

## Medicaid Health Plan Accreditation v1.0

### RISK MANAGEMENT

- RM 1: Regulatory Compliance and Internal Controls
  - RM 1-1: Regulatory Compliance
- RM 2: Regulatory Compliance
  - RM 2-1: Regulatory Compliance
- RM 3: Information Systems
  - RM 3-1: Information Systems Management
  - RM 3-2: Systems Risk Assessment
- RM 4: Business Continuity
  - RM 4-1: Business Continuity Plan
- RM-HP 5: Mental Health Parity
  - RM-HP 5-1: Mental Health Parity Analysis

### OPERATIONS AND INFRASTRUCTURE

- OPIN 1: Business Management
  - OPIN 1-1: Policy and Process Maintenance
  - OPIN 1-2: Delegation Management
- OPIN 2: Staff Management
  - OPIN 2-1: Clinical Staff Credentialing
  - OPIN 2-2: Employment Screening
  - OPIN 2-3: Staff Training Programs
  - OPIN 2-4: Code of Ethical Conduct
  - OPIN 2-5: Employee Diversity, Equity and Inclusion
- OPIN 3: Clinical Leadership
  - OPIN 3-1: Clinical Staff Leadership

### PERFORMANCE MONITORING AND IMPROVEMENT

- PMI 1: Quality Management Scope
  - PMI 1-1: Quality Structure
- PMI 2: Quality Data Collection and Evaluation
  - PMI 2-1: Data Collection and Evaluation
- PMI-HP 3: Health Plan Quality Management
  - PMI-HP 3-1: Quality Management Program Structure
  - PMI-HP 3-2: Quality Management Program Evaluation
- PMI-HP 4: Health Plan Quality Improvement Projects
  - PMI-HP 4-1: Quality Improvement Projects

### CONSUMER PROTECTION AND EMPOWERMENT

- CPE 1: Protection of Consumer Information
  - CPE 1-1: Privacy and Security of Consumer Information
- CPE 2: Consumer Safeguards and Communication
  - CPE 2-1: Consumer Diversity, Equity and Inclusion
  - CPE 2-2: Consumer Safety Protocols
  - CPE 2-3: Consumer Complaint Process
  - CPE 2-4: Health Literacy Promotion
  - CPE 2-5: Consumer Marketing Safeguards
- CPE-HP 3: Health Plan Marketing
  - CPE-HP 3-1: Marketing Safeguards
  - CPE-HP 3-2: Health Benefit Plan Information Disclosure
- CPE-HP 4: Financial Incentives
  - CPE-HP 4-1: Monitoring Financial Incentives

### NETWORK MANAGEMENT

- NM 1: Network Management Program
  - NM 1-1: Network Management Program Structure
- NM 2: Provider Network Adequacy
  - NM 2-1: Measuring Network Access and Availability
- NM 3: Network Adequacy Maintenance
  - NM 3-1: Out of Network and Emergency Services
  - NM 3-2: Network Access and Availability by Provider Category
  - NM 3-3: Factors Impact Network Access and Availability
- NM 4: Provider Relations
  - NM 4-1: Participating Provider Written Agreements
  - NM 4-2: Participating Provider Representation
  - NM 4-3: Provider Dispute Resolution Mechanisms
  - NM 4-4: Disputes Impacting Network Status
- NM 5: Provider Access Management
  - NM 5-1: Provider Directory Database
  - NM 5-2: Disruptions to Health Services

## CREDENTIALING

- CR 1: Credentialing Program
  - CR 1-1: Credentialing Program Structure
- CR 2: Credentialing Requirements
  - CR 2-1: Credentialing Program Policy
- CR 3: Credentialing Process
  - CR 3-1: Credentialing Application
  - CR 3-2: Primary Source Verification
  - CR 3-3: Credentialing Confidentiality
  - CR 3-4: Credentialing Time Frame
  - CR 3-5: Notification of Credentialing Decision
  - CR 3-6: Participating Provider Credentials Monitoring
  - CR 3-7: Recredentialing
  - CR 3-8: Credentialing Delegation Oversight

## MEMBER SERVICE AND COMMUNICATIONS

- MSC 1: Rights and Responsibilities
  - MSC 1-1: Member Rights and Responsibilities
- MSC 2: Member Communications
  - MSC 2-1: Member Communications Regarding Health Benefits
- MSC 3: Optimizing the Member Experience
  - MSC 3-1: Member Support Services
- MSC 4: Member Support and Input
  - MSC 4-1: Accessing Member Support Services
  - MSC 4-2: Member Input and Surveys
  - MSC 4-3: Analysis and Reporting on Member Communications

## PHARMACY AND THERAPEUTICS COMMITTEE

- PBM-PT 1: Committee Members
  - PBM-PT 1-1: Membership
  - PBM-PT 1-2: Conflict of Interest
  - PBM-PT 1-3: Membership Exclusions
- PBM-PT 2: Committee Meetings and Responsibilities
  - PBM-PT 2-1: Meetings
  - PBM-PT 2-2: Responsibilities

## FORMULARY AND DRUG MANAGEMENT

- PBM-FDM 1: Formulary Management
  - PBM-FDM 1-1: Formulary Management
- PBM-FDM 2: Formulary Exceptions and Coverage Exclusions
  - PBM-FDM 2-1: Formulary Exceptions
  - PBM-FDM 2-2: Coverage Exclusions

## UTILIZATION MANAGEMENT

- UM 1: Program Management
  - UM 1-1: Program Management
  - UM 1-2: Utilization Review Monitoring
- UM 2: Clinical Review Criteria
  - UM 2-1: Review Criteria Requirements
- UM 4: Limitations of Initial Screening
  - UM 4-1: Initial Screening Policy
- UM 5: Initial Screening Process
  - UM 5-1: Initial Screening Staff Resources
  - UM 5-2: Non-Clinical Staff Provide Administrative Support
- UM 6: Limitations of Initial Clinical Review
  - UM 6-1: Initial Clinical Review Policy
  - UM 6-2: Automated-Only Review
  - UM 6-3: Initial Clinical Reviewer Licensure
- UM 7: AI and ML Medical Software Selection Criteria
  - UM 7-1: AI and ML Medical Software Used in Utilization Review
- UM 8: Initial Clinical Review Process
  - UM 8-1: Initial Clinical Reviewer Resources
- UM 9: Clinical Peer Review
  - UM 9-1: Clinical Peer Review Policy
- UM 10: Clinical Peer Review Qualifications
  - UM 10-1: Clinical Peer Reviewer Licensure
  - UM 10-2: Additional Clinical Peer Reviewer Qualifications
- UM 11: Clinical Peer Review Process
  - UM 11-1: Peer-to-Peer Conversation
- UM 12: Utilization Review Timelines and Notification
  - UM 12-1: Utilization Review Notification Time Frames
  - UM 12-2: Lack of Information Policy
  - UM 12-3: Information Upon Which to Base Review Determinations

- UM 12-4: Certification Decision Notice
- UM 12-5: Written Notice of Non-Certification Decisions
- UM 13: Utilization Review Appeals
  - UM 13-1: Appeal Policy
- UM 14: Appeal Reviewer Qualifications
  - UM 14-1: Appeal Peer Reviewer Licensure
  - UM 14-2: Additional Appeal Peer Reviewer Qualifications
  - UM 14-3: Additional Appeal Peer Reviewer Requirements
- UM 16: Appeals
  - UM 16-1: Appeal Process
  - UM 16-2: Appeal Notification Time Frames
  - UM 16-3: Written Notice of Non-Certifications Upheld on Appeal
- UM 17: Drug Utilization Management
  - UM 17-1: Initial Determinations
  - UM 17-2: Initial Denial and Appeal Determinations

## POPULATION HEALTH

- PHM 1: Population Health Management Coverage
  - PHM 1-1: Scope of Population Health Management
- PHM 2: Population Health Management
  - PHM 2-1: Approach to Population Health Management
  - PHM 2-2: Member Communications and Participation
- PHM 3: Population Health Status and Needs
  - PHM 3-1: Baseline Health Status and Needs
  - PHM 3-2: Ongoing Population Health Monitoring
  - PHM 3-3: Annual Population Health Management Evaluation
- PHM 4: Strategic Relationship Management
  - PHM 4-1: Participating Provider Support
  - PHM 4-2: Strategic Partnerships
- PHM 5: Case Management in Population Health
  - PHM 5-1: Structured Case Management Services
  - PHM 5-2: Members Identified for Case Management
- PHM 6: Comprehensive Assessment
  - PHM 6-1: Assessment Categories
  - PHM 6-2: Medication Review, Assessment and Interventions
  - PHM 6-3: Member Input into Assessment
  - PHM 6-4: Assessing Available Resources

- PHM 6-5: Assessing Coordination Needs
- PHM 7: Person-Centered Care Plan
  - PHM 7-1: Person-Centered Care Plan Features
  - PHM 7-2: Additional Care Plan Features
  - PHM 7-3: Ongoing Care Plan Management
  - PHM 7-3: Closure of Case Management Services

## MEASURES REPORTING

- RPT 1: Reporting Mandatory Performance Measures to URAC
  - RPT 1-1: Reporting Mandatory Performance Measures to URAC
- RPT 2: Reporting Exploratory Performance Measures to URAC
  - RPT 2-1: Reporting Exploratory Performance Measures to URAC

## BENEFITS AND SERVICES

- SVS 1: Screening Services
  - SVS 1-1: practice Guidelines
  - SVS 1-2: Health Risk Assessment Tool
  - SVS 1-3: Initial Screening
- SVS 2: Access to Services
  - SVS 2-1: Scope of Services
  - SVS 2-2: Emergency and Out-of-Network Services
  - SVS 2-3: Service Requirements
  - SVS 2-4: Use of Technology
- SVS 3: Federal and State Requirements
  - SVS 3-1: Federal Requirements
  - SVS 3-2: Demonstrating State Compliance

## CARE COORDINATION AND CONTINUITY

- CC 1: Coordination of Services
  - CC 1-1: Care Coordinator Responsibilities
  - CC 1-2: Coordination with External Entities
- CC 2: Care Continuity
  - CC 2-1: Continuation of Health Care Services
- CC 3: Care Transitions
  - CC 3-1: Planning for Transitions of Care
  - CC 3-2: Transitions of Care Facilitation
  - CC 3-3: Transitions of Care Information

CC 3-4: Transitions of Care Follow-Up

CC 3-5: Medication Safety Care Coordination

CC 4: Integrated Care

CC 4-1: Medical and Behavioral Integration

## QUALITY SERVICES

QS 1: Participating Provider Involvement

QS 1-1: Data Received from Providers

QS 1-2: Provider Relations

QS 2: Quality Management

QS 2-1: Quality Improvement

QS 2-2: Enrollee Satisfaction

QS 3: Fraud Waste and Abuse Program

QS 3-1: Program Requirements

## MEDICAID UTILIZATION MANAGEMENT

MUM 1: Initial Review Process

MUM 1-1: Initial Review Requirements

MUM 1-2: Review Time Frame Extensions

MUM 2: Appeals Process

MUM 2-1: Appeals Requirements

MUM 2-2: Deemed Exhaustion of the Appeals Process

MUM 3: External Review Process

MUM 3-1: External Review Requirements

## MEDICAID ENROLLEE SERVICE AND COMMUNICATIONS

MESC 1: Enrollee Communications

MESC 1-1: Notification of Changes

MESC 1-2: General Information

MESC 1-3: Cost Information

MESC 1-4: Enrollee Rights and Responsibilities

MESC 2: Provider Information

MESC 2-1: Provider Directories

MESC 2-2: Provider Status Notifications