|  |
| --- |
| **Delegated Group Name** |

|  |
| --- |
| **HEALTH PLAN NAME** |

|  |  |
| --- | --- |
| **Type of Assessment:** | **Person(s) Conducting the Assessment:**  |
| **[ ]  Pre-Delegation\*****[ ]  Annual Audit****[ ]  Shared Annual****[ ]  Compliance Audit****[ ]  Virtual [ ]  Onsite** |  |
|  | **Staff Interviewed:** |
|  |  |

**Credentialing Activities/Responsibilities Delegated (Y/N)?**

Credentialing/Recredentialing Application Mailing/Receipt N/A

 Primary Source Verification of Required Data N/A

 Making Credentialing Decisions N/A

 Ongoing Monitoring Data Collection and Review N/A

 Handling Appeals/Fair Hearings on Decisions/Proposed Actions N/A

 Reporting Decisions/Actions to NPDB/State Boards N/A

 Organizational Provider (Facility) Credentialing N/A

 Oversight of Sub-Delegated Credentialing Activities N/A

 Practitioner Office Site Quality N/A

**Reviewed and Approved By:**

|  |
| --- |
|  |

##  (Chairperson, Credentialing Committee) Date

**[ ]  Delegation with no Corrective Action**

**[ ]  Delegation with Corrective Action**

**[ ]  Denied Delegation**

**Pre-Assessment\* or Original Oversight Date:**

**Current Oversight Date:**

**Next Oversight Date:**

\*Pre-Delegation assessments are not part of the WCSG SDA program.

 **OVERALL SCORES AND COMMENTS PER STANDARD**

|  |  |  |
| --- | --- | --- |
|  | **Points Possible** |  |
| **Standards** | **Pre-Delegation (all product lines)** | **Annual Audit or Compliance Audit (all product lines including Medicaid)** | **Annual Audit or Compliance Audit (all product lines excluding Medicaid)** | **Points Received** |
| ***CR 1:*** *Credentialing Policies* | **3.00** | **3.00** | **1.00** |  |
| ***CR 2:*** *Credentialing Committee* | **1.00** | **1.00** | **1.00** |  |
| ***CR 3:*** *Credentialing Verification* | **3.00** | **3.00** | **3.00** |  |
| ***CR 4:*** *Recredentialing Cycle Length* | **NA** | **1.00** | **1.00** |  |
| ***CR 5:*** *Ongoing Monitoring and Interventions* | **2.00** | **2.00** | **2.00** |  |
| ***CR 6:*** *Notification to Authorities and Practitioner Appeal Rights* | **1.00** | **NA** | **NA** |  |
| ***CR 7:*** *Assessment of Organizational Providers* | **5.00** | **2.00** | **2.00** |  |
| ***CR 8:*** *Delegation of CR* | **4.00** | **4.00** | **4.00** |  |
| **TOTAL NCQA SCORE** | **%** | **19.00** | **16.00** | **14.00** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Additional Elements Score***(plan specific criteria beyond NCQA)* |  |  |  |  |
| **TOTAL COMBINED SCORE** | **%** |  |  |  |  |

 **Compliance Rating: [ ]  Fully Met [ ]  Not Met**

**Fully Met** = XX% or greater compliance

**Not Met** = Less than XX% compliance

| Standard | **Strengths / Concerns / Comments** |
| --- | --- |
| Credentialing Policies |  |
| Credentialing Committee/Minutes\* | Include dates of committee minutes reviewed  |
| Credentialing Verification |  |
| Recredentialing Cycle Length |  |
| Ongoing Monitoring and Interventions |  |
| Notification to Authorities & Practitioner Appeal Rights |  |
| Assessment of Organizational Providers |  |
| Delegation of CR |  |
| Additional Health Plan Elements |  |

**\*Note: Credentialing Committee/Minutes is a required WCSG Shared Delegation Audit Team field.**

**Note: The must-pass threshold for all must-pass elements is “Met.”**

**If an organization does not score “Met” in any must-pass element:**

**– The Delegate may be required submit a Corrective Action Plan (CAP) to the Health Plan within 30 calendar days.**

**CORRECTIVE ACTION / RECOMMENDATION SUMMARY**

|  |  |  |
| --- | --- | --- |
| Standard | **Open Corrective Action Items from Previous XXXX Audit** | Due Date |
|       |       |       |
|       |       |       |
|       |       |       |

|  |  |  |
| --- | --- | --- |
| Standard | **Corrective Action Items\*** | Due Date |
|       |       |       |
|       |       |       |
|       |       |       |
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| --- |
| **Recommendations** |
|       |
|       |
|       |

|  |  |
| --- | --- |
| **Action Items for Health Plan** | **Due Date** |
|       |       |
|       |       |
|       |       |
|       |       |

|  |
| --- |
| **Notes** |
|       |
|       |
|       |

**\*Note: Corrective Action Items for audited Group is a required WCSG Shared Delegation Audit Team field.GENERAL AUDIT INFORMATION**

**Types of Practitioners:**

* Group credentials and recredentials the following practitioner types:

 [ ]  ARNPs [ ]  Oral Surgeons/Dentists (DDS/DMD) [ ]  Optometrists (OD) [ ]  Podiatrists (DPM)

 [ ]  Acupuncturists (Lac) [ ]  Dieticians (RD) [ ]  PA/PA-C [ ]  RN First Assistants

 [ ]  Audiologists (CCC-A) [ ]  Genetic Counselor [ ]  Pharmacists [ ]  Speech Language Pathologists

 [ ]  Chiropractors (DC) [ ]  Massage Therapists (LMP/LMP) [ ]  Physicians (MD/DO) [ ]  Surgical Assistants

 [ ]  CRNAs [ ]  Naturopaths (ND) [ ]  Physical Therapist (PT) [ ]  Other:

 [ ]  Certified Diabetic Educator [ ]  Occupational Therapists (OT)

Behavioral Health Practitioners:

 [ ]  ARNPs [ ]  Chemical Dependency Counselors [ ]  LICSW [ ]  LCSW [ ]  LASW [ ]  LMFT

 [ ]  Psychologists (PhD/PsyD) [ ]  Psychiatrists (MD/DO) [ ]  Registered Counselors [ ]  Licensed Mental Health Counselors

 [ ]  Other:

 Women’s Health Practitioners:

 [ ]  Certified Nurse Midwives [ ]  Licensed Midwives [ ]  Women’s Healthcare Specialist ARNPs [ ]  Other:

**Recredentialing Cycle:** [ ]  24-month or [ ]  36-month

**Policies and Procedures**

* Last Revision/Reviewed Date?       Annual Revision/Reviewed? [ ]  Yes [ ]  No

**Medicare Contracts with Any WCSG Plans?** [ ]  Yes [ ]  No

**File Review**

* Group uses WPA Application for initial credentialing? [ ]  Yes [ ]  No [ ]  Other
* Group uses WPA Attestation Questions for initial and recredentialing? [ ]  Yes [ ]  No [ ]  Other
* Group submits clean files to Medical Director for review/approval in place of committee review? [ ]  Yes [ ]  No
* Medical Director uses electronic signature when approving clean files? [ ]  Yes [ ]  No [ ]  N/A
* Group uses the DOH to verify education/training? [ ]  Yes [ ]  No
* Group annually obtains written confirmation from DOH that it performs PSV? [ ]  Yes [ ]  No [ ]  N/A
* File Review Look-Back Period: mm/yy – mm/yy
* Total number of initials and recredentialing files completed within look-back period:
* File Selection Methodology used:       (5%, 10% or 8/30)

**Practitioner Office Site Quality**

* Is there a policy that defines the compliant threshold for doing a site visit? [ ]  Yes [ ]  No
* Have there been complaints about physical access/appearance that met/exceeded threshold? [ ]  Yes [ ]  No
* Did the organization do site visits? [ ]  Yes [ ]  No [ ]  N/A [ ]
* Was any corrective action necessary? [ ]  Yes [ ]  No [ ]  N/A
* Have follow-up site visits been performed? [ ]  Yes [ ]  No [ ]  N/A

**Notification to Authorities and Practitioner Appeal Rights**

* Have the conditions of a practitioner’s participation been altered based on issues of quality of care or service?

 [ ]  Yes [ ]  No

* Has the organization reported a practitioner’s suspension or termination to the appropriate authorities?

 [ ]  Yes [ ]  No [ ]  N/A

**Delegation of CR**

* Group sub-delegates credentialing activities? [ ]  Yes, CVO [ ]  Yes, Other       [ ]  No
* Name of Delegated Entity:
* Effective Date:       NCQA Certified/Accredited? [ ]  Yes [ ]  No

**Organizational**

* Group supplies Malpractice coverage for all practitioners? [ ]  Yes [ ]  No
* Group has DEA Coverage Plan? [ ]  Yes [ ]  No
* Group has Admitting Coverage Arrangement? [ ]  Yes [ ]  No

**CR 1 Credentialing Policies**

The organization has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members.

Intent: The organization has a rigorous process to select and evaluate practitioners.

| **Element A: Practitioner Credentialing Guidelines** | **Page/Section** | **Points** |
| --- | --- | --- |
| The organization’s credentialing policies & procedures specify:1. The types of practitioners to credential & recredential
2. The verification sources used & define the organization’s process for documenting information in credentialing files
3. The criteria for credentialing & recredentialing
4. The process used for making credentialing & recredentialing decisions
5. The process for managing credentialing files that meet the organization’s established criteria
6. The process (which includes a statement, preventing, monitoring at least annually) for requiring that credentialing & recredentialing are conducted in a nondiscriminatory manner
7. The process for notifying practitioners if information obtained during the organization’s credentialing process varies substantially from the information they provided to the organization
8. The process for notifying practitioners of the credentialing & recredentialing decision within 60 calendar days of the credentialing committee’s decision
9. The medical director or other designated physician’s direct responsibility and participation in the credentialing program
10. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law
11. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty.
 |  |  |

|  |  |
| --- | --- |
| **Element A Scoring \*** |  **Points** |
| **Met** | The organization meets 8-11 factors  | **1.00 points** |
|  **Partially Met**  | The organization meets 5-7 factors  | **0.50 points** |
|  **Not Met** | The organization meets 0-4 factors  | **0.00 points** |

\*For NCQA, this element applies only to Medicaid for Annual Audits (Renewal Surveys) and Compliance Audits. It is scored NA for commercial, Exchange and Medicare Annual Audits (Renewal Surveys). Health Plans with Medicare/Medicaid lines of business will assess for compliance and score.

|  |  |  |
| --- | --- | --- |
| **Element B: Practitioner Rights** | **Page/Section** | **Points** |
| The organization notifies practitioners about their right to:1. Review information submitted to support their credentialing application
2. Correct erroneous information
3. Receive the status of their credentialing or recredentialing application, upon request.
 |  |  |

|  |  |
| --- | --- |
| **Element B Scoring\*** |  **Points** |
| **Met** | The organization meets 2-3 factors | **1.00 points** |
|  **Partially Met** | No scoring option | **NA** |
|  **Not Met** | The organization meets 0-1 factors | **0.00 points** |

\*For NCQA, this element applies only to Medicaid for Annual Audits (Renewal Surveys). It is scored NA for commercial, Exchange and Medicare Annual Audits (Renewal Surveys). Health Plans with Medicare/Medicaid lines of business will assess for compliance and score.

|  |  |  |
| --- | --- | --- |
| **Element C: Credentialing System Controls - MUST-PASS ELEMENT** | **Page/Section** | **Points** |
| The organization’s credentialing process describes:1. How primary source verification information is received, dated and stored.
2. How modified information is tracked and dated from its initial verification.
3. Staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate.
4. The security controls in place to protect the information from unauthorized modification.
5. How the organization audits the processes and procedures in factors 1–4.
 |  |  |

|  |  |
| --- | --- |
| **Element C Scoring**  |  **Points** |
| **Met** | The organization meets all 5 factors | **1.00 points** |
| **Partially Met** | No Scoring Option | **NA** |
| **Not Met** | The organization meet 0-4 factors | **0.00 points** |

|  |  |
| --- | --- |
| **CR 1 SCORE *(Element A + Element B + Element C)*** |  |

| **CR 1 Element** | **Comments** |
| --- | --- |
| **A** |  |
| **B** |  |
| **C** |  |

**CR 2 Credentialing Committee**

**The organization designates a Credentialing Committee that uses a peer-review process to make recommendations regarding credentialing decisions.**

**Intent: The organization obtains meaningful advice and expertise from participating practitioners when it makes credentialing decisions.**

|  |  |  |
| --- | --- | --- |
| **Element A: Credentialing Committee** | **Page/Section/Report** | **Points** |
| The organization’s Credentialing Committee\*. 1. Uses participating practitioners to provide advice and expertise for credentialing decisions.
2. Reviews credentials for practitioners who do not meet established thresholds.
3. Ensures that files that meet established criteria are reviewed and approved by a medical director or designated physician.
 |  |  |

|  |  |
| --- | --- |
| **Element A Scoring**  |  **Points** |
| **Met** | The organization meets 2-3 factors. | **1.0 points** |
|  **Partially Met** | No scoring option | **NA** |
|  **Not Met** | The organization meets 0-1 factors | **0.0 points** |

|  |  |
| --- | --- |
| **CR 2 SCORE *(Element A)*** |  |

| **CR 2 Element** | **Comments** |
| --- | --- |
| **A** | Include dates of committee minutes reviewed |

\* NCQA requires review of Credentialing Committee minutes from at least three different meetings for each year of the look-back period.

**CR 3 Credentialing Verification**

**The organization verifies credentialing information through primary sources, unless otherwise indicated.**

**Intent: The organization conducts timely verification of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care.**

|  |  |
| --- | --- |
| **Element A: Verification of Credentials – MUST-PASS ELEMENT** | **Points** |
| The organization verifies that the following are within the prescribed time limits:1. A current and valid license to practice
2. A valid DEA or CDS certificate, if applicable
3. Education and training as specified in the explanation (highest of the following three levels obtained: Board Certification; Residency; Graduation from medical or professional school)
4. Board certification status, if applicable
5. Work history
6. A history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner
 |  |

|  |  |
| --- | --- |
| **Element A Scoring**  |  **Points** |
| **Met** | High (90-100%) on file review for at least 4 factors and medium (60-89%) on file review for any remaining factors | **0.50 points** |
|  **Partially met** | High (90-100%) or medium (60-89%) on file review for 6 factors | **0.25 points** |
| **Not met** | Low (0-59%) on file review for any factor | **0.00 points** |

|  |  |
| --- | --- |
| **Element RA: Verification of Recredentialing – MUST-PASS ELEMENT** | **Points** |
| The organization verifies that the following are within the prescribed time limits:1. A current and valid license to practice2. A valid DEA or CDS certificate, if applicable3. Education and training **N/A for recredentialing**4. Board certification status, if applicable5. Work history **N/A for recredentialing**6. A history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner |  |

|  |  |
| --- | --- |
| **Element RA Scoring** |  **Points** |
| **Met** | High (90-100%) on file review for at least 4 factors and medium (60-89%) on file review for any remaining factors | **0.50 points** |
|  **Partially Met** | High (90-100%) or medium (60-89%) on file review for 6 factors | **0.25 points** |
|  **Not Met** | Low (0-59%) on file review for any factor | **0.00 points** |

|  |  |
| --- | --- |
| **Element B: Sanction Information – MUST-PASS ELEMENT** | **Points** |
| The organization verifies the following sanction information for initial credentialing: 1. State sanctions, restrictions on licensure or limitations on scope of practice *(minimum of most recent five-year period)*
2. Medicare and Medicaid sanctions
 |  |

|  |  |
| --- | --- |
| **Element B Scoring**  |  **Points** |
| **Met** | High (90-100%) on file review for at least 1 factor and medium (60-89%) on file review for any remaining factor | **0.50 points** |
|  **Partially Met** | Medium (60-89%) on file review for 2 factors  | **0.25 points** |
|  **Not Met** | Low (0-59%) on file review for any factor | **0.00 points** |

|  |  |
| --- | --- |
| **Element RB: Sanction Information – MUST-PASS ELEMENT** | **Points** |
| The organization verifies the following sanction information for recredentialing: 1. 1. State sanctions, restrictions on licensure and limitations on scope of practice *(minimum of most recent five year*
2. *period)*
3. 2. Medicare and Medicaid sanctions
 |  |

|  |  |
| --- | --- |
| **Element RB Scoring** |  **Points** |
| **Met** | High (90-100%) on file review for at least 1 factor and medium (60-89%) on file review for any remaining factor | **0.50 points** |
|  **Partially Met** | Medium (60-89%) on file review for 2 factors  | **0.25 points** |
| **Not Met** | Low (0-59%) on file review for any factor | **0.00 points** |

|  |  |
| --- | --- |
| **Element C: Credentialing Application – MUST-PASS ELEMENT** | **Points** |
| Applications for credentialing include the following:1. Reasons for inability to perform the essential functions of the position2. Lack of present illegal drug use 1. 3. History of loss of license and felony convictions
2. 4. History of loss or limitation of privileges or disciplinary actions
3. 5. Current malpractice insurance coverage
4. 6. Current and signed attestation confirming the correctness and completeness of the application
 |  |

|  |  |
| --- | --- |
| **Element C Scoring**  |  **Points** |
| **Met** | High (90-100%) on file review for at least 4 factors and medium (60-89%) on file review for any remaining factors | **0.50 points** |
|  **Partially Met** | High (90-100%) or medium (60-89%) on file review for 6 factors | **0.25 points** |
| **Not Met** | Low (0-59%) on file review for any factor | **0.00 points** |

|  |  |
| --- | --- |
| **Element RC: Recredentialing Application – MUST PASS-ELEMENT** | **Points** |
| Applications for recredentialing include the following:1. 1. Reasons for inability to perform the essential functions of the position
2. 2. Lack of present illegal drug use
3. 3. History of loss of license and felony convictions, since the previous decision
4. 4. History of loss or limitation of privileges or disciplinary actions, since the previous decision
5. 5. Current malpractice insurance coverage

6. Current and signed attestation confirming the correctness and completeness of the application |  |

|  |  |
| --- | --- |
| **Element RC Scoring** |  **Points** |
|  **Met** | High (90-100%) on file review for at least 4 factors and medium (60-89%) on file review for any remaining factors | **0.50 points** |
|  **Partially Met** | High (90-100%) or medium (60-89%) on file review for 6 factors | **0.25 points** |
|  **Not Met** | Low (0-59%) on file review for any factor | **0.00 points** |

|  |  |
| --- | --- |
| **CR 3 SCORE *(Element A + Element B + Element C)*** |  |

| **CR 3 Element** | **Comments** |
| --- | --- |
| **A** |  |
| **B** |  |
| **C** |  |

**CR 4 Recredentialing Cycle Length**

The organization formally recredentials its practitioners at least every 36 months.

**Intent: The organization conducts timely recredentialing.**

|  |  |
| --- | --- |
| **Element A: Recredentialing Cycle Length – MUST-PASS ELEMENT** | **Points** |
| The length of the recredentialing cycle is within the required 36-month time frame. |  |

|  |  |
| --- | --- |
| **Element A Scoring\*** |  **Points** |
|  **Met** | High (90-100%) on file review  | **1.00 points** |
|  **Partially Met** | Medium (60-89%) on file review | **0.50 points** |
| **Not Met** | Low (0-59%) on file review | **0.00 points** |

\*For NCQA, N/A for Pre-Delegation Assessments (First Surveys). Health Plans with Medicare/Medicaid lines of business will assess for compliance and score.

|  |  |
| --- | --- |
| **CR 4 SCORE *(Element A)*** |  |

| **CR 4 Element** | **Comments** |
| --- | --- |
| **A** |  |

**CR 5 Ongoing Monitoring and Interventions**

**The organization develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality.**

**Intent: The organization identifies and, when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing.**

| **Element A: Ongoing Monitoring and Interventions** | **Page/Section/Report** | **Points** |
| --- | --- | --- |
| The organization implements ongoing monitoring and takes appropriate interventions by:1. Collecting and reviewing Medicare and Medicaid sanctions *(within 30 calendar days of release of information)*
2. Collecting and reviewing sanctions and limitations on licensure *(within 30 calendar days of release of information)*
3. Collecting and reviewing complaints *(at least every six months)*
4. Collecting and reviewing information from identified adverse events *(at least every six months)*
5. Implementing appropriate interventions when it identifies instances of poor quality related to factors 1-4.
 |  |  |

|  |  |
| --- | --- |
| **Element A Scoring**  |  **Points** |
| **Met** | The organization meets 4-5 factors | **2.00 points** |
|  **Partially met** | The organization meets 3 factors | **1.00 points** |
|  **Not Met** | The organization meet 0-2 factors | **0.00 points** |

|  |  |
| --- | --- |
| **CR 5 SCORE *(Element A)*** |  |

| **CR 5 Element**  | **Comments** |
| --- | --- |
| **A, Factor 1** |  |
| **A, Factor 2** |  |
| **A, Factor 3** |  |
| **A, Factor 4** |  |
| **A, Factor 5** |  |

**\*Note:** For each factor, describe reports reviewed and indicate if copies were provided by the delegate. If monitoring is performed by another department, make note of who is responsible for the activity.

**CR 6 Notification to Authorities and Practitioner Appeal Rights**

**An organization that has taken action against a practitioner for quality reasons reports the action to the appropriate authorities and offers the practitioner a formal appeal process.**

**Intent: The organization uses objective evidence and patient-care considerations when deciding on a course of action for dealing with a practitioner who does not meet its quality standards.**

|  |  |  |
| --- | --- | --- |
| **Element A: Actions Against Practitioners** | **Page/Section** | **Points** |
| The organization has policies & procedures for:1. The range of actions available to the organization
2. Making the appeal process known to practitioners.
 |  |  |

|  |  |
| --- | --- |
| **Element A Scoring\*** |  **Points** |
| **Met** | The organization meets 2 factors  | **1.00 points** |
|  **Partially Met** | The organization meets 1 factor  | **0.50 points** |
| **Not Met** | The organization meets 0 factors  | **0.00 points** |

\*For NCQA, N/A for Annual Assessments (Renewal Surveys) for all product lines. Health Plans with Medicare/Medicaid lines of business will assess for compliance and score.

|  |  |
| --- | --- |
| **CR 6 SCORE *(Element A)*** |  |

| **CR 6 Element** | **Comments** |
| --- | --- |
| **A** |  |

**CR 7 Assessment of Organizational Providers ✓ Not Applicable**

**The organization has written policies and procedures for the initial and ongoing assessment of providers with which it contracts.**

**Intent: The organization evaluates the quality of providers with which it contracts.**

|  |  |  |
| --- | --- | --- |
| **Element A: Review and Approval of Provider** | **Page/Section** | **Points** |
| The organization’s policy for assessing health care delivery providers specifies that before it contracts with a provider, and for at least every 36 months thereafter, it:1. Confirms that the provider is in good standing with state and federal regulatory bodies
2. Confirms that the provider has been reviewed and approved by an accrediting body
3. Conducts an onsite quality assessment if the provider is not accredited.
 |  |  |

|  |  |
| --- | --- |
| **Element A Scoring\*** |  **Points** |
| **Met** | The organization meets 2-3 factors  | **1.00 points** |
|  **Partially Met** | The organization meets 1 factor | **0.50 points** |
|  **Not Met** | The organization meets 0 factors | **0.00 points** |

\*N/A for Annual Assessments (Renewal Surveys). Health Plans with Medicare/Medicaid lines of business will assess for compliance and score.

|  |  |  |
| --- | --- | --- |
| **Element B: Medical Providers** | **Page/Section** | **Points** |
| The organization includes at least the following medical providers in its assessment:1. Hospitals (critical factor: This factor must be scored “yes” to score at least “Partially Met.”)
2. Home health agencies
3. Skilled nursing facilities
4. Free-standing surgical centers
 |  |  |

|  |  |
| --- | --- |
| **Element B Scoring\*** |  **Points** |
| **Met** | The organization meets 3-4 factors  | **1.00 points** |
|  **Partially Met** | The organization meets 2 factors  | **0.50 points** |
|  **Not Met** | The organization meets 0-1 factors | **0.00 points** |

\*N/A for Annual Assessments (Renewal Surveys). Health Plans with Medicare/Medicaid lines of business will assess for compliance and score.

|  |  |  |
| --- | --- | --- |
| **Element C: Behavioral Healthcare Providers** | **Page/Section** | **Points** |
| The organization includes behavioral healthcare facilities providing mental health or substance abuse services in the following settings:1. Inpatient
2. Residential
3. Ambulatory
 |  |  |

|  |  |
| --- | --- |
| **Element C Scoring \*** |  **Points** |
| **Met** | The organization meets 3 factors  | **1.00 points** |
|  **Partially Met** | The organization meets 1-2 factors  | **0.50 points** |
| **Not Met** | The organization meets 0 factors  | **0.00 points** |

\*N/A for Annual Assessments (Renewal Surveys). Health Plans with Medicare/Medicaid lines of business will assess for compliance and score.

|  |  |  |
| --- | --- | --- |
| **Element D: Assessing Medical Providers** | **Reference Document** | **Points** |
| The organization assesses contracted medical health care providers against the requirements and within the timeframe in Element A.  |  |  |

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| **Element D Scoring** |  **Points** |
| **Met** | The organization meets the requirement | **1.00 points** |
|  **Partially Met \*** | No scoring option | **NA** |
| **Not Met** | The organization does not meet the requirement | **0.00 points** |

\*N/A for Pre-Assessments (First Surveys) and Annual Assessments (Renewal Surveys). Health Plans with Medicare/Medicaid lines of business will assess for compliance and score.

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| **Element E: Assessing Behavioral Healthcare Providers** | **Reference Document** | **Points** |
| The organization assesses contracted behavioral healthcare providers against the requirements and within the time frame in Element A. |  |  |

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| **Element E Scoring**  |  **Points** |
| **Met** | The organization meets the requirement | **1.00 points** |
|  **Partially Met \*** | No scoring option | **NA** |
| **Not Met** | The organization does not meet the requirement | **0.00 points** |

\*N/A for Pre-Assessments (First Surveys) and Annual Assessments (Renewal Surveys). Health Plans with Medicare/Medicaid lines of business will assess for compliance and score.

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| **CR 7 SCORE *(Element A + Element B + Element C + Element D + Element E)*** |  |

| **CR 7 Element** | **Comments** |
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| **A** |  |
| **B** |  |
| **C** |  |
| **D** |  |
| **E** |  |

##### CR 8 Delegation of CR

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

**Intent: The organization remains responsible for credentialing and recredentialing its practitioners, even if it delegates all or part of these activities.**

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| **Element A: Delegation Agreement** | **Reference Document** | **Points** |
| The written delegation agreement:1. Is mutually agreed upon, and in place prior to delegation of activities
2. Describes the delegated activities and the responsibilities of the organization and the delegated entity – if the delegate subdelegates an activity, the delegation agreement must specify that the delegate or the organization is responsible for subdelegate oversight.
3. Requires at least semiannual reporting of the delegated entity to the organization
4. Describes the process by which the organization evaluates the delegated entity’s performance
5. Specifies that the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making
6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement
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| **Element A Scoring**  | **Points** |
| **Met** | The organization meets 5-6 factors  | **1.00 points** |
|  **Partially Met** | The organization meets 3-4 factors  | **0.50 Points** |
| **Not Met** | The organization meets 0-2 factors  | **0.00 points** |

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| **Element B: Predelegation Evaluation** | **Reference Document** | **Points** |
| For new delegation agreements initiated in the look-back period, the organization evaluated delegate’s capacity to meet NCQA requirements before delegation began. |  |  |

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| **Element B Scoring**  | **Points** |
| **Met** | The organization evaluated delegate capacity before delegation began *(Note: Pre-assessment may still be needed for CMS and/or state requirements)* | **1.00 points** |
|  **Partially Met** | The organization evaluated delegate capacity after delegation began | **0.50 points** |
|  **Not Met** | The organization did not evaluate delegate capacity | **0.00 points** |

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| **Element C: Review of Delegate’s Credentialing Activities** | **Reference Document** | **Points** |
| For delegation arrangements in effect for 12 months or longer, the organization:1. Annually reviews its delegate’s credentialing policies and procedures
2. Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect.
3. Annually evaluates delegate performance against NCQA standards for delegated activities.
4. Semiannually evaluates regular reports, as specified in Element A.
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| **Element C Scoring**  | **Points** |
|  **Met** | The organization meets 3-4 factors | **1.00 points** |
|  **Partially Met** | The organization meets 2 factors | **0.50 Points** |
| **Not Met** | The organization meets 0-1 factors | **0.00 points** |

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| **Element D: Opportunities for Improvement** | **Page/Section/Document** | **Points** |
| For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable |  |  |

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| **Element D Scoring**  | **Points** |
| **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 | **1.00 points** |
|  **Partially Met** | The organization took inappropriate or weak action, or has acted only in the past year | **0.50 points** |
| **Not Met** | The organization has not acted on identified problems | **0.00 points** |

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| **CR 8 SCORE *(Element A + Element B + Element C + Element D)*** |  |

| **CR 8 Element** | **Comments** |
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| **B** |  |
| **C** |  |
| **D** |  |

**Additional Elements Required by Health Plan:**

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| **Element A. Initial Credentialing File Review** | **Points** |
| 1. Medicare Opt Out list CMS.gov Affidavits
2. OIG website - Medicare/Medicaid sanctions
3. SAM website verification for Medicare/Medicaid sanctions
4. Admitting privileges or coverage arrangement stated on application
5. Verification of malpractice coverage via facesheet or carrier
6. PSV of fellowship via board certification or fellowship program
7. Date the Release of Information is signed (MM/DD/YY)
8. Letter in file advising practitioner of committee decision (MM/DD/YY)
9. All attestation questions answered
10. Social Security Administration and Death Master File
11. National Plan and Provider Enumeration System (NPPES) – NPI
12. Medicaid Provider Termination & Exclusion List(s)
13. CMS’ Medicare Preclusion List
14. PSV of Temporary WA License. BC-MD/DO, BG-PA-C, N3-NP, N2-RN
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| **Element A Scoring**  | **Points** |
| **100%** | High (90-100%) for all factors | **0.40 points** |
| **80%** | High (90-100%) for all but 1 factor, Medium (60-89%) for 1 factor | **0.32 points** |
| **50%** | High (90-100%) for all but 2-3 factors, Medium (60-89%) for other factors | **0.20 points** |
| **20%** | Medium (60-89%) for most factors, Low (0-59%) for no more than 1 factor  | **0.16 points** |
| **0%** | Low (0-59%) for all or most factors | **0.00 points** |

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| **Element B. Recredentialing File Review** | **Points** |
| 1. Medicare Opt Out List CMS.gov Affidavits
2. OIG website - Medicare/Medicaid sanctions
3. SAM website verification for Medicare/Medicaid sanctions
4. Admitting privileges or coverage arrangement stated on application
5. Verification of malpractice coverage via facesheet or carrier
6. Performance monitoring
7. Date the Release of Information is signed (MM/DD/YY)
8. Letter in file advising practitioner of committee decision (MM/DD/YY)
9. All attestation questions answered
10. Social Security Administration and Death Master File
11. National Plan and Provider Enumeration System (NPPES) – NPI
12. Medicaid Provider Termination & Exclusion List(s)
13. CMS’ Medicare Preclusion List
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| **Element B Scoring**  | **Points** |
| **100%** | High (90-100%) for all factors | **0.40 points** |
| **80%** | High (90-100%) for all but 1 factor, Medium (60-89%) for other factors | **0.32 points** |
| **50%** | High (90-100%) for all but 2-3 factors, Medium (60-89%) for other factors | **0.20 points** |
| **20%** | Medium (60-89%) for most factors, Low (0-59%) for no more than 1 factor  | **0.16 points** |
| **0%** | Low (0-59%) for all or most factors | **0.00 points** |

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| **Element C. Credentialing Policy** | **Page/Section** | **Points** |
| 1. Policy states committee meeting frequency
2. Policy covers checking the Medicare opt out list CMS.gov Affidavits, SAM, and OIG websites
3. If delegate is contracted for Medicare and they allow providers to opt out, there is a policy statement that the organization/physician/practitioner will not submit a claim for any services furnished to a Medicare beneficiary during opt out period
4. Policy covers checking Medicaid Provider Termination & Exclusion List(s)
5. Policy covers checking CMS’ Medicare Preclusion List
6. Policy covers checking the SSA DMF
7. Policy covers the process for delegating credentialing or recredentialing
8. Policy covers the process for reporting to authorities
9. Policy covers a well-defined appeal process
10. Policy statement requiring majority of Hearing Panel providers be a peer of the appealing practitioner
11. Policy states primary admitting privileges are verified
12. Policy states current malpractice is verified with carrier or facesheet
13. Policy states that Performance Monitoring data is considered at recredentialing
14. Policy states that practitioners must be notified of committee decision within 10 days of decision
15. Policy states that verification of board certification occurs as required by plan
16. Policy provides the definition of a “clean file”
17. Policy states that all files (including clean files) approved for initial credentialing and recredentialing pass through Committee process for final determination
18. Policy covers validation of NPI at Initial and Recredentialing
19. Policy covers the process for practitioner termination and reinstatement
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| **Element C Scoring**  | **Points** |
| **100%** | Policy covers all factors | **0.20 points** |
| **80%** | Policy covers all but 1 factor | **0.16 points** |
| **50%** | Policy covers half the factors | **0.10 points** |
| **20%** | Policy covers 1 factor | **0.08 points** |
| **0%** | Policy covers 0 factors | **0.00 points** |

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| **Element D. Practitioner Office Site Quality - Performance Standards and Thresholds** | **Page/Section/****Document** | **Points** |
| The organization is contracted for Medicare/Medicaid and sets site performance standards and thresholds for:1. Physical accessibility
2. Physical appearance
3. Adequacy of waiting and examining room space
4. Adequacy of medical/treatment record keeping
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| **Element D Scoring**  | **Points** |
| **100%** | The organization meets all 4 factors | **0.20 points** |
| **80%** | The organization meets 3 factors | **0.16 points** |
| **50%** | The organization meets 2 factors | **0.10 points** |
| **20%** | The organization meets 1 factor | **0.08 points** |
| **0%** | The organization meets no factors | **0.00 points** |

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| **Element E. Practitioner Office Site Quality - Site visits and Ongoing Monitoring** | **Page/Section** | **Points** |
| The organization is contracted for Medicare/Medicaid and implements appropriate interventions by:1. Continually monitoring member complaints for all practitioner sites
2. Conducting site visits of offices within 60 calendar days of determining that the complaint threshold was met
3. Instituting actions to improve offices that do not meet site standards and thresholds in Element A
4. Evaluating the effectiveness of the actions at least every 6 months, until deficient offices meet the site standards and thresholds
5. Documenting follow up visits for offices that had subsequent deficiencies
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| **Element E Scoring**  | **Points** |
| **100%** | The organization meets all 5 factors | **0.20 points** |
| **80%** | The organization meets 3 -4 factors | **0.16 points** |
| **50%** | The organization meets 2 factors | **0.10 points** |
| **20%** | The organization meets 1 factor | **0.08 points** |
| **0%** | The organization meets no factors | **0.00 points** |

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| **Element F. Ongoing Monitoring of Medicare Opt Out List CMS.gov Affidavits list** | **Points** |
| Delegate is contracted for Medicare and monitors the opt out list within 30 days of its monthly release |  |

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| **Element F Scoring**  | **Points** |
| **100%** | Documented review of the last 4 quarters | **0.20 points** |
| **80%** | Documented review of 3 of the last 4 quarters | **0.16 points** |
| **50%** | Documented review of 2 of the last 4 quarters | **0.10 points** |
| **20%** | Documented review of 1 of the last 4 quarters | **0.08 points** |
| **0%** | Documented review of 0 of the last 4 quarters | **0.00 points** |

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| **Element G. Ongoing Monitoring of OIG Exclusions Database**  | **Points** |
| Delegate is contracted for Medicare/Medicaid and monitors the OIG list within 30 days of its monthly release  |  |

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| **Element G Scoring**  | **Points** |
| **100%** | Documented review of all reports for 4 quarters | **0.20 points** |
| **80%** | Documented review of all reports for 3 quarters; documented review reports for 4 quarters | **0.16 points** |
| **50%** | Documented review of 1 report for 4 quarters and review of 2 reports for 2 quarters; documented review of 2 reports for 4 quarters | **0.10 points** |
| **20%** | Documented review of all reports for 2 quarters; documented review of 2 reports for 2 quarters | **0.08 points** |
| **0%** | Documented review of 0 reports for 0 quarters | **0.00 points** |

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| **Element H. Ongoing Monitoring of System for Award Management List**  | **Points** |
| Delegate is contracted for Medicare/Medicaid and monitors the SAM list monthly by the 15th of each month |  |

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| **Element H Scoring**  | **Points** |
| **100%** | Documented review of all reports for 4 quarters | **0.20 points** |
| **80%** | Documented review of all reports for 3 quarters; documented review reports for 4 quarters | **0.16 points** |
| **50%** | Documented review of 1 report for 4 quarters and review of 2 reports for 2 quarters; documented review of 2 reports for 4 quarters | **0.10 points** |
| **20%** | Documented review of all reports for 2 quarters; documented review of 2 reports for 2 quarters | **0.08 points** |
| **0%** | Documented review of 0 reports for 0 quarters | **0.00 points** |

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| **Element I. Ongoing Monitoring of Medicaid Provider Termination & Exclusion List(s)**  | **Points** |
| Delegate is contracted for Medicaid and monitors monthly all applicable state lists |  |

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| **Element I Scoring**  | **Points** |
| **100%** | Documented review of all reports for 4 quarters | **0.20 points** |
| **80%** | Documented review of all reports for 3 quarters; documented review reports for 4 quarters | **0.16 points** |
| **50%** | Documented review of 1 report for 4 quarters and review of 2 reports for 2 quarters; documented review of 2 reports for 4 quarters | **0.10 points** |
| **20%** | Documented review of all reports for 2 quarters; documented review of 2 reports for 2 quarters | **0.08 points** |
| **0%** | Documented review of 0 reports for 0 quarters | **0.00 points** |

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| **Element J. Ongoing Monitoring of CMS’ Medicare Preclusion List**  | **Points** |
| Delegate is contracted for Medicare and monitors the Preclusion List monthly |  |

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| **Element J Scoring**  | **Points** |
| **100%** | Documented review of all reports for 4 quarters | **0.20 points** |
| **80%** | Documented review of all reports for 3 quarters; documented review reports for 4 quarters | **0.16 points** |
| **50%** | Documented review of 1 report for 4 quarters and review of 2 reports for 2 quarters; documented review of 2 reports for 4 quarters | **0.10 points** |
| **20%** | Documented review of all reports for 2 quarters; documented review of 2 reports for 2 quarters | **0.08 points** |
| **0%** | Documented review of 0 reports for 0 quarters | **0.00 points** |

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| **Additional SCORE *(Element A + Element B + Element C + Element D + Element E + Element F + Element G + Element H + Element I + Element J)*** |  |

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| **Additional Element** | **Comments** |
| **A** |  |
| **B** |  |
| **C** |  |
| **D** |  |
| **E** |  |
| **F** |  |
| **G** |  |
| **H** |  |
| **I** |  |
| **J** |  |

**\*Note:** For factors F-J, describe reports reviewed and indicate if copies were provided by the delegate. If monitoring is performed by another department, make note of who is responsible for the activity.