Population Health Management

Standards for Population Health Management

PHM 1: PHM Strategy

Refer to Appendix 1 for points

The organization outlines its population health management (PHM) strategy for meeting the care needs of its member population.

Intent

The organization has a cohesive plan of action for addressing member needs across the continuum of care.

Element A: Strategy Description

The strategy describes:

1. **Goals and populations targeted for each of the four areas of focus.***
2. **Programs or services offered to members.**
3. **Activities that are not direct member interventions.**
4. **How member programs are coordinated.**
5. **How members are informed about available PHM programs.**

Critical factors: These factors must be scored "yes" to score at least "Partially Met."

Summary of Changes

Clarifications

- Revised the scope of review to state that NCQA reviews and scores by each product line brought forward for Accreditation.
- Revised the look-back period for Renewal Surveys from 12 months to 24 months.
- Revised the "critical factor" language to state that factor 1 must be scored "yes" for an organization to score at least "partially met."
- Added ACO, PCMH and VBP acronyms to the Examples for factor 3.

Scoring

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

Data source Documented process

Scope of review

Product lines

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

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

Documentation

NCQA reviews a description of the organization's comprehensive PHM strategy that is in place throughout the look-back period. The strategy may be fully described in one document or the organization may provide a summary document with references or links to supporting documents provided in other PHM elements.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

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

Factor 1 is a critical factor; the factor must be scored "yes" for the organization to score at least "Partially Met" on this element.

***Factors 1, 2:* Four areas of focus**

The organization has a comprehensive strategy for population health management that, *at a minimum,* addresses member needs in the following four areas of focus:

- Keeping members healthy.
- Managing members with emerging risk.
- Patient safety or outcomes across settings.
- Managing multiple chronic illnesses.

At a minimum, the description includes the following for each of the four areas of focus:

- A goal (factor 1).
- A target population (factor 1).
- A program or service (factor 2).

Goals are measurable and specific to a target population. A **program** is a collection of services or activities to manage member health. A **service** is an activity or intervention in which individuals can participate to help reach a specified health goal.

***Factor 2*: Programs and services**

Programs and services offered to the organization's members align with its comprehensive strategy and the areas of focus in factor 1.

NCQA does not prescribe a specific number of programs or services that must be offered to members, nor does it require all programs and services to be included or limited to each focus area in factor 1. The organization must include a description of the programs and services that align with the goals in its comprehensive PHM strategy. This may include programs and services involving any level of member interactive contact.

***Factor 3:* Activities that are not direct member interventions**

The organization describes the activities it offers in its PHM strategy, including activities not directed at individual members.

The organization has at least one activity in place that supports the PHM strategy. An activity may be specific to one area of focus or apply to more than one area of focus.

NCQA does not prescribe a specific number of activities that must be offered to members, nor does it require all activities unrelated to the PHM strategy to be included or limited to each focus area in factor 1. The organization must include a description of all activities that align with the goals in its comprehensive PHM strategy.

Factor 4: **Coordination of member programs**

The organization coordinates programs or services it directs and those facilitated by providers, external management programs and other entities. The PHM strategy describes how the organization coordinates programs across settings, providers and levels of care to minimize the confusion for members being contacted from multiple sources. Coordination activities are not required to be exclusive to one area of focus and may apply across the continuum of care and to other organization initiatives.

Factor 5: **Informing members**

The organization describes its process for informing members about all available PHM programs and services, regardless of level of contact. The organization may make the information available on its website; by mail, email, text or other mobile application; by telephone; or in person.

The organization communicates the information to members by mail, telephone or in person. If the organization posts the information on its website, it uses alternative methods to notify members that the information is available online.

Exceptions

None.

Examples

Factors 1, 2: **Goals, target populations, opportunities, programs or services**

Keeping members healthy

- *Goal:* 55 percent of members in the target population report receiving annual influenza vaccinations.
- *Target populations:*
  1. Members with no risk factors.
  2. Members enrolled in wellness programs.
- *Programs or services:* Community flu clinics, email and mail reminders, radio and TV advertisement reminding the public to get vaccinated.
- *Goal:* 10 percent of the target population reports meeting a self-determined weight-loss goal.
- *Target population:* Members with BMI 27 or above enrolled in wellness program.
- *Programs or services:* Wellness program focusing on weight management.

Managing members with emerging risk

- *Goal:* Lower or maintain HbA1c control <8.0% rate by 2 percent compared to baseline.
- *Target population:*
  1. Members discovered to be at risk for diabetes during predictive analysis.
  2. Members with controlled diabetes.
- *Programs or services:* Diabetes management program.
- *Goal:* Improve asthma medication ratio (total rate) by 3 percent compared to baseline.
- *Target population:* Diagnosed asthmatic members 18–64 years of age with at least one outpatient visit in the prior year.
- *Programs or services:* Condition management program.

Patient safety

- *Goal:* Improve the safety of high-alert medications.
- *Target population:* Members who are prescribed high-alert medications and receive home health care.
- *Activity:* Collaborate with community-based organizations to complete medication reconciliation during home visits.
- *Goal:* Improve clinical safety by reducing hospital-acquired infection by 5% over 3 years.
- *Target population:* Members receiving in-patient surgical procedures.
- *Activity:* Distribute information to members that facilitates informed decisions regarding care, such as:
  - Questions to ask surgeons before surgery.
- *Activity:* Implement follow-up system to contact members after discharge to confirm receipt of care and post-surgical care instructions.

Outcomes across settings

- *Goal:* Reduce 30-day readmission rate after hospital stay (all causes) of 3 days or more by 2 percentage points compared to baseline.
- *Target population:* Members admitted through the emergency department who remain in the hospital for three days or more.
- *Program or services:* Organization-based case manager conducts a follow-up interview post-stay to coordinate needed care.
- *Activity:* Collaborate with network hospitals to develop and implement a discharge planning process.

Managing multiple chronic illnesses

- *Goal:* Reduce ED visits in target population by 3 percentage points in 12 months.
- *Target population:* Members with uncontrolled diabetes and cardiac episodes that led to hospital stay of two days or more.
- *Programs or services:* Complex case management.
- *Goal:* Improve antidepressant medication adherence rate.
- *Target population:* Members with multiple behavioral health diagnoses, including severe depression, who lack access to behavioral health specialists.
- *Programs or services:* Complex case management with behavioral health telehealth counseling component.

***Factor 3:* Activities that are not direct member interventions**

- Share data and information with practitioners.
- Interact with and integrate delivery systems (e.g., contract with accountable care organizations [ACO]).
- Provide technology support to or integrate with patient-centered medical homes (PCMH).
- Integrate with community resources.
- Value-based payment (VBP) arrangements.
- Collaborate with community-based organizations and hospitals to improve transitions of care from the post-acute setting to the home.
- Collaborate with hospitals to improve patient safety.

Element B: Informing Members

The organization informs members eligible for programs that include interactive contact:

1. How members become eligible to participate.

2. How to use program services.

3. How to opt in or opt out of the program.

Summary of Changes

Clarifications

- Revised the look-back period for Renewal Surveys to 12 months for materials and 24 months for documented process.
- Revised the text under "Distribution of materials."

Scoring

Met	Partially Met	Not Met
The organization meets 2-3 factors	No scoring option	The organization meets 0-1 factors

Data source

Documented process, Materials

Scope of review

Product lines

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

The score for the element for all programs brought forward for Accreditation is the average of the scores for all programs or services.

Documentation

For All Surveys: NCQA reviews the organization's policies and procedures in effect during the look-back period from up to four randomly selected programs or services that involve interactive contact, or reviews all programs if the organization has fewer than four.

For First Surveys and Renewal Surveys: NCQA also reviews materials sent to members from up to four randomly selected programs or services that involve interactive contact, or reviews all programs if the organization has fewer than four.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 12 months for materials; 24 months for documented process.

Explanation

This element applies to PHM programs or services in the PHM strategy that require interactive contact with members, including those offered directly by the organization.

Interactive contact

Programs with interactive contact have two-way interaction between the organization and the member, during which the member receives self-

management support, health education or care coordination through one of the following methods:

- Telephone.
- In-person contact (i.e., individual or group).
- Online contact:
  - Interactive web-based module.
  - Live chat.
  - Secure email.
  - Video conference.

Interactive contact does not include:

- Completion of a health appraisal.
- Contacts made only to make an appointment, leave a message or verify receipt of materials.
- Contact made to inform members of the availability of affinity programs (e.g., subsidized gym memberships, device purchases, discounted weight loss subscriptions).

Distribution of materials

The organization distributes information to members by mail, fax or email, or through messages to members' mobile devices, through real-time conversation or on its website, if it informs members that the information is available online through another method listed here. The organization mails information to members who do not have fax, email, telephone, mobile device or internet access. If the organization uses telephone or other verbal conversations, it provides a transcript of the conversation or script used to guide the conversation.

Factors 1–3: **Member information**

The organization provides eligible members with information on specific programs with interactive contact.

Exceptions

None.

Related information

Use of vendors for services or activities in the PHM strategy. The organization may contract with a vendor to provide technology services. NCQA does not consider the relationship to be delegation, but evaluates the vendor's technology-supported processes against requirements. Refer to *Vendor Relationships* in Appendix 2.

Use of organizations that have interactive contact with members. Arrangements with contracted organizations to administer programs within the scope of the PHM strategy are considered delegation.

Examples

Dear Member,

Because you had a recent hospital stay, you have been selected to participate in our Transitions Case Management Program. Sometime in the next three days, a nurse will call you to make sure you understand the instructions you were given when you left the hospital, and to make sure you have an appropriate provider to see for follow-up care. To contact the nurse directly, call 555-555-1234. If you do not want to participate in the Transitions Case Management Program, let us know by calling 555-123-4567.

PHM 2: Population Identification

Refer to Appendix 1 for points

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

Intent

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

Element A: Data Integration

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

1. Medical and behavioral claims or encounters.

2. Pharmacy claims.

3. Laboratory results.

4. Health appraisal results.

5. Electronic health records.

6. Health services programs within the organization.

7. Advanced data sources.

Summary of Changes

Clarifications

- Revised the look-back period for Renewal Surveys from 12 months to 24 months.

Scoring

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

Data source Documented process, Reports, Materials

Scope of review

Product lines

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

Documentation

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

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

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

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

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

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

Factors 2, 3

No additional explanation required.

***Factor 4:* Health appraisals**

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

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

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

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

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

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

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

Exceptions

None.

Related information

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

Examples

***Factor 5:* EHR integration**

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

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

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

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

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

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

Element B: Population Assessment

The organization annually:

1. **Assesses the characteristics and needs, including social determinants of health, of its member population.**
2. **Identifies and assesses the needs of relevant member subpopulations.**
3. **Assesses the needs of child and adolescent members.**
4. **Assesses the needs of members with disabilities.**
5. **Assesses the needs of members with serious and persistent mental illness (SPMI).**

Summary of Changes

Clarifications

- Revised the scope of review and look-back period for Renewal Surveys.
- Clarified the Explanation to state that organizations must use data annually for its assessment reports.

Scoring

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

Data source Documented process, Reports

Scope of review

Product lines

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

Documentation

For Interim Surveys: NCQA reviews the organization's policies and procedures.

For First Surveys: NCQA reviews the organization's most recent annual assessment reports.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's annual assessment reports.

Look-back period

For Interim Surveys: Prior to the survey date.

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

For Renewal Surveys: 24 months.

Explanation

At least annually, the organization uses data at its disposal (e.g., claims, encounters, lab, pharmacy, utilization management, socioeconomic data, demographics) to identify the needs of its population.

Factor 1: **Characteristics and needs**

To determine the necessary structure and resources for its PHM program, the organization assesses the characteristics and needs of the member population. The assessment includes the characteristics of the population and associated needs identified.

At a minimum, the organization assesses social determinants of health. **Social determinants of health**[1] are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks. The organization defines the determinants assessed.

Characteristics that define a relevant population may also include, but are not limited to:

- Federal or state program eligibility (e.g., Medicare or Medicaid, SSI, dual-eligible).
- Multiple chronic conditions or severe injuries.
- At-risk ethnic, language or racial group.

Factor 2: **Identifying and assessing characteristics and needs of subpopulations**

The organization uses the assessment of the member population to identify and assess the characteristics and needs of relevant subpopulations.

Factor 3: **Needs of children and adolescents**

The organization assesses the needs of members 2–19 years of age (children and adolescents). If the organization's regulatory agency's definition of children and adolescents is different from NCQA's, the organization uses the regulatory agency's definition. The organization provides the definition to NCQA, which determines whether the organization's needs assessment is consistent with the definition.

[1]https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Factors 4, 5: **Individuals with disabilities and SPMI**

Members with disabilities and with serious and persistent mental illness (SPMI) have particularly acute needs for care coordination and intense resource use (e.g., prevalence of chronic diseases).

Exception

Factor 3 is NA for the Medicare product line.

Examples

Factors 1, 2: **Relevant characteristics**

Social determinants of health include:

- Resources to meet daily needs.
- Safe housing.
- Local food markets.
- Access to educational, economic and job opportunities.
- Access to health care services.
- Quality of education and job training.
- Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities.
- Transportation options.
- Public safety.
- Social support.
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government).
- Exposure to crime, violence and social disorder (e.g., presence of trash and lack of cooperation in a community).
- Socioeconomic conditions.
- Residential segregation.
- Language/literacy.
- Access to mass media and emerging technologies.
- Culture.

Physical determinants include:

- Natural environment, such as green space (e.g., trees and grass) or weather (e.g., climate change).
- Built environment, such as buildings, sidewalks, bike lanes and roads.
- Worksites, schools and recreational settings.
- Housing and community design.
- Exposure to toxic substances and other physical hazards.
- Physical barriers, especially for people with disabilities.
- Aesthetic elements (e.g., good lighting, trees, benches).
- Eligibility categories included in Medicaid managed care (e.g., TANF, low-income, SSI, other disabled).
- Nature and extent of carved out benefits.
- Types of Special Needs Plan (SNP) (e.g., dual eligible, institutional, chronic).
- Race/ethnicity and language preference.

Element C: Activities and Resources

The organization annually uses the population assessment to:

1. **Review and update its PHM activities to address member needs.**
2. **Review and update its PHM resources to address member needs.**
3. **Review community resources for integration into program offerings to address member needs.**

Summary of Changes

Clarifications

- Rearranged the text under *Factors 1, 2: PHM activities and resources.*
- Moved the examples in the Explanation to the "Examples" section.

Scoring

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

Data source

Documented process, Reports, Materials

Scope of review

Product lines

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

Documentation

For Interim Surveys: NCQA reviews the organization's policies and procedures.

For First and Renewal Surveys: NCQA reviews committee minutes or similar documents showing process and resource review and updates.

Look-back period

For Interim Surveys: Prior to the survey date.

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

Explanation

***Factors 1, 2:* PHM activities and resources**

The organization uses assessment results to review and update its PHM strategy, including programs, services, activities and resources to meet member needs.

***Factor 3:* Community resources**

The organization connects members with community resources or promotes community programs. Integrating community resources indicates that the organization actively and appropriately responds to members' needs. Community resources correlate with member needs discovered during the population assessment.

Actively responding to member needs is more than posting a list of resources on the organization's website; active response includes referral services and helping members access community resources.

Exceptions

None.

Examples

***Factor 2:* PHM resources**

- Staffing ratios.
- Clinical qualifications.
- Job training.
- External resource needs and contacts.
- Cultural competency.

***Factor 3:* Community resources and programs**

- Population assessment determines a high population of elderly members without social supports. The organization partners with the Area Agency on Aging to help with transportation and meal delivery.
- Connect at-risk members with shelters.
- Connect food-insecure members with food security programs or sponsor community gardens.
- Sponsor or set up fresh food markets in communities lacking access to fresh produce.
- Participate as a community partner in healthy community planning.
- Partner with community organizations promoting healthy behavior learning opportunities (e.g., nutritional classes at local supermarkets, free fitness classes).
- Support community improvement activities by attending planning meetings or sponsoring improvement activities and efforts.
- Social workers or other community health workers that contact members to connect them with appropriate community resources.
- Referrals to community resources based on member need.
- Discounts to health clubs or fitness classes.

Element D: Segmentation

At least annually, the organization segments or stratifies its entire population into subsets for targeted intervention.

Summary of Changes

Clarifications

- Revised the scope of review and look-back period for Renewal Surveys.
- Rearranged text in the Explanation under the subhead “Methodology.”

Scoring

Met	Partially Met	Not Met
The organization meets the requirement	No scoring option	The organization does not meet the requirement

Data source Documented process, Reports

Scope of review

Product lines

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

Documentation

NCQA reviews a description of the methods used.

For First Surveys: NCQA also reviews the organization's most recent annual report demonstrating implementation.

For Renewal Surveys: NCQA also reviews the organization's most recent and previous year's annual reports demonstrating implementation.

Look-back period

For Interim Surveys: Prior to the survey date.

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

For Renewal Surveys: 24 months.

Explanation

Population segmentation divides the population into meaningful subset using information collected through population assessment and other data sources.

Risk stratification uses the potential risk or risk status of individuals to assign them to tiers or subsets. Members in specific subsets may be eligible for programs or receive specific services.

Segmentation and risk stratification result in the categorization of individuals with care needs at all levels and intensities. Segmentation and risk stratification are means of targeting resources and interventions to individuals who can most benefit from them. Either process may be used to meet this element.

Methodology

The organization describes its method for segmenting or stratifying its membership, including the subsets to which members are assigned. The organization may use more than one risk stratification methods to determine actionable subsets.

Segmentation and stratification use the findings from the population assessment and data integration (e.g., clinical and behavioral data, population and social needs) to determine programs or services for which members are eligible. Although these methods may include utilization/resource use or cost information. Methods that use only cost information for segmentation and stratification do not meet the intent of this element.

Reports

The organization provides reports specifying the number of members in each category and the programs or services for which they are eligible. Reports are a "point-in-time" snapshot during the look-back period.

Reports reflect the number of members eligible for each PHM program. They display data in raw numbers and as a percentage of the total enrolled member population, and may total more than 100% if members fall into more than one category.

PHM programs or services provided to members include, but are not limited to, complex case management.

Exceptions

None.

Examples

Health Plan A: **Commercial HMO/PPO**

Subset of Population	Targeted Intervention for Which Members Are Eligible	Number of Members	Percentage of Membership
Pregnancy: Over 35 years, multiple gestation	High-risk pregnancy care management	55	0.5%
Type I Diabetes: Moderate risk	Diabetes management	660	6%
Tobacco use	Smoking cessation	110	1%
Behavioral health diagnosis in ages 15-19, rural	Telephone or video behavioral health counseling sessions	330	3%
Women of child-bearing age	Targeted women's health newsletter	3,850	35%
No risk factors	Routine member newsletters	2,750	25%
No associated data	None	3,850	35%

Health Plan A: **Medicare**

Subset of Population	Targeted Intervention for Which Members Are Eligible	Number of Members	Percentage of Membership
Multiple chronic conditions	Complex case management: Over 65	2,000	5%
Over 65, needs assistance with 2 or more ADLs	Long-term services and supports	2,800	7%
COPD: High risk	Complex case management: Over 65	1,600	4%
Osteoporosis: High-risk women	Targeted member newsletter	8,800	22%
BMI over 30	Weight management program	4,800	12%
No risk factors	Routine member newsletters	12,000	30%
No associated data	None	8,000	20%

PHM 3: Delivery System Supports

Refer to Appendix 1 for points

The organization describes how it supports the delivery system, patient-centered medical homes and use of value-based payment arrangements.

Intent

The organization works with practitioners or providers to achieve population health management goals.

Element A: Practitioner or Provider Support

The organization supports practitioners or providers in its network to achieve population health management goals by:

1. Sharing data.

2. Offering evidence-based or certified decision-making aids.

3. Providing practice transformation support to primary care practitioners.

4. Providing comparative quality information on selected specialties.

5. Providing comparative pricing information on selected services.

6. One additional activity to support practitioners or providers in achieving PHM goals.

Summary of Changes

Clarifications

- Added a fourth paragraph to the scope of review clarifying documentation for factor 2.
- Revised the look-back period for Renewal Surveys from 12 months to 24 months.

Scoring

Met	Partially Met	Not Met
The organization meets 2-6 factors	No scoring option	The organization meets 0-1 factors

Data source Documented process, Materials

Scope of review

Product lines

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

Documentation

For Interim Surveys: NCQA reviews the organization's description of how it supports practitioners or providers.

For First Surveys and *Renewal Surveys:* NCQA reviews the organization's description that is in place throughout the look-back period of how it supports practitioners or providers and materials demonstrating implementation.

For factor 2: NCQA reviews materials for evidence that they were developed using established criteria or certified by a third entity.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization identifies and implements activities that support practitioners and providers in meeting population health goals. Practitioners and providers may include accountable care entities, primary or specialty practitioners, PCMHs, or other providers included in the organization's network. Organizations may determine the practitioners or providers they support.

Factor 1: **Data sharing**

Data sharing is transmission of member data from the health plan to the provider or practitioner that assists in delivering services, programs, or care to the member. The organization determines the frequency for sharing data.

Factor 2: **Evidence-based or certified decision-making aids**

Shared decision-making (SDM) aids provide information about treatment options and outcomes. SDM aids are designed to complement practitioner counselling, not replace it. SDM aids facilitate member and practitioner discussion on treatment decisions.

SDM aids may focus on preference-sensitive conditions, chronic care management or lifestyle changes, to encourage patient commitment to self-care and treatment regimens.

SDM aids are certified by a third party that evaluates quality, or are created using evidence-based criteria. If certified, the organization provides information about how, when, under what conditions and to whom certified SDM aids are offered. If created using evidence-based criteria, criteria must be cited. At least one certified or evidence-based SDM aid must be offered to meet the intent.

Factor 3: **Practice transformation support**

Transformation includes movement to becoming a more-integrated or advanced practice (e.g., ACO, PCMH) and toward value-based care delivery.

The organization provides documentation that it supports practice transformation.

Factor 4: **Comparative quality and cost information on selected specialties**

The organization provides comparative quality information about selected specialties to practitioners or providers and reports cost information if it is available. Comparative cost information may be cost or efficiency information and may be represented as relative rates or as a relative range.

Comparative quality information may be reported without cost information if cost information is not available.

To meet this requirement, the organization must provide quality information (with or without cost information) for at least one specialty and show that it has provided the information to at least one provider that refers members to the specialty.

Factor 5: **Comparative pricing information for selected services**

Comparative pricing information may contain actual unit prices per service or relative prices per service, compared across practitioners or providers.

To meet this requirement, the organization must provide comparative pricing information on at least one service and show that it has provided the information to at least one provider that prescribes the service to members.

***Factor 6:* Another activity**

Other activities include those that cannot be categorized in factors 1–5. The organization describes the activity, how it supports providers or practitioners and how it contributes to achieving PHM goals.

Data sharing activities that use a different method of data sharing from that in factor 1 may be used to meet this factor. The method indicates how data are shared.

Exceptions

None.

Related information

Partners in Quality. The organization receives automatic credit for factors 3 and 6 if it is an NCQA-designated Partner in Quality.

The organization must provide documentation of its status.

Practice transformation support. The organization can support its practitioners/providers in meeting their population health management goals through any of the following methods:

- Incentive payments for PCMH arrangement.
- Technology support.
- Best practices.
- Supportive educational information, including webinars or other education sessions.
- Help with application fees for NCQA PCMH Recognition (beyond the NCQA program's sponsor discount).
- Help practices transform into a medical home.
- Provide incentives for NCQA PCMH Recognition, such as pay-for-performance.
- Use NCQA PCMH Recognition as a criterion for inclusion in a restricted or tiered network.

Examples

Factor 1: Data sharing

- Sharing patient-specific data listed below that the practitioner or provider does not have access to:
  - Pharmacy data.
  - ED reports.
  - Enrollment data.
  - Eligibility in the organization's intervention programs (e.g., enrollment in a wellness or complex case management program).
  - Reports on gaps in preventive services (e.g., a missed mammogram, need for a colonoscopy).
    - Claims data indicate if these services were not done; practitioners or staff can remind members to receive services.

  - Claims data.
  - Data generated by specialists, urgent care clinics or other care providers.
- Methods of data sharing:
  - Transmitted through electronic channels as “raw” data to practitioners who conduct data analysis to drive improved patient outcomes.
  - Practitioner or provider portals that have accessible patient-specific data.
  - Submit data to a regional HIE.
  - Reports created for practitioners or providers about patients or the attributed population.
    - A direct link to EHRs, to automatically populate recent claims for relevant information and alert practitioners or providers to changes in a patient’s health status.

Factor 2: Decision-making aids

- Certification bodies:
  - National Quality Forum.
  - Washington State Health Care Authority.

Factor 4: Quality and cost information

- Selected specialties:
  - Specialties that a primary care practitioner refers members to most frequently.
- Quality information:
  - Organization-developed performance measures based on evidence-based guidelines.
    - AHRQ patient safety indicators associated with a provider.
    - In-patient quality indicators.
    - Risk-adjusted measures of mortality, complications and readmission.
    - Physician Quality Reporting System (PQRS) measures.
    - Non-PQRS Qualified Clinical Data Registry (QCDR) measures.
    - CAHPS Clinician and Group Survey.
    - The American Medical Association’s Physician Consortium for Performance Improvement (PCPI) measures.
  - Cost information:
    - Relative cost of episode of care.
    - Relative cost of practitioner services.
    - In-office procedures.
  - Care pattern reports that include quality and cost information.

Factor 5: Pricing information

- Selected services:
  - Services for which the organization has unit price information.
  - Services commonly requested by primary care practitioners that are not conducted in-office.
  - Radiology services.
  - Outpatient procedures.
  - Pharmaceutical costs.

Factor 6: Another activity

- Health plan staff located full-time at the provider facility to assist with member issues.
- The ability to view evidence-based practice guidelines on demand (e.g., practitioner portal).
- Incentives for two-way data sharing.

Element B: Value-Based Payment Arrangements

The organization demonstrates that it has a value-based payment (VBP) arrangement(s) and reports the percentages of total payments tied to VBP.

Summary of Changes

Clarifications

- Revised the scope of review to state that NCQA reviews and scores by each product line brought forward for Accreditation.
- Revised the look-back period for First and Renewal Surveys to "at least once during the prior 24 months."
- Revised the first sentence in the third paragraph of the Explanation to clarify that the organization's VBP arrangement must be in place during the look-back period.
- Replaced "payments" with "arrangement" in the second paragraph under the subhead "Calculating VBP reach."

Scoring

Met	Partially Met	Not Met
The organization meets the requirement	No scoring option	The organization does not meet the requirement

Data source

Reports

Scope of review

Product lines

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

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

Documentation

For First Surveys and *Renewal Surveys:* NCQA reviews the VBP worksheet to demonstrate that the organization has VBP arrangements in each product line.

Look-back period

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

Explanation

This element may not be delegated.

There is broad consensus that payment models need to evolve from payment based on volume of services provided to models that consider value or outcomes. The fee-for-service (FFS) model does not adequately address the importance of non-visit-based care, care coordination and other functions that are proven to support achievement of population health goals.

The organization demonstrates that it has at least one VBP arrangement during the look-back period and reports the percentage of total payments made to providers and practitioners associated with each type of VBP arrangement.

The organization uses the following VBP types, sourced from *CMS Report to Congress: Alternative Payment Models and Medicare Advantage* to report arrangements to NCQA. The organization is not required to use them for internal purposes. If the organization uses different labels for its VBP arrangements, it categorizes them using the NCQA provided definitions.

Pay-for-performance (P4P): Payments are for individual units of service and triggered by care delivery, as under the FFS approach, but providers or practitioners can qualify for bonuses or be subject to penalties for cost and/or quality related performance. Foundational payments or payments for supplemental services also fall under this payment approach.

Shared savings: Payments are FFS, but provider/practitioners who keep medical costs below the organization's established expectations retain a portion (up to 100 percent) of the savings generated. Providers/practitioners who qualify for a shared savings award must also meet standards for quality of care, which can influence the portion of total savings the provider or practitioner retains.

Shared risk: Payments are FFS, but providers/practitioners whose medical costs are above expectations, as predetermined by the organization, are liable for a portion (up to 100 percent) of cost overruns.

Two-sided risk sharing: Payments are FFS, but providers/practitioners agree to share cost overruns in exchange for the opportunity to receive shared savings.

Capitation/population-based payment: Payments are not tied to delivery of services, but take the form of a fixed per patient, per unit of time sum paid in advance to the provider/practitioner for delivery of a set of services (partial capitation) or all services (full or global capitation). The provider/practitioner assumes partial or full risk for costs above the capitation/ population-based payment amount and retains all (or most) savings if costs fall below the capitation/population-based payment amount. Payments, penalties and awards depend on quality of care.

Calculating VBP reach

Percentage of payments is calculated by:

- Numerator: The value-based payments made during the look-back period, *divided by*,
- Denominator: All payments (including fee-for-service) made during the entire look-back period.

The percentage of payments can reflect the current year to date or the previous year's arrangements, and can be based on allowed amounts, actual payments or forecasted payments.

Types of providers/practitioners

For each type of VBP arrangement, the organization reports a percentage of total payments and indicates the provider/practitioner types included in the arrangement.

Exceptions

None.

Examples **Calculating VBP reach**

The denominator is 12 months of all payments, but if there are 3 months of value-based payments in the look-back period, the numerator is the 3 months of value-based payments.

PHM 4: Wellness and Prevention

Refer to Appendix 1 for points

The organization offers wellness services focused on preventing illness and injury, promoting health and productivity and reducing risk.

Intent

The organization helps adult members identify and manage health risks through evidence-based tools that maintain member privacy and explain how the organization uses collected information.

Element A: Frequency of Health Appraisal Completion

The organization has the capability to administer an HA annually.

Summary of Changes

Clarifications

- Relettered elements to account for retired elements (see **Deletions**).
- Revised the "Use of vendor" language in "Related information" to clarify that providing the vendor's HA is only required for nonaccredited/noncertified vendors.

Deletions

- Retired Element A: Health Appraisal Components.
- Retired Element B: Health Appraisal Disclosure.
- Retired Element C: Health Appraisal Scope.
- Retired Element D: Health Appraisal Results.
- Retired Element E: Health Appraisal Format.
- Retired Element G: Health Appraisal Review and Update Process.
- Retired Element I: Usability Testing of Self-Management Tools.
- Retired Element J: Review and Update Process for Self-Management Tools.
- Retired Element K: Self-Management Tools Format.

Scoring

Met	Partially Met	Not Met
The organization meets the requirement	No scoring option	The organization does not meet the requirement

Data source Documented process, Reports, Materials

Scope of review

Product lines

This element applies to First Surveys for all product lines.

Documentation

NCQA reviews the organization's policies and procedures for administering annual HAs, or documentation that the organization administered an annual HA.

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

Explanation The organization provides evidence that it has the capability to administer HAs, even if it does not provide services to any employer or plan sponsor.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a non-accredited/noncertified vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 2.

Examples **Evidence of capability to administer**

- Contracts that specify at least annual administration of the HA.
- Reports that demonstrate at least annual administration of the HA.

Element B: Topics of Self-Management Tools

The organization offers self-management tools, derived from available evidence, that provide members with information on at least the following wellness and health promotion areas:

1. Healthy weight (BMI) maintenance.

2. Smoking and tobacco use cessation.

3. Encouraging physical activity.

4. Healthy eating.

5. Managing stress.

6. Avoiding at-risk drinking.

7. Identifying depressive symptoms.

Summary of Changes

Clarifications

- Relettered elements to account for retired elements (see **Deletions**).

Deletions

- Retired Element A: Health Appraisal Components.
- Retired Element B: Health Appraisal Disclosure.
- Retired Element C: Health Appraisal Scope.
- Retired Element D: Health Appraisal Results.
- Retired Element E: Health Appraisal Format.
- Retired Element G: Health Appraisal Review and Update Process.
- Retired Element I: Usability Testing of Self-Management Tools.

- Retired Element J: Review and Update Process for Self-Management Tools.
- Retired Element K: Self-Management Tools Format.

Scoring

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

Data source Documented process, Materials

Scope of review

Product lines

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

Documentation

NCQA reviews the organization's policies and procedures for developing evidence based self-management tools, and reviews the organization's self-management tools. Both must be available throughout the look-back period.

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

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation The organization provides evidence that it can perform all activities required by this element, even if it does not provide services to any employer or plan sponsor.

Self-management tools

Self-management tools help members determine risk factors, provide guidance on health issues, recommend ways to improve health or support reducing risk or maintaining low risk. They are interactive resources that allow members to enter specific personal information and provide immediate, individual results based on the information. This element addresses self-management tools that members can access directly from the organization's website or through other methods (e.g., printed materials, health coaches).

Evidence-based information

The organization meets the requirement of "evidenced-based" information if recognized sources are cited prominently in the self-management tools.

If the organization's materials do not cite recognized sources, NCQA also reviews the organization's documented process detailing the sources used, and how they were used in developing the self-management tools.

Factors 1–7

No additional explanation required.

Exceptions

None.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's self-management tools against the requirements. Refer to *Vendor Relationships* in Appendix 2.

Examples

Self-management tools

- Interactive quizzes.
- Worksheets that can be personalized.
- Online logs of physical activity.
- Caloric intake diary.
- Mood log.

PHM 5: Complex Case Management

Refer to Appendix 1 for points

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

Intent

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

Element A: Access to Case Management

The organization has multiple avenues for members to be considered for complex case management services, including:

1. Medical management program referral.

2. Discharge planner referral.

3. Member or caregiver referral.

4. Practitioner referral.

Summary of Changes

Deletions

- Retired PHM 5, Element F: Experience with Case Management.

Scoring

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

Data source Documented process, Reports, Materials

Scope of review

Product lines

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

Documentation

NCQA reviews the organization's policies and procedures.

For First Surveys and Renewal Surveys: NCQA also reviews evidence that the organization has multiple referral avenues in place throughout the look-back period and that it communicates the referral options to members and practitioners at least once during the look-back period.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The overall goal of complex case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

NCQA considers complex case management to be an opt-out program: All eligible members have the right to participate or to decline to participate.

The organization offers a variety of programs to its members and does not limit eligibility to one complex condition or to members already enrolled in other organization's program.

In addition to the process described in PHM 2, Element D: Segmentation, multiple referral avenues can minimize the time between identification of a need and delivery of complex case management services.

The organization has a process for facilitating referrals listed in the factors, even if it does not currently have access to the source.

***Factor 1:* Medical management program referral**

Medical management program referrals include referrals that come from other organization programs or through a vendor or delegate. These may include disease management programs, UM programs, health information lines or similar programs that can identify needs for complex case management and are managed by organization or vendor staff.

***Factor 2:* Discharge planner referral**

No additional explanation required.

***Factors 3, 4:* Member, caregiver and practitioner referral**

The organization communicates referral options to members (factor 3) and practitioners (factor 4).

Exceptions

None.

Examples

Facilitating referrals

- Correspondence from members, caregivers or practitioners about potential eligibility.
- Monthly or quarterly reports, from various sources, of the number of members identified for complex case management.
- Brochures or mailings to referral sources about the complex case management program and instructions for making referrals.
- Web-based materials with information about the case management program and instructions for making referrals.

Element B: Case Management Systems

The organization uses case management systems that support:

1. **Evidence-based clinical guidelines or algorithms to conduct assessment and management.**
2. **Automatic documentation of staff ID, and the date and time of action on the case or when interaction with the member occurred.**
3. **Automated prompts for follow-up, as required by the case management plan.**

Summary of Changes

Deletions

- Retired PHM 5, Element F: Experience with Case Management.

Scoring

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

Data source

Documented process, Reports, Materials

Scope of review

Product lines

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

Documentation

NCQA reviews the organization's policies and procedures.

For First Surveys and Renewal Surveys: NCQA also reviews the organization's complex case management system or annotated screenshots of system functionality. The system must be in place throughout the look-back period.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

Factor 1: **Evidence-based clinical guidelines or algorithms**

The organization develops its complex case management system using one of the following sources:

- Clinical guidelines, ***or***
- Algorithms, ***or***
- Other evidence-based materials.

NCQA does not require the entire evidence-based guideline or algorithm to be embedded in the automated system, but the components used to conduct assessment and management of patients must be embedded in the system.

Factor 2: **Automated documentation**

The complex case management system includes automated features that provide accurate documentation for each entry (record of actions or interaction with

members, practitioners or providers) and use automatic date, time and user (user ID or name) stamps.

Factor 3: **Automated prompts**

The complex case management system includes prompts and reminders for next steps or follow-up care.

Exceptions

None.

Examples None.

Element C: Case Management Process

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

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

Summary of Changes

Clarifications

- Added a second paragraph under the subhead "Assessment and evaluation" regarding recording dates in the file.

Deletions

- Retired PHM 5, Element F: Experience with Case Management.

Policy Changes

- This element will not be reviewed for Renewal Surveys for all product lines.

Scoring

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

Data source

Documented process

Scope of review

Product lines

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

Documentation

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

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

Explanation

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

Assessment and evaluation

Assessment and evaluation each require the case manager or other qualified individual to draw and document a conclusion about data or information collected. It is not sufficient to just have raw data or answers to questions. Procedures describe the process for collecting information and summarizing its meaning or implications with regard to the member's situation so the information can be used in the case management plan.

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

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

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

- Screening for presence or absence of comorbidities and their current status.
- Member's self-reported health status.

- Information on the event or diagnosis that led to the member's identification for complex case management.
- Current medications, including schedules and dosages.

Factor 2: **Documentation of clinical history**

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

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

Dates are a necessary component of accurate documentation of the member's clinical history. To the extent possible, the organization collects dates as part of documenting clinical history; however, NCQA does not penalize an organization if a member or other individual providing the information cannot provide dates.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Factor 9: **Evaluation of caregiver resources**

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

Factor 10: **Evaluation of available benefits**

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

Factor 11: **Evaluation of community resources**

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

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

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

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

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

***Factor 13:* Identification of barriers**

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

- Language or literacy level.
- Access to reliable transportation.
- Understanding of a condition.
- Motivation.
- Financial or insurance issues.
- Cultural or spiritual beliefs.
- Visual or hearing impairment.
- Psychological impairment.

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

***Factor 14:* Referrals to available resources**

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

***Factor 15:* Follow-up schedule**

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

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

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

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

***Factor 17:* Assessing progress**

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

Exceptions

None.

Examples

Factor 3: **Activities of daily living**

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

Factor 4: **Cognitive functioning assessment**

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

Factor 5: **Social determinants of health**

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

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

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

Factor 9: **Caregiver assessment**

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

***Factor 10:* Assessment of available benefits**

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

***Factor 13:* Assessment of barriers**

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

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

***Factor 16:* Self-management**

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

Element D: Initial Assessment

An NCQA review of a sample of the organization's complex case management files demonstrates that the organization follows its documented processes for:

1. **Initial assessment of member health status, including condition-specific issues.**
2. **Documentation of clinical history, including medications.**
3. **Initial assessment of the activities of daily living (ADL).**
4. **Initial assessment of behavioral health status, including cognitive functions.**
5. **Initial assessment of social determinants of health.**
6. **Evaluation of cultural and linguistic needs, preferences or limitations.**
7. **Evaluation of visual and hearing needs, preferences or limitations.**
8. **Evaluation of caregiver resources and involvement.**
9. **Evaluation of available benefits.**
10. **Evaluation of available community resources.**
11. **Assessment of life-planning activities.**

Summary of Changes

Clarifications

- Added a second paragraph under the subhead "Assessment and evaluation" regarding recording dates in the file.
- Replaced "opened during" with "identified during" in the scope of review.

Deletions

- Retired PHM 5, Element F: Experience with Case Management.

Scoring

Met	Partially Met	Not Met
High (90-100%) on file review for at least 7 factors and medium (60-89%) on file review for any remaining factors	High (90%-100%) or medium (60-89%) on file review for 11 factors	Low (0-59%) on file review for any factor

Data source

Records or files

Scope of review

Product lines

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

Documentation

NCQA reviews initial assessments in a random sample of up to 40 complex case management files. Files are selected from active or closed member cases that were identified during the look-back period and remained open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management.

The organization must provide the identification date for each case in the file universe.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

Initial assessment files are reviewed on the requirements outlined in PHM 5, Element C.

Documentation to meet the factors includes evidence that the assessments were completed and documented results of each assessment. A checklist of assessments without documentation of results does not meet the requirement.

Assessment components may be completed by other members of the care team and with the assistance of the member's family or caregiver. Assessment results for each factor must be clearly documented in case management notes, even if a factor does not apply.

If the member is unable to communicate because of infirmity, assessment may be completed by professionals on the care team, with assistance from the patient's family or caregiver.

If case management stops when a member is admitted to a facility and the stay is longer than 30 calendar days, a new assessment must be performed after discharge if the member is identified for case management.

Dispute of file review results

Onsite file review is conducted in the presence of the organization's staff. The survey team works to resolve disputes that arise during the onsite survey. In the event that a dispute cannot be resolved, the organization must contact NCQA before the end of the onsite survey. File review results may not be disputed or appealed once the onsite survey is complete.

Assessment and evaluation

Assessment and evaluation each require that the case manager or other qualified individual draw and document a conclusion about data or information collected. It is not sufficient to just have raw data or answers to questions. There is a documented summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan.

Timeliness of assessment

The organization begins the initial assessment within 30 calendar days of identifying a member for complex case management and completes it within 60 calendar days of identification. If the initial assessment was started after the first 30 calendar days of member identification, NCQA scores only factor 1 "No"; the remaining factors are not marked down for starting after the first 30 calendar days of identification.

Additionally, NCQA scores any factor for which the initial assessment is completed more than 60 calendar days from member identification "No," unless the delay was due to circumstances beyond the organization's control:

- The member is hospitalized during the initial assessment period.
- The member cannot be contacted or reached through telephone, letter, email or fax.
- Natural disaster.
- The member is deceased.

The organization documents the reasons for the delay and actions it has taken to complete the assessment.

The assessment may be derived from care or encounters occurring up to 30 calendar days prior to determining identification, if the information is related to the current episode of care (e.g., health history taken as part of disease management or during a hospitalization).

Members are considered eligible upon identification unless they subsequently opt out or additional information reveals them to be ineligible.

Files excluded from review

The organization excludes files from review that meet one of the following criteria:

- Eligible members whom it cannot locate or contact after three or more attempts across a 2-week period, within the first 30 calendar days after identification, through at least two of the following mechanisms:
  - Telephone.
  - Regular mail.
  - Email.
  - Fax.
- Members in complex case management for less than 60 calendar days during the look-back period.
  - The organization provides evidence that the member was identified less than 60 calendar days before the look-back period.

Files that meet these criteria and are inadvertently included in the organization's file review are scored NA for all factors.

NCQA confirms that the files met the criteria for an NA score.

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

The file or case record documents the case manager's assessment of the member's current health status, including:

- Information on presence or absence of comorbidities and their current status.
- Self-reported health status.
- Information on the event or diagnosis that led to identification for complex case management.
- Current medications, including dosages and schedule.

Factor 2: **Documentation of clinical history**

The file or case record contains information on the member's clinical history, including:

- Past hospitalization and major procedures, including surgery.
- Significant past illnesses and treatment history.
- Past medications.

Dates are a necessary component of accurate documentation of the member's clinical history. To the extent possible, the organization collects dates as part of documenting clinical history; however, NCQA does not penalize an organization if a member or other individual providing the information cannot provide dates.

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

The file or case record documents the results of the ADL assessment.

For activities with which the member needs assistance, the case manager documents the reason and type of assistance. The case manager is not required to describe activities for which the member does not need assistance.

If the member needs no assistance with any ADLs, the case file or case notes reflect this (e.g., "Member is fully independent with ADLs").

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

The file or case record documents the case manager's assessment of:

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

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

The case manager assesses social determinants of health, which are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes, and assesses risks that may affect a member's ability to meet goals.

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

Factor 6: **Evaluation of cultural and linguistic needs**

The file or case record documents the case manager's evaluation of the member's culture and language needs and their impact on communication, care or acceptability of specific treatments. At a minimum, the case manager evaluates:

- Cultural health beliefs and practices.
- Preferred languages.

Factor 7: **Evaluation of visual and hearing needs**

The file or case record documents the case manager's evaluation of the member's vision and hearing. The document describes specific needs to consider in the case management plan and barriers to effective communication or care.

Factor 8: **Evaluation of caregiver resources**

The file or case record documents the case manager's evaluation of the adequacy of caregiver resources (e.g., family involvement in and decision making about the care plan) during initial member evaluation. Documentation describes the resources in place and whether they are sufficient for the member's needs, and notes specific gaps to address.

Factor 9: **Evaluation of available benefits**

The file or case record documents the case manager's evaluation of the adequacy of the member's health insurance benefits in relation to the needs of the treatment plan. The evaluation goes beyond checking insurance coverage; it includes a determination of whether the resources available to the member are adequate to fulfill the treatment plan.

Factor 10: **Evaluation of community resources**

The file or case record documents the case manager's evaluation of the member's eligibility for community resources and the availability of those resources and documents which the member may need.

For the community resources the member needs, the availability and member's eligibility is also recorded in the file. The case manager does not need to address community resources the member does not need.

If the member needs no community resources, the case file or case notes reflect this (e.g., "Member does not need any of the available community resources").

Factor 11: **Initial assessment of life planning activities**

The file or case record documents the case manager's assessment of whether the member has in place or has considered the need for wills, living wills or advance directives, Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms and health care powers of attorney.

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

As an alternative to an assessment of life planning needs, the organization may provide life planning information (e.g., brochure, pamphlet) to members in complex case management during the time frame allowed for completing the initial assessment. The file must document that the information was provided and the date.

Exceptions

None.

Examples None.

Element E: Case Management—Ongoing Management

NCQA's review of a sample of the organization's complex case management files demonstrate that the organization follows its documented processes for:

1. **Development of case management plans that include prioritized goals, that take into account member and caregiver goals, preferences and desired level of involvement in the complex case management program.**
2. **Identification of barriers to meeting goals and complying with the case management plan.**
3. **Development of schedules for follow-up and communication with members.**
4. **Development and communication of member self-management plans.**
5. **Assessment of progress against case management plans and goals, and modification as needed.**

Summary of Changes

Clarifications

- Revised the last sentence in the factor 4 explanation to clarify that the self-management plan includes documentation of actions the member has agreed to.

Deletions

- Retired PHM 5, Element F: Experience with Case Management.

Scoring

Met	Partially Met	Not Met
High (90%-100%) on file review for at least 3 factors and medium (60-89%) on file review for any remaining factors	High (90%-100%) or medium (60-89%) on file review for 5 factors	Low (0-59%) on file review for any factors

Data source

Records or files

Scope of review

Product lines

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

Documentation

NCQA reviews initial assessments in a random sample of up to 40 complex case management files. Files are selected from active or closed cases that were opened during the look-back period and remained open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management.

The organization must provide the identification date for each case in the file universe.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation Assessment files are based on the requirements outlined in PHM 5, Element C.

Dispute of file review results

Onsite file review is conducted in the presence of the organization's staff. The survey team works to resolve disputes that arise during the onsite survey. In the event that a dispute cannot be resolved, the organization must contact NCQA before the end of the onsite survey. File review results may not be disputed or appealed once the onsite survey is complete.

Excluded files from review

The organization excludes files from review that meet one of the following criteria:

- Identified members whom it cannot locate or contact after three or more attempts across a 2-week period, within the first 30 calendar days after identification, through at least two of the following mechanisms:
  - Telephone.
  - Regular mail.
  - Email.
  - Fax.
- Members in complex case management for less than 60 calendar days during the look-back period.
  - The organization provides evidence that the patient was identified less than 60 calendar days before the look-back period.

Files that meet these criteria and are inadvertently included in the organization's file review are scored NA for all factors.

NCQA reserves the right to confirm that the files met the criteria for an NA score.

Factor 1: **Case management plans and goals**

The organization documents a plan for case management that:

- Is specific to the member's situation and needs, and
- Includes goals that reflect issues identified in the member assessment and the supporting rationale for each selected goal.
  - Goals are specific, measurable and timebound (i.e., have a target completion date).

Case management goals are prioritized. The organization prioritizes goals using high/low, numeric rank or other similar designation. Priorities reflect input from the member or a caregiver, demonstrating the member or caregiver's preferences and priorities. Designating goals as long-term or short-term is not sufficient to meet the requirement. The organization must rank or prioritize goals.

Factor 2: **Identification of barriers**

The file or case record identifies barriers related to the member or to the member's circumstances (not to the case management process). The organization documents barriers to the member meeting the goals specified in the case management plan.

Factor 3: **Follow-up and communication with members**

The organization documents the next scheduled contact with the member, including the scheduled time or time frame, which may be an exact date or relative (e.g., "October 15," "in two weeks"), and the contact method.

Factor 4: **Self-management plan**

A self-management plan includes actions the member agrees to take to manage a condition or circumstances. The organization documents that the plan has been communicated to the member. Communication may be verbal or written. The self-management plan documents the member's acknowledgment of and agreement with actions the member will take.

Factor 5: **Assessment of progress**

The organization documents the member's progress toward goals. If the member does not demonstrate progress over time, the organization reassesses the applicability of the goals to the member's circumstances and modifies the goals, as appropriate.

Exceptions

None.

Examples ***Factors 1–5:*** **Case Management—Ongoing Management**

<table>
<tr><td colspan="2">Member Diagnosis: Severe mental illness (depression); chronic homelessness (unstable housing for 8 months)</td></tr>
<tr><td>Identification date: 1/5/2019</td><td>Initial Assessment Completed: 1/30/2019</td></tr>
<tr><td>Goal 1:</td><td>Secure stable housing for member by 2/11/2019. (Factor 1)</td></tr>
<tr><td colspan="2">Goal case notes: Member did not identify a family or friend caregiver. Member expresses a desire for a home and is willing to accept case manager's help to manage other conditions, once in stable housing. (Factor 1)

Strategies to achieve goal: Referral to community housing resources; secure temporary safe housing, pending a more permanent solution; accompany member to housing services.

Barriers to goal: Member was previously evicted from temporary shelter due to unwillingness to comply with shelter staff rules. (Factor 2)

Progress assessment: Member moved out of initial temporary shelter because he felt his belongings were unsafe. Asked for help getting into a home where he can lock up his belongings. CM adjusted completion date to 2/21/2019 and investigated group housing. (Factor 5)</td></tr>
<tr><td>Goal 1 completed:</td><td>2/16/2019.
Note: Member was accepted into adult male group housing, once he understood and accepted house rules, is comfortable with secure locker for belongings. (Factor 5)</td></tr>
<tr><td>Goal 2:</td><td>• Improve member's Patient Health Questionnaire-9 (PHQ-9) score from baseline (23 at initial assessment 1/30/2019) over 3–6 months.
• Improve 5 points from baseline by 4/30/2019.
• Improve 11 points from baseline by 7/30/2019. (Factor 1)</td></tr>
</table>

Goal case notes: Member did not identify a family or friend caregiver. Member expresses a desire for a home and is willing to accept case manager's help to manage other conditions, once in stable housing. Member feels that stable housing will help depression and is willing to attend therapy sessions. **(Factor 1)**

Strategies to achieve goal: Implement a reminder system for taking medications; arrange transportation for therapist visits; check in weekly to discuss progress.

Barriers to goal: Member uncertain about how to get to therapy sessions and states that he feels overwhelmed by having to change buses and remember schedules. Member said his medication has been stolen in shelters before. **(Factor 2)**

Progress assessment: Member feels his medications are safe in group home lockers. CM helped the member set up a calendar pill case and clock alarm as medication reminders. CM arranged van transportation to twice weekly therapy sessions.

CM assessed PHQ score at weekly call on 4/28/2019. Score was 16 (9 less than baseline). Member stated that housing greatly improved depression. Therapy sessions adjusted to weekly.

CM assessed PHQ score at weekly call on 7/28/2019. Score was 12 (11 less than baseline). **(Factor 5)**

Goal 2 completed:	7/28/2019. ***Note:*** *Member attends therapy. Member can navigate bus lines without anxiety; assisted transportation to sessions discontinued.* **(Factor 5)**
Follow-up and communication plan:	CM scheduled weekly follow-up calls at 5pm on Fridays via the group home's phone line. CM gave member direct emergency line and is working to secure cell phone for member. **(Factor 3)**
Self-management plan:	• Member will attend weekly follow-up calls on Fridays at 5pm via ***-***-****. • Member will continue to follow rules of group home. • Member will alert CM if changes to housing occur. • Member will use alarm clock reminders to take medication on schedule. Member and CM will discuss monthly refills to medications box. • CM arranges medication to be mailed to group home; member agrees to verify medication with CM during weekly calls. • Member attends therapy sessions and alerts group home staff to dramatic changes in mood (e.g., suicidal ideation). • Member will work with group home staff and other residents to learn bus routes and how to change buses on route. **(Factor 4)** ***Note*:** *Member signed and has copies of the agreed-on self-management and case management plans. Signed copies attached.* **(Factor 4)**

PHM 6: Population Health Management Impact

Refer to Appendix 1 for points

The organization measures the effectiveness of its PHM strategy.

Intent

The organization has a systematic process to evaluate whether it has achieved its goals and to gain insights into areas needing improvement.

Element A: Measuring Effectiveness

At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following:

1. Quantitative results for relevant clinical, cost/utilization and experience measures.

2. Comparison of results with a benchmark or goal.

3. Interpretation of results.

Summary of Changes

Clarifications

- Revised the scope of review to state that NCQA reviews and scores by each product line brought forward for Accreditation.
- Clarified in the factor 1 explanation what is included in qualitative results.

Scoring

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

Data source

Reports

Scope of review

Product lines

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

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

Documentation

NCQA reviews the organization's most recent annual comprehensive analysis of PHM strategy impact.

Look-back period

For First Surveys and Renewal Surveys: At least once in the prior year.

Explanation

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

The organization conducts an annual comprehensive quantitative analysis of the impact of the organization's PHM strategy.

Factor 1: **Quantitative results**

Quantitative results include at least one clinical measure, one cost or utilization measure and member feedback measures from at least two programs.

Relevant measures align with the areas of focus, activities or programs as described in PHM 1, Element A. The organization describes why measures are relevant. Measures may focus on one segment of the population or on populations across the organization.

Clinical measures

Measures can be activities, events, occurrences or outcomes for which data can be collected for comparison with a threshold, benchmark or prior performance. Clinical measures may be:

1. *Outcome measures:* Incidence or prevalence rates for desirable or undesirable heath status outcomes (e.g., infant mortality), ***or***
2. *Process measures:* Measures of clinical performance based on objective clinical criteria defined from practice guidelines or other clinical specifications (e.g., immunization rates).

Cost/Utilization measures

Utilization is an unweighted count of services (e.g., inpatient discharges, inpatient days, office visits, prescriptions). Utilization measures capture the frequency of services provided by the organization. Cost-related measures can be used to demonstrate utilization. The organization measures cost, resource use or utilization.

Cost of care considers the mix and frequency of services, and is determined using actual unit price per service or unit prices found on a standardized fee schedule. Examples of cost of care measurement include:

- Dollars per episode, overall or by type of service.
- Dollars per member, per month (PMPM), overall or by type of service.
- Dollars per procedure.

Resource use considers the cost of services in addition to the count of services across the spectrum of care, such as the difference between a major surgery and a 15-minute office visit.

Experience

The organization obtains and analyzes member feedback from at least two programs (e.g., disease management or wellness programs), using focus groups or satisfaction surveys. Feedback is specific to the programs being evaluated and covers, at a minimum:

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.
- Percentage of members indicating that the program helped them achieve health goals.

The organization may also analyze complaints to identify opportunities to improve satisfaction.

CAHPS and other general survey questions do not meet the intent of this element.

Factor 2: **Comparison of results**

The organization performs quantitative data analysis that compares results with an established, explicit and quantifiable goal or benchmark. Analysis includes past performance, if a previous measurement was performed.

Tests of statistical significance are not required, but may be useful when analyzing trends.

Factor 3: **Interpretation of results**

Measures are assessed together to provide a comprehensive analysis of the effectiveness of the PHM strategy. Interpretation is more than simply a presentation of results; it gives the organization insight into its PHM programs and strategy, and helps it understand the programs' effectiveness and impact on areas of focus. The organization conducts a qualitative analysis if stated goals are not met.

Note:

- *Participation rates do not qualify for this element.*
- *If the organization uses SF-8®, SF-12® or SF-36® to measure health status, results may count for two measures of effectiveness: one each for physical and mental health functioning.*

Exceptions

None.

Examples

Factor 1: **Quantitative results**

Utilization includes measures of waste, overutilization, access, cost or underutilization.

Experience

- Patient Health Questionnaire (PHQ-9).
- Patient-Reported Outcomes Measurement Information System (PROMIS) tools.
- Program-specific surveys.

Element B: Improvement and Action

The organization uses results from the PHM impact analysis to annually:

1. Identify opportunities for improvement.

2. Act on one opportunity for improvement.

Summary of Changes

Clarifications

- Revised the scope of review to state that NCQA reviews and scores by each product line brought forward for Accreditation.
- Added "documented process" as a data source.
- Clarified the scope of review to state that NCQA reviews the organization's documented process or materials, depending on the opportunities identified.

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Reports

Scope of review

Product lines

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

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

Documentation

NCQA reviews the organization's most recent annual comprehensive analysis of PHM strategy impact.

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

Look-back period

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

Explanation

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

Factor 1: **Opportunities for improvement**

The organization uses the results of its analysis to identify opportunities for improvement, which may be different each time data are measured and analyzed. NCQA does not prescribe a specific number of improvement opportunities.

Factor 2: **Act on opportunity for improvement**

The organization acts on at least one identified opportunity for improvement.

Exceptions

None.

Examples

None.

PHM 7: Delegation of PHM

Refer to Appendix 1 for points

If the organization delegates NCQA-required PHM activities, there is evidence of oversight of the delegated activities.

Intent

The organization remains responsible for and has appropriate structures and mechanisms to oversee delegated PHM activities.

Element A: Delegation Agreement

The written delegation agreement:

1. **Is mutually agreed upon.**
2. **Describes the delegated activities and the responsibilities of the organization and the delegated entity.**
3. **Requires at least semiannual reporting by the delegated entity to the organization.**
4. **Describes the process by which the organization evaluates the delegated entity's performance.**
5. **Describes the process for providing member experience and clinical performance data to its delegates when requested.**
6. **Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.**

Summary of Changes

Clarifications

- Revised the look-back period for new requirements for Renewal Surveys from 12 months to 24 months.
- Clarified the Explanation under *Factor 5: Providing member and clinical data.*

Scoring

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

Data source Materials

Scope of review

Product lines

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

Documentation

NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

Delegation agreements implemented on or after January 1, 2019, must include a description of the process required in factor 5.

For delegation agreements in place prior to January 1, 2019, the organization may provide documentation that it notified the delegate of the process. This documentation of notification is not required to be mutually agreed upon.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim Surveys and First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

This element may not be delegated.

This element applies to agreements that are in effect during the look-back period.

The delegation agreement describes all delegated PHM activities. A generic policy statement about the content of delegated arrangements does not meet this element.

Factor 1: **Mutual agreement**

Delegation activities are mutually agreed on before delegation begins, in a dated, binding document or communication between the organization and the delegated entity.

NCQA considers the effective date specified in the delegation agreement as the mutually agreed-upon effective date. The effective date may be before or after the signature date on the agreement. If the agreement has no effective date, NCQA considers the signature date (the date of last signature) as the mutually agreed upon effective date.

NCQA may accept other evidence of the mutually agreed-upon effective date: a letter, meeting minutes or other form of communication between the organization and the delegate that references the parties' agreement on the effective date of delegated activities.

NCQA requires submitted evidence for all other delegation factors to consider the same mutually agreed-upon date as the effective date for the delegate's performance of delegated activities.

Factor 2: **Assigning responsibilities**

The delegation agreement or an addendum thereto or other binding communication between the organization and the delegate specifies the PHM activities:

- Performed by the delegate, in detailed language.
- Not delegated, but retained by the organization.
- The organization may include a general statement in the agreement addressing retained functions (e.g., the organization retains all other PHM functions not specified in this agreement as the delegate's responsibility).

If the delegate subdelegates an activity, the delegation agreement must specify that the delegate or the organization is responsible for subdelegate oversight.

Factor 3: **Reporting**

The organization determines the method of reporting and the content of the reports, but the agreement must specify:

- That reporting is at least semiannual.
- What information is reported by the delegate about PHM delegated activities.

- How, and to whom, information is reported (i.e., joint meetings or to appropriate committees or individuals in the organization).

The organization must receive regular reports from all delegates, even NCQA-Accredited/Certified delegates.

Factor 4: **Performance monitoring**

The delegation agreement specifies how the organization evaluates the delegate's performance.

Factor 5: **Providing member and clinical data**

The organization's delegation agreement describes what the delegate must do to obtain the following data when it is needed or on an ongoing basis:

Member experience data: Complaints, CAHPS 5.0H survey results or other data collected on members' experience with the delegate's services.

Clinical performance data: HEDIS measures, claims and other clinical data collected by the organization. The organization may provide data feeds for relevant claims data or clinical performance measure results.

Factor 6: **Consequences for failure to perform**

The delegation agreement specifies consequences if a delegate fails to meet the terms of the agreement and, at a minimum, circumstances that would cause revocation of the agreement.

Exception

This element is NA if the organization does not delegate PHM activities.

Examples None.

Element B: Predelegation Evaluation

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Summary of Changes

- No changes to this element.

Scoring

Met	Partially Met	Not Met
The organization evaluated delegate capacity before delegation began	The organization evaluated delegate capacity after delegation began	The organization did not evaluate delegate capacity

Data source Reports

Scope of review

Product lines

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

This element applies if delegation was implemented in the look-back period.

Documentation

NCQA reviews the organization's predelegation evaluation for up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim and First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

This element may not be delegated.

NCQA-Accredited/Certified delegates

Automatic credit is available for this element if all delegates are NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

Predelegation evaluation

The organization evaluated the delegate's capacity to meet NCQA requirements within 12 months prior to implementing delegation.

NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.

If the time between the predelegation evaluation and implementation of delegation exceeds the 12 months, the organization conducts another predelegation evaluation.

If the organization amends the delegation agreement to include additional PHM activities within the look-back period, it performs a predelegation evaluation for the additional activities.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for longer than the look-back period.

Related information

Use of collaboratives. The organization may enter into a statewide collaboration to perform any or all of the following:

- Predelegation evaluation.
- Annual evaluation.
- Annual audit of files.

The collaborative must agree on the use of a consistent audit tool and must share data. Each organization is responsible for meeting NCQA delegation standards, but may use the shared data collection process to reduce burden.

Examples

Predelegation evaluation

- Site visit.
- Telephone consultation.
- Documentation review.
- Committee meetings.
- Virtual review.

Element C: Review of PHM Program

For arrangements in effect for 12 months or longer, the organization:

1. Annually reviews its delegate's PHM program.

2. Annually audits complex case management files against NCQA standards for each year that delegation has been in effect, if applicable.

3. Annually evaluates delegate performance against NCQA standards for delegated activities.

4. Semiannually evaluates regular reports, as specified in Element A.

Summary of Changes

Clarifications

- Revised the look-back period for new requirements for Renewal Surveys from "once during the prior year" to 24 months.

Scoring

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

Data source

Reports

Scope of review

Product lines

Factor 1 applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.

All factors in this element apply to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews a sample from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

For Interim Surveys: NCQA reviews the organization's review of the delegate's PHM program (factor 1).

For First Surveys: NCQA reviews the organization's most recent annual review, audit, performance evaluation and semiannual evaluation.

For Renewal Surveys: NCQA reviews the organization's most recent and the previous year's annual reviews, audits, performance evaluations and four semiannual evaluations.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim Surveys and First Surveys: Once during the prior year.

For Renewal Surveys: 24 months.

Explanation

This element may not be delegated.

Automatic credit is available for factors 2 and 3 if all delegates are NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

Factor 1: **Review of the PHM program**

Appropriate organization staff or committee reviews the delegate's PHM program. At a minimum, the organization reviews parts of the PHM program that apply to the delegated functions.

Factor 2: **Annual file audit**

If the organization delegates complex case management , it audits the delegate's complex case management files against NCQA standards. The organization uses either of the following to audit the files:

- 5 percent or 50 of its files, whichever is less.
- The NCQA "8/30 methodology" available at http://www.ncqa.org/Programs/Accreditation/PolicyUpdatesSupportingDocuments.aspx

The organization bases its annual audit on the responsibilities described in the delegation agreement and the appropriate NCQA standards.

Factor 3: **Annual evaluation**

No additional explanation required.

Factor 4: **Evaluation of reports**

No additional explanation required.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for less than 12 months.

Factor 2 is NA if the organization does not delegate complex case management activities.

Factors 2–4 are NA for Interim Surveys.

Related information

Use of collaboratives. The organization may enter into a statewide collaboration to perform any or all of the following:

- Predelegation evaluation.
- Annual evaluation.
- Annual audit of files.

The collaborative must agree on the use of a consistent audit tool and must share data. Each organization is responsible for meeting NCQA delegation standards, but may use the shared data collection process to reduce burden.

Examples

None.

Element D: Opportunities for Improvement

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Summary of Changes

Clarifications

- Revised the look-back period for new requirements for Renewal Surveys from 12 months to 24 months.

Scoring

Met	Partially Met	Not Met
The organization has acted on identified problems, if any, at least once in each of the past 2 years that the delegation arrangement has been in effect	The organization took inappropriate or weak action, or acted only in the past year	The organization has not acted on identified problems

Data source

Documented process, Reports, Materials

Scope of review

Product lines

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

Documentation

NCQA reviews reports for opportunities for improvement if applicable from up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues.

For First Surveys: NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's annual reviews and follow-up on improvement opportunities.

The score for the element is the average of the scores for all delegates.

Look-back period

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

For Renewal Surveys: 24 months.

Explanation

This element may not be delegated.

NCQA-Accredited/Certified delegates

Automatic credit is available for this element if all delegates are NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

Identify and follow up on opportunities

The organization uses information from its predelegation evaluation, ongoing reports, or annual evaluation to identify areas of improvement.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for less than 12 months.
- The organization has no opportunities to improve performance.
  - NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples

None.