original date" of the denial or appeal letter, it is recommended that the organization maintain hard copies of these letters.
- Organizations can decrease the time frames for appeal determinations and eliminate the need for a specialty peer review if a clinical nurse reviewer or the organizational medical director (who may have rendered the original non-certification) reviews new/additional information submitted and is able to overturn a non-certification based on the new/additional information. NOTE: If the clinical nurse reviewer or medical director cannot overturn the non-certification, the appeal review needs to be referred for a same/similar specialty peer review.
- Establish an appeal file for each appeal (by member or case identification) to include all documents received, documentation of the appeals process and copies of all correspondence. Include in the appeals file documentation references to any meeting minutes or transcripts.

Related Standards

P-HUM 42 - Independent (External) Review Process

The *organization* has a mechanism for *consumer*s to access an *independent review* process, after all internal *appeal* mechanisms have been exhausted, for clinical determinations relating to the necessity or appropriateness of medical services (including determinations that proposed medical services are experimental in nature). Independent review entities conducting the independent review process: (4)

(a) Must access and rely on appropriate clinical expertise in rendering *independent review* determinations; (4)

(b) Must not have any direct financial interest in the *organization* or in the outcome of the *independent review*; (Mandatory)

(c) Render determinations for non-urgent *cases*, within 45 calendar days from the date the *consumer* initiated the *independent review*; (4)

(d) Render determinations for *cases* involving *urgent care* within 72 hours from the date the *consumer* initiated the *independent review*; (4)

(e) May not have been involved in the original determination under *appeal*. (Mandatory)

Interpretive Information/Commentary

- The process described in P-HUM 42 occurs after the internal review processes described in standards P-HUM 1 through P-HUM 41 have been exhausted, unless otherwise allowed prior to that by state or federal law or regulation.
- Organizations can establish reasonable criteria to define the scope of the independent review process and consumers' right to the process. At a minimum, the scope of the independent review process must include disputes regarding clinical determinations relating to the necessity or appropriateness of medical services (including determinations that proposed medical services are experimental in nature).
- The term "direct financial interest" in P-HUM 42(b) refers to a material or direct interest in the organization. URAC has developed detailed standards for the independent review process and for independent review organizations (to whom organizations may refer independent review cases). These standards are entitled "Independent Review Organization Standards" and are available through URAC.

Points to Remember

- This standard includes element(s) that support Medical Loss Ratio (MLR) quality improvement activities: P-HUM 42, P-HUM 42(b) and P-HUM 42(e). For more information regarding MLR, please refer to the introductory document in this guide entitled "Medical Loss Ratio (MLR) & URAC Accreditation Fees." There are tables following this document that contain a complete listing of the MLR standard elements for this accreditation.
- State and federal laws influence the independent review process. Be sure to include the applicable state and federal laws and regulations in the application for accreditation when referenced in order to clarify the organization's policies and procedures.

- P-HUM 42(b): Policies need to include a description of the organization's process for determining whether the external review entity has a direct financial interest in the case or the outcome of the case.
- Consumers may designate an individual to act on their behalf during the course of requesting an independent review appeal; however, it must be apparent that the consumer has given his or her permission to do so.

Scope of Standards

- Consumer appeals for certification of services including appeals involving issues related to medical necessity/appropriateness of care or services that may be considered experimental in nature.

Evidence for Meeting the Standard - Desktop Review Materials

- Written policies and/or documented procedures or UM program description addressing the independent review process.
- Sample template letter for adverse appeal determinations that includes the steps for initiating an independent review.
- Report covering the previous 12 months listing the independent reviews that occurred during that period of time and the appeal outcome (please redact/remove any patient-identifying information).

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Review of appeal case documentation for those that included an independent review.
- Interview with the medical director and UM operations management regarding the independent review process.

Bright Ideas

- Develop a template form for documentation of the appeal request (submitted to the IRO) to provide documentation of the outcome of the appeal review. Include within the template the name and specialty of the individual who completed the independent review.
- Establish a database or use a contact management system to document and manage the status and outcomes of all external (independent) appeal reviews.
- Develop job aids/workflows for the external review process.
- Develop a table that includes all state and federal regulatory requirements specific to independent review requirements. Place the table on the organization's intranet for improved accessibility.

Related Standards

Measures Reporting

P-RPT 1 - Reporting Mandatory Performance Measures to URAC

The *organization* reports on all mandatory measures required for this accreditation and submits a copy of the Information Systems Capacity Assessment (ISCA) and all associated attachments. (Mandatory)

Interpretive Information/Commentary

- The use of performance measures is an important component of an organization's internal performance improvement effort. While an organization may have a broad array of measures, to maintain accreditation, measures specified by URAC must be reported on an annual basis. URAC will review and update measure evidence and codes annually by October 1st. Therefore, organizations will be required to use the most current set of measure specifications issued by URAC for each reporting year.
- Performance measures are either mandatory [M] or exploratory [E]. Organizations are expected to produce the mandatory performance measures as designated by URAC and report them via a specified reporting platform to maintain their ongoing accreditation status.
- A measure classified as "Mandatory" means that URAC will designate a set of unique measures with their specifications that have undergone URAC's evaluation and vetting process and that have been approved by the URAC Board of Directors. These measures must be reported to URAC on an annual basis or more frequent as specified by URAC to maintain accreditation status.
  - Mandatory measures will be updated annually and the reporting organization must use the updated specifications regardless of the standards version of the program.
  - **Failure to report mandatory measures will result in a re-evaluation of the organization's accreditation status and may result in actions from developing a corrective action plan up to and including rescinding the URAC accreditation.**

- Although an organization may be using a different specification for internal reporting of the same type of measure in the URAC mandatory performance measure set, it must adhere to URAC reporting specifications when reporting performance measures for URAC accreditation.
- Reporting of mandatory performance measures to URAC is required to maintain accreditation. Please refer to the Measures at a Glance and/or the Reporting Instructions and Templates to view the mandatory measures required to be reported to URAC. **A copy of the Measures at a Glance and the Reporting Instructions and Templates are located in the Resources section of AccreditNet or may also be requested through your Account Manager or by emailing** ResearchMeasurement@urac.org
- A measure designated as "Exploratory" means that URAC will include measures with specifications that are considered "experimental" within the industry. These measures are "on the cutting edge" of the performance measurement know-how and need further refinement and evaluation before becoming a requirement of a program.

- Organizations are not required to report exploratory measures, although reporting these measures is strongly encouraged. Additionally, if an exploratory measure will not be reported, providing responses to any of the background questions will greatly facilitate URAC's moving the measurement development process forward.
    - Measures are deemed "exploratory" when no agreed upon methodology exists for assessing the specific measure concept. For exploratory measures, URAC will gather input from accredited organizations on how the organization calculates the measure. This input will be gathered from the information and data organizations report and from accreditation related site visits.
    - In future versions of the standards, exploratory measures may evolve into mandatory measures as consensus builds on appropriate reporting specifications.

- If an organization is not performing an activity for which there is a related performance measure, the organization is not required to report that measure (i.e., it is not required to begin a new program in order to produce the information).
    - The organization must indicate this to URAC in the 'Measures' tab of its application. URAC staff will review whether the reason is applicable. Organizations may be required to submit data if the reason is found to be insufficient.

- The measurement reporting period is the calendar year. Measures must be reported to URAC no later than June 30th of the year following the measurement reporting period.
- Organizations are expected to be able to produce and report on the mandatory performance measures to maintain their accreditation status once they have completed their first accreditation. Organizations' first measurement period is the year following the year the organization receives accreditation. Organizations also have the option to report data for the year prior to the accreditation year. Measures are due to URAC or its designee between April 1st and June 30th of the year following the first measurement period. For example, if an organization is accredited in 2013, its first measurement period is 2012 (optional), 2013, and 2014, and measures for this period are due to URAC by June 30, 2015. Measures are then reported annually to URAC while the organization is accredited.
- As further defined in a particular set of specifications, an organization may be expected to produce a measure at the organization level, by population segment and/or line of business.

Points to Remember

- URAC will review an accredited organization's annual measurement report as a component of ongoing monitoring and as a component of re-accreditation. URAC review staff will look at the data collection process and monitoring that enables the capability to accurately report.
- Applicant organizations must submit data on mandatory measures via a specified platform during their reporting year.

Scope of Standards

- This reporting standard for measures applies to all organizations applying for URAC accreditation under these standards (RPT 1 and RPT 2); however, certain measures and thus their associated standard element within a standard may be determined not applicable ("N/A") depending upon the organization's lines or books of business, services provided, structure and processes, or other factors. This information must be noted in the 'Measures' tab and submitted to URAC. URAC staff will review whether the information is applicable; please note organizations may be required to submit data if reason is found to be insufficient.
- For information on the specific measures, please refer to the "Measures at a Glance" and the "Measure Technical Specifications and Reporting" documents located in the Resources section of AccreditNet; a copy can also be requested through your Account Manager or by emailing ResearchMeasurement@urac.org.

Evidence for Meeting the Standard - Desktop Review Materials

- Signed attestation indicating that the organization can upload and submit data to URAC via a specified reporting platform
    - A copy of the attestation is located under the Resources section in your application

- A completed attestation addendum indicating the measures your organization plans to submit over the life of your accreditation
    - A copy of the attestation addendum is located under the Resources section in your application

- If you are submitting URAC Health Plan measures, complete the Information System Capacity Assessment form (ISCA)
    - If you are not reporting the URAC Health Plan measures, or are submitting other measures to satisfy an accreditation requirement, the ISCA form is not required

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- Interview with individuals responsible for the organization's measurement program
    - Note: Interview questions related to measurement are found in the Resources section of AccreditNet

Bright Ideas

Related Standards

P-RPT 2 - Reporting Exploratory Performance Measures to URAC

The *organization* can choose to report on any of the exploratory (leading) measures that may be included with this accreditation. (Leading Indicator)

Interpretive Information/Commentary

- Performance measures are classified as either mandatory [M] or exploratory [E]. A measure designated as "Exploratory" means that URAC will include measures as part of the unique measure set and include measure specifications that are considered "experimental" within the industry. These measures are "on the cutting edge" of the performance measurement know-how and need further refinement and evaluation before becoming a requirement of a program.
- Organizations are not required to report exploratory measures, although reporting these measures is strongly encouraged. Additionally, if an exploratory measure will not be reported, providing responses to any of the background questions will greatly facilitate URAC's moving the measurement development process forward.
    - Measures are deemed "exploratory" when no standardized methodology exists for assessing the specific measure concept. For exploratory measures, URAC will gather input from accredited organizations on how the organization calculates the measure. This input will be gathered from the information and data organizations report and from accreditation related site visits.
    - In future versions of the standards, exploratory measures may evolve into mandatory measures as consensus builds on appropriate reporting specifications for the measures.

- For information on the measurement reporting period, please reference the guide information for standard RPT 1.

Points to Remember

- An organization has the option of submitting data to URAC on applicable exploratory measures; the organization's accreditation status will not be affected either way.
- Applicant organizations have the option to submit data on exploratory measures via a specified platform during their reporting year.

Scope of Standards

- This reporting standard for measures applies to all organizations applying for URAC accreditation under these standards; however, if the organization chooses not to submit data on exploratory measures , then the organization needs to indicate it under the 'Measures' tab in their application. Submitting data on exploratory measures does not affect the organization's accreditation score or the category awarded.
- For information on the specific measures, please refer to the "Measures at a Glance" and the "Measure Technical Specifications and Reporting" documents located in the Resources section of AccreditNet; a copy can also be requested through your Account Manager or by emailing ResearchMeasurement@urac.org.

Evidence for Meeting the Standard - Desktop Review Materials

- See this section for standard RPT 1 – the same materials are required

Evidence for Meeting the Standard - Onsite Review Materials and Activities

- See this section for standard RPT 1 – the same materials and activities are required

Bright Ideas

Related Standards