

NCQA Health Plan Accreditation Standards on Network Adequacy

Below is a summary level abstraction of applicable NCQA 2015 Health Plan Accreditation Standards.

Quality Improvement (QI) 4: Availability of Practitioners. The health plan ensures that its practitioner network has sufficient numbers and types of practitioners who provide primary care, behavioral healthcare and specialty care.

Intent: Ensure that health plan practitioner networks provide culturally appropriate, timely and effective care for members.

Element A: Cultural Needs and Preferences. The health plan assesses the cultural ethnic racial and linguist needs of its members and adjusts its network accordingly.

1. Assesses membership
2. Adjusts availability of practitioners, if necessary

Element B: Practitioners Providing Primary Care. The health plan sets standards for the number of geographic distribution of primary care practitioners and assesses its performance against those standards annually.

1. Sets standards for number of primary care practitioners
2. Sets standards for the geographic distribution of practitioners
3. Assesses performance against standard set in factor 1 at least once annually
4. Assesses performance against the standard set in factor 2 at least once annually

Element C: Practitioners Providing Specialty Care. The health plan sets standards for the number of geographic distribution of specialty care practitioners and assesses its performance against those standards annually.

1. Defines high-volume specialists
2. Sets standards for number of high-volume specialists
3. Sets standards for geographic distribution of high-volume specialists
4. Assess performance against standards in factors 2 and 3 at least once annually

Element D: Practitioners Providing Behavioral Healthcare. The health plan sets standards for the number of geographic distribution of behavioral health care practitioners and assesses its performance against those standards annually.

1. Defines high-volume behavioral healthcare practitioners
2. Sets standards for number of high-volume behavioral health care practitioners
3. Sets standards for geographic distribution of behavioral health care practitioners
4. Assess performance against standards in factors 2 and 3 at least once annually

QI 5: Accessibility of Services. The health plan establishes mechanisms to ensure access to primary care services, behavioral healthcare services and member services.

Intent: Ensure the health plan provides and maintains appropriate access to care for its members.

Element A: Assessment Against Access Standards. The health plan collects and performs an annual analysis to measure its performance against access standards.

1. Regular and routine care appointments
2. Urgent care appointments
3. After-hours care
4. Member services, by telephone

Element B: Behavioral Healthcare Access Standards. The health plan collects and annually analyzes data to measure performance against standards for behavioral healthcare access.

1. Care for non-life-threatening emergency within 6 hours
2. Urgent care within 48 hours
3. Appointments for routine office visits within 10 business days

Element C: Behavioral Healthcare Telephone Access Standards. The health plan collects and analyzes data to measure its performance against the following behavioral healthcare telephone access standards

1. The quarterly average for screening and triage calls shows that telephones are answered by a live voice within 30 seconds.
2. The quarterly average for screening and triage calls reflects a telephone abandonment rate within 5 percent.

QI 12: Marketplace Network Transparency and Experience. The health plan provides information to individuals about the criteria it uses to select hospitals and practitioners for participation in Marketplace plan networks, and monitors member experience with its Marketplace plan services.

Intent: Ensure that individuals have useful information to help them select a Marketplace plan. Monitor member experience to identify opportunities for improving plan offerings.

Element A: Network Design Criteria for Practitioners. The health plan's practitioner directory contains easy-to-understand language explaining the criteria for selecting practitioners for participation in its Marketplace Silver-tier plans, including:

1. The types of practitioners included.
2. Consideration of geographic distribution.
3. Quality measures, member experience measures or cost-related measures used, if any.

Element B: Network Design Criteria for Hospitals. The health plan's hospital directory contains easy-to-understand language explaining the criteria for selecting hospitals for participation in Marketplace plans, including:

1. Consideration of geographic distribution.
2. Quality measures, member experience measures, patient safety measures or cost-related measures used, if any.

Element C: Marketplace Member Experience. The health plan performs an annual analysis of member complaints, appeals and requests for out-of-network services, using the methods in factors 1–3, and performs the tasks in factors 4 and 5.

1. If a sample is used, draws appropriate samples from the affected population.
2. Collects valid measurement data for each of the five required categories of complaints/ appeals.
3. Compiles data on requests for out-of-network services.
4. Analyzes data.
5. Identifies opportunities, sets priorities and chooses opportunities to pursue based on the analysis.

QI 10: Continuity and Coordination of Medical Care. The health plan monitors and takes action to improve continuity and coordination of care.

Intent: The health plan uses information at its disposal to facilitate continuity and coordination of medical care across its delivery system.

Element D: Notification of Termination. The health plan notifies members affected by termination of a practitioner or practice group in general, family or internal medicine or pediatrics at least 30 calendar days prior to the effective termination date and helps them select a new practitioner.

Element E: Continued Access to Practitioners. If a practitioner’s contract is terminated, the health plan allows affected members to continue to see that practitioner under two circumstances.

1. If a member has a chronic or acute medical condition for which they are under active treatment, they may continue to see their provider for 90 days or until the period of treatment is over, whichever is less.
2. If a pregnant member is in her second or third trimester of pregnancy, then she may be able to continue to see her provider through the postpartum period.

Standards Below Pertain to Provider Directories

RR 4: Physician and Hospital Directories. The health plan provides information to help members and prospective members choose physicians and hospitals.

Intent

The organization’s directories offer information to members and prospective members that is useful in selecting a physician and hospital.

Element A: Physician Directory Data. The health plan has a Web-based physician directory that includes the following physician information:

1. Name.
2. Gender.
3. Specialty.

4. Hospital affiliations.
5. Medical group affiliations.
6. Board certification.
7. Accepting new patients.
8. Languages spoken by the physician or clinical staff.

Element B: Physician Directory Updates. The health plan updates the physician directory within 30 calendar days of receiving new information from the physician.

Element C: Physician Information Validation. In each physician listing in its Web-based directory, the organization provides an explanation of the item, its source, the frequency of validation and limitations of each of the following:

1. Name.
2. Gender.
3. Specialty.
4. Hospital affiliations.
5. Medical group affiliations.
6. Board certification.
7. Accepting new patients.
8. Languages spoken by the physician or clinical staff.
9. Office locations.

Element D: Searchable Physician Web-Based Directory. The health plan's Web-based physician directory includes search functions with instructions on how to find the following physician information:

1. Name.
2. Gender.
3. Specialty.
4. Hospital affiliations.
5. Medical group affiliations.
6. Accepting new patients.
7. Languages spoken by the physician or clinical staff.
8. Office locations.

Element E: Hospital Directory Data. The health plan has a Web-based hospital directory that includes the following information to help members and prospective members choose a hospital:

1. Hospital name.
2. Hospital location.
3. Hospital accreditation status.
4. Hospital quality data from recognized sources.

Element F: Hospital Directory Updates. The health plan updates its hospital directory information within 30 calendar days of receiving new information from the hospital.

Element G: Hospital Information Validation. In each listing in its Web-based hospital directory, the organization provides an explanation of the item, its source, the frequency of validation and limitations of each of the following:

1. Hospital name.
2. Hospital location.
3. Hospital accreditation status.

Element H: Searchable Hospital Web-Based Directory. The health plan's Web-based directory includes search functions for specific data types and instructions for searching for the following information:

1. Hospital name.
2. Hospital location.

Element I: Usability Testing. The health plan's evaluates its Web-based physician and hospital directories for understandability and usefulness to members and prospective members at least every three years, and considers the following:

1. Font size.
2. Reading level.
3. Intuitive content organization.
4. Ease of navigation.
5. Directories in additional languages, if applicable to the membership.

Element J: Availability of Directories. The health plan makes Web-based physician and hospital directories' information available to members and prospective members through alternative media, including:

1. Print.
2. Telephone.