RISK MANAGEMENT
RM 1: Regulatory Compliance and Internal Controls
   RM 1-1: Regulatory Compliance Management
RM 2: Regulatory Compliance
   RM 2-1: Maintaining 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 1-2: Internal Safeguards
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 and Communication Safeguards
CPE-HP 3: Financial Incentives
   CPE-HP 3-1: Monitoring Financial Incentives
CPE-HP 4: Health Plan Marketing
   CPE-HP 4-1: Marketing Safeguards
   CPE-HP 4-2: Health Benefit Plan Information Disclosure

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 Impacting 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 Structure
UM 1-2: Utilization Review Monitoring
UM 2: Clinical Review Criteria
UM 2-1: Review Criteria Requirements
UM 3: Limitations of Initial Screening
UM 3-1: Initial Screening Policy
UM 4: Initial Screening Process
UM 4-1: Initial Screening Staff Resources
UM 4-2: Non-Clinical Staff Provide Administrative Support
UM 5: Limitations of Initial Clinical Review
UM 5-1: Initial Clinical Review Policy
UM 5-2: Automated-Only Review
UM 5-3: Initial Clinical Reviewer Licensure
UM 6: AI and ML Medical Software Selection Criteria
UM 6-1: AI and ML Medical Software Used in Utilization Review
UM 7: Initial Clinical Review Process
UM 7-1: Initial Clinical Reviewer Resources
UM 8: Clinical Peer Review
UM 8-1: Clinical Peer Review Policy
UM 9: Clinical Peer Review Qualifications
UM 9-1: Clinical Peer Reviewer Licensure
UM 9-2: Additional Clinical Peer Reviewer Qualifications
UM 10: Clinical Peer Review Process
UM 10-1: Peer-to-Peer Conversation
UM 11: Utilization Review Timelines and Notification
  UM 11-1: Utilization Review Notification Time Frames
  UM 11-2: Lack of Information Policy
  UM 11-3: Information Upon Which to Base Review Determinations
  UM 11-4: Certification Decision Notice
  UM 11-5: Written Notice of Non-Certification Decisions
UM 12: Utilization Review Appeals
  UM 12-1: Appeal Policy
UM 13: Appeal Reviewer Qualifications
  UM 13-1: Appeal Peer Reviewer Licensure
  UM 13-2: Additional Appeal Peer Reviewer Qualifications
  UM 13-3: Additional Appeal Peer Reviewer Requirements
UM 14: Appeals
  UM 14-1: Appeal Process
  UM 14-2: Appeal Notification Time Frames
  UM 14-3: Written Notice of Non-Certifications Upheld on Appeal
UM 15: Drug Utilization Management
  UM 15-1: Initial Determinations
  UM 15-2: 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