# NCQA Corrections, Clarifications and Policy Changes to the 2020 MBHO Standards and Guidelines

***November 23, 2020***

This document includes the corrections, clarifications and policy changes to the 2020 MBHO standards and guidelines. NCQA has identified the appropriate page number in the printed publication and the standard and head—subhead for each update. Updates have been incorporated into the Interactive Review Tool (IRT). NCQA operational definitions for correction, clarification and policy changes are as follows:

- A ***correction (CO)*** is a change made to rectify an error in the standards and guidelines.
- A ***clarification (CL)*** is additional information that explains an existing requirement.
- A ***policy change (PC)*** is a modification of an existing requirement.

An organization undergoing a survey under the 2020 MBHO standards and guidelines must implement corrections and policy changes within 90 calendar days of the IRT release date, unless otherwise specified. The 90-calendar-day advance notice does not apply to clarifications or FAQs, because they are not changes to existing requirements.

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| 19 | Policies and Procedures— Section 2: Accreditation Scoring and Status Requirements | Corrective Action | Replace the text with the following:<br>In certain circumstances, NCQA may require corrective action and submission of a corrective action plan (CAP) by the organization. Corrective actions are steps taken to improve performance when an organization does not meet specific NCQA Accreditation requirements. Failure to timely comply with requested corrective action may result in a lower score or reduction or loss of Accreditation status.<br>A CAP is considered complete when NCQA notifies the organization that all identified deficiencies are resolved and corrective actions have been implemented. If the CAP is not completed within the agreed-on time frame, the organization must notify NCQA of the reason.<br>The ROC determines completion of the CAP. If the CAP is considered incomplete, the ROC may extend the CAP, reduce the organization's status or issue a Denied Accreditation status as specified below. | **CL** | **11/23/20** |

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<tr><td></td><td></td><td></td><td><table><tr><th>If the Organization…</th><th>The ROC May…</th></tr><tr><td>Formulates a satisfactory CAP but fails to adequately implement it within the time frame specified in the CAP.</td><td>Extend the CAP or reduce the organization's status from Accredited to Provisional or Provisional to Denied.</td></tr><tr><td>Does not complete the CAP after an extension.</td><td>Reduce the organization's status from Accredited to Provisional or Provisional to Denied.</td></tr><tr><td>Is unwilling or unable to formulate a satisfactory CAP within the required time frame, or<br>Makes no attempt to complete an agreed-on CAP.</td><td>Issue a Denied Certification status.</td></tr></table></td><td></td><td></td></tr>
<tr><td>144, 147</td><td>QI 12, Elements B and D</td><td>NCQA-Accredited/Certified delegates</td><td>Revise the Explanation to read:<br>Automatic credit is available for this element if all delegates are NCQA-Accredited health plans, MBHOs or CM Organizations, NCQA-Accredited or NCQA-Certified DM Organizations, NCQA-Accredited PHP Organizations or NCQA-Prevalidated Health IT Solutions, unless the element is NA.</td><td>CL</td><td>11/23/20</td></tr>
<tr><td>146</td><td>QI 12, Element C</td><td>Explanation</td><td>Revise the third paragraph of the Explanation to read:<br>Automatic credit is available for factor 3 if all delegates are NCQA-Prevalidated Health IT Solutions or NCQA-Accredited PHP Organizations, unless the element is NA.</td><td>CL</td><td>11/23/20</td></tr>
<tr><td>159</td><td>CC 2, Element A</td><td>Explanation—Factor 1: Exchange of information</td><td>Add the following as the first sentence:<br>The exchange of information is bidirectional.</td><td>CL</td><td>11/23/20</td></tr>
<tr><td>160</td><td>CC 2, Element A</td><td>Examples—Factor 1: Exchange of information</td><td>Remove the third bullet in the factor 1 example, which reads:</td><td>CL</td><td>11/23/20</td></tr>
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| | | | • Evaluation of behavioral healthcare treatment records to determine if behavioral healthcare practitioners receive feedback from primary care practitioners. | | |
| 189 | UM 2, Element B | Look-back period | Revise the text for Initial Surveys to read:<br>*For Initial Surveys:* 24 months for factor 1 and 6 months for factor 2. | **CO** | **11/23/20** |
| 231, 232 | UM 9, Elements E, F | Scope of review | Remove the following text:<br>NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined. | **CO** | **11/23/20** |
| 231, 232 | UM 9, Elements E, F | Scope of review | Remove the following text:<br>The score for the element is the average of the scores for all files. | **CO** | **11/23/20** |
| 239, 241 | UM 11, Elements A, B | Explanation—Factor 6: Securing system data | Revise the fourth subbullet under the third bullet of *Factor 6: Securing system data* to read:<br>– Change passwords when requested by staff or if passwords are compromised.<br>***Note:*** *If the organization's policies and procedures state that it follows the National Institute of Standards and Technology guidelines, this is acceptable to describe the process for password-protecting electronic systems.* | **CL** | **11/23/20** |
| 261 | CR 1, Element C | Explanation—Factor 4: Securing information | Revise the fourth subbullet under the third bullet of *Factor 4: Securing information* to read:<br>– Change passwords when requested by staff or if passwords are compromised.<br>***Note:*** *If the organization's policies and procedures state that it follows the National Institute of Standards and Technology guidelines, this is acceptable to describe the process for password-protecting electronic systems.* | **CL** | **11/23/20** |
| 266 | CR 3, Element A | Explanation—Factor 2: DEA or CDS certificates | Add a note under the fourth bullet of the Factor 2 Explanation that reads:<br>***Note:*** *Effective November 17, 2020, NTIS is no longer an acceptable source to verify a practitioner's DEA certificate is valid. Please see https://dea.ntis.gov/ for more information.* | **CL** | **11/23/20** |

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| 25 | Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements | Must-Pass Elements and Corrective Action Plan | Add the following bullet immediately above the last bullet in the "Note":<br>• *If an organization scores lower than 80% in three or more must-pass elements, it receives Provisional Accreditation status and must undergo a Resurvey within 6–9 months to confirm completion of the CAP.* | **CO** | **3/30/20** |
| 103, 110 | QI 8, Elements G, H | Explanation—Factor 2: Documentation of clinical history | Add the following text as the last paragraph:<br>Factor 2 does not require assessment or evaluation. | **CL** | **3/30/20** |
| 110 | QI 8, Element H | Explanation—Files excluded from review | Revise the subbullet under the second bullet to read:<br>– The organization provides evidence of the member's identification date and that the member was in complex case management for less than 60 calendar days during the look-back period. | **CL** | **7/27/20** |
| 113 | QI 8, Element I | Explanation—Excluded files from review | Add the following as a subbullet under the second bullet that reads:<br>– The organization provides evidence of the member's identification date and that the member was in complex case management for less than 60 calendar days during the look-back period. | **CL** | **7/27/20** |
| 144, 147 | QI 12, Elements B, D | NCQA-Accredited/Certified delegates | Add "NCQA-Prevalidated Health IT Solutions" to the sentence so the text reads:<br>Automatic credit is available for this element if all delegates are NCQA-Accredited health plans, MBHOs or CM Organizations, NCQA-Accredited or NCQA-Certified DM Organizations, or are NCQA-Prevalidated Health IT Solutions, unless the element is NA. | **CL** | **7/27/20** |
| 146 | QI 12, Element C | Explanation | Add "factor 2" to the second paragraph so the text reads:<br>Automatic credit is available for factors 2 and 3 if all delegates are NCQA-Accredited health plans, MBHOs or CM Organizations, or are NCQA-Accredited or NCQA-Certified DM Organizations, unless the element is NA. | **CO** | **7/27/20** |
| 146 | QI 12, Element C | Explanation | Add the following text as the third paragraph:<br>Automatic credit is available for factor 3 if all delegates are NCQA-Prevalidated Health IT Solutions, unless the element is NA. | **CL** | **7/27/20** |

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| 198 | UM 4, Element D | Exception | Add the following as the last sentence:<br>Network practitioners are not considered part of the organization. | **CL** | **7/27/20** |
| 203 | UM 5, Element A | Related information | Revise the bullets under "Factor 1: Urgent concurrent requests for commercial and Exchange product lines" to read:<br>• The organization may extend the decision notification time frame if the request to extend urgent concurrent care was made less than 24 hours prior to the expiration of the previously approved period of time or number of treatments. The organization may treat the request as urgent preservice and send a decision notification within 72 hours.<br>• The organization may extend the decision notification time frame if the request to approve additional days for urgent concurrent care is related to care not previously approved by the organization and the organization documents that it made at least one attempt and was unable to obtain the needed clinical information within the initial 24 hours after the request for coverage of additional days. In this case, the organization has up to 72 hours to make the decision. | **CL** | **3/30/20** |
| 203 | UM 5, Element A | Related information | Revise the second bullet under the factors 2, 3 subhead to read:<br>The organization may extend the time frame by up to 14 calendar days if it needs additional information and notifies the member **or** the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension. | **CL** | **3/30/20** |
| 203 | UM 5, Element A | Related information—Factors 2, 3: Urgent concurrent and urgent preservice requests for Medicare and Medicaid product lines | Revise the bullets under factors 2, 3 subhead to read:<br>*For Medicare,* the organization may extend the timeframe once, by up to 14 calendar days, under the following conditions:<br>• The member requests an extension, ***or***<br>• The organization needs additional information, ***and***<br>– The organization documents that it made at least one attempt to obtain the necessary information.<br>– The organization notifies the member or the member's authorized representative of the delay. | **CL** | **7/27/20** |

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| | | | The organization must notify the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.<br>*For Medicaid,* the organization may extend the timeframe once, by up to 14 calendar days, if the organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.<br>The organization notifies the member or the member's authorized representative of its decision, but no later than the expiration of the extension. | | |
| 219 | UM 8, Element A | Explanation—Factor 5: Person or people deciding the appeal | Revise the text to read:<br>Appeal policies and procedures specify who in the organization decides appeals.<br>The organization may designate any individual or group (e.g., a panel) in its policies and procedures to overturn appeals and to uphold appeals that do not require medical necessity review.<br>However, for appeals that require medical necessity review, the final decision to uphold an appeal must be made by an appropriate practitioner who was not involved in the initial denial decision and is not subordinate to the practitioner who made the initial denial decision.<br>NCQA considers the following practitioner types to be appropriate for review of the specified UM denial decisions:<br>• *Physicians, all types:* Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials.<br>• *Nurse practitioners*:* Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials.<br>• *Doctoral-level clinical psychologists or certified addiction-medicine specialists:* Behavioral healthcare denials.<br>• *Pharmacists:* Pharmaceutical denials.<br>• *Dentists:* Dental denials.<br>• *Chiropractors:* Chiropractic denials. | **CL** | **7/27/20** |

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| | | | • *Physical therapists:* Physical therapy denials.<br>• *Doctoral-level board-certified behavioral analysts:* Applied behavioral analysis denials.<br>*In states where the organization has determined that practice acts or regulations allow nurse practitioners to practice independently, nurse practitioners may review requests that are within the scope of their license. | | |
| 219 | UM 8, Element A | Explanation—Factor 6: Same-or-similar specialist review | Revise the text to read:<br>Appeal policies and procedures require same-or-similar specialist review as part of the process to uphold the initial decision in an appeal that requires medical necessity review.<br>The purpose of same-or-similar specialist review of appeals is to apply specific clinical knowledge and experience when determining if an appeal meets criteria for medical necessity and clinical appropriateness.<br>The same-or-similar specialist may be the same individual designated to make the appeal decision or may be a separate reviewer who provides a recommendation to the individual making the decision. The same-or-similar specialist may be any of the practitioner types specified in factor 5, with the exception of pharmacists, because pharmacists generally treat patients only in limited situations and therefore are not considered same-or-similar specialists for the purposes of deciding appeals.<br>To be considered a same-or-similar specialist, the reviewing specialist's training and experience must meet the following criteria:<br>• Includes treating the condition.<br>• Includes treating complications that may result from the service or procedure.<br>• Is sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate.<br>"Training and experience" refers to the practitioner's clinical training and experience.<br>When reviewing appeal files, NCQA reviews whether the specialist's training and experience aligns with the condition, service or procedure in | **CL** | **7/27/20** |

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| | | | question, as opposed to requiring an exact match to the referring or treating practitioner type or specialty.<br>The intent is that the specialist reviewing the appeal would have encountered a patient with this condition who is considering or has received the service or procedure in a clinical setting. Because of this, more complex services and procedures require review by practitioners with more specialized training and experience. For example, while a decision to uphold a denial of hospital admission for arrhythmia might be reviewed by any number of practitioners, including, but not limited to, a cardiologist, cardiothoracic surgeon, internist, family practitioner, geriatrician or emergency medicine physician, a decision to uphold a denial of surgery to repair an atrial septal defect in a newborn would require review by a cardiothoracic surgeon with pediatric experience.<br>NCQA accepts board certification in a specialty as a proxy for clinical training and experience. A specialist who maintains board certification in a general and specialty area (e.g., internal medicine and pulmonology) is considered to have training and experience in both areas. NCQA does not require that the same-or-similar specialist reviewer be actively practicing.<br>Experience with the condition, service or procedure that is limited to UM decision making in cases similar to the appeal in question is not considered sufficient experience, nor do UM decision-making criteria supersede the requirement for same-or-similar specialist review.<br>If the organization's clinical criteria limits who can perform a service or procedure, or who can prescribe a pharmaceutical to specific practitioner types or specialties, then only those practitioner types or specialties may be considered same-or-similar specialist reviewers. | | |
| 220 | UM 8, Element A | Explanation— Factor 13: Titles and qualifications | Revise the text to read:<br>Appeal policies and procedures require the appeal notice to identify all reviewers who participated in making the appeal decision, including the same-or-similar specialist reviewer, when applicable, as they provide specific clinical knowledge and experience that affects the decision. | **CL** | **7/27/20** |

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| | | | For each individual, the notice includes:<br>• *For a benefit appeal*: The title (position or role in the organization).<br>• *For a medical necessity appeal*: The title (position or role in the organization), qualifications (clinical credentials such as MD, DO, PhD, physician) and specialty (e.g., pediatrician, general surgeon, neurologist, clinical psychologist).<br>The organization is not required to include individuals' names in the written notification. | | |
| 221 | UM 8, Element A | Explanation | Revise the text that follows *"Medicare appeals for factors 7–13"* to read:<br>The organization's policies and procedures describe its process for sending an upheld denial to MAXIMUS. | **CL** | **3/30/20** |
| 222, 226 | UM 8, Element A<br>UM 9, Element B | Related information | Revise the third paragraph regarding Medicaid appeals to read:<br>For Medicaid appeals, verbal notification is appropriate for nonurgent preservice, postservice and expedited appeals. Verbal notification of a decision does not extend the electronic or written notification time frame. Organizations may verbally inform members if there is a delay and must resolve appeals as expeditiously as the member's health requires. | **CL** | **3/30/20** |
| 225 | UM 9, Element B | Explanation—Factors 1-3: Timeliness of appeal process | Revise the third paragraph to read:<br>NCQA measures timeliness of notification from the date when the organization receives the request from the member or the member's authorized representative, even if the organization does not have all the information necessary to make a decision, to the date when the notice was provided to the member or member's authorized representative, as applicable. | **CL** | **3/30/20** |
| 227 | UM 9, Element C | Explanation | Add a subhead and text above the Exceptions that read:<br>**Person or people deciding the appeal**<br>The organization may designate any individual or group (e.g., a panel) to overturn appeals and to uphold appeals that do not require medical necessity review. | **CL** | **7/27/20** |

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| | | | However, for appeals that require medical necessity review, the final decision to uphold an appeal must be made by an appropriate practitioner who was not involved in the initial denial decision and is not subordinate to the practitioner who made the initial denial decision.<br>NCQA considers the following practitioner types to be appropriate for review of the specified UM denial decisions:<br>• *Physicians, all types:* Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials.<br>• *Nurse practitioners*:* Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials.<br>• *Doctoral-level clinical psychologists or certified addiction-medicine specialists:* Behavioral healthcare denials.<br>• *Pharmacists:* Pharmaceutical denials.<br>• *Dentists:* Dental denials.<br>• *Chiropractors:* Chiropractic denials.<br>• *Physical therapists:* Physical therapy denials.<br>• *Doctoral-level board-certified behavioral analysts:* Applied behavioral analysis denials.<br>*In states where the organization has determined that practice acts or regulations allow nurse practitioners to practice independently, nurse practitioners may review requests that are within the scope of their license. | | |
| 227 | UM 9, Element C | Explanation | Add a subhead and text below above the Exceptions that read:<br>**Same-or-similar specialist review**<br>Same-or-similar specialist review is a required part of the process to uphold the initial decision in an appeal that requires medical necessity review.<br>The purpose of same-or-similar specialist review of appeals is to apply specific clinical knowledge and experience when determining if an appeal meets criteria for medical necessity and clinical appropriateness. | **CL** | **7/27/20** |

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| | | | The same-or-similar specialist may be the same individual designated to make the appeal decision or may be a separate reviewer who provides a recommendation to the individual making the decision. The same-or-similar specialist may be any of the practitioner types specified above, with the exception of pharmacists, because pharmacists generally treat patients only in limited situations and therefore are not considered same-or-similar specialists for the purposes of deciding appeals.<br>To be considered a same-or-similar specialist, the reviewing specialist's training and experience must meet the following criteria:<br>• Includes treating the condition.<br>• Includes treating complications that may result from the service or procedure.<br>• Is sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate.<br>"Training and experience" refers to the practitioner's clinical training and experience.<br>When reviewing appeal files, NCQA reviews whether the specialist's training and experience aligns with the condition, service or procedure in question, as opposed to requiring an exact match to the referring or treating practitioner type or specialty.<br>The intent is that the specialist reviewing the appeal would have encountered a patient with this condition who is considering or has received the service or procedure in a clinical setting. Because of this, more complex services and procedures require review by practitioners with more specialized training and experience. For example, while a decision to uphold a denial of hospital admission for arrhythmia might be reviewed by any number of practitioners, including, but not limited to, a cardiologist, cardiothoracic surgeon, internist, family practitioner, geriatrician or emergency medicine physician, a decision to uphold a denial of surgery to repair an atrial septal defect in a newborn would require review by a cardiothoracic surgeon with pediatric experience.<br>NCQA accepts board certification in a specialty as a proxy for clinical training and experience. A specialist who maintains board certification in a general and specialty area (e.g., internal medicine and pulmonology) is | | |

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| | | | considered to have training and experience in both areas. NCQA does not require that the same-or-similar specialist reviewer be actively practicing.<br>Experience with the condition, service or procedure that is limited to UM decision making in cases similar to the appeal in question is not considered sufficient experience, nor do UM decision-making criteria supersede the requirement for same-or-similar specialist review.<br>If the organization's clinical criteria limits who can perform a service or procedure, or who can prescribe a pharmaceutical to specific practitioner types or specialties, then only those practitioner types or specialties may be considered same-or-similar specialist reviewers. | | |
| 229 | UM 9, Element D | Explanation—Factor 1: The appeal decision | Add the following text as the last paragraph:<br>For appeals resulting from medical necessity review of out-of-network requests, the reason for upheld appeal decision must explicitly address the reason for the request (e.g., if the request is related to accessibility issues, that may be impacted by the clinical urgency of the situation, the appeal decision must address whether or not the requested service can be obtained within the organization's accessibility standards). | **CL** | **3/30/20** |
| 230 | UM 9, Element D | Explanation— Factor 5: Titles and qualifications | Revise the text to read:<br>The upheld appeal decision notification identifies all reviewers who participated in making the appeal decision, including the same-or-similar specialist reviewer, when applicable, as they provide specific clinical knowledge and experience that affects the decision.<br>For each individual, the notice includes:<br>• *For a benefit appeal:* The title (position or role in the organization).<br>• *For a medical necessity appeal:* The title (position or role in the organization), qualifications (clinical credentials such as MD, DO, PhD, physician) and specialty (e.g., pediatrician, general surgeon, neurologist, clinical psychologist).<br>The organization is not required to include individuals' names in the written notification. | **CL** | **7/27/20** |

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| 238, 240 | UM 11, Elements A, B | Scope of review | Replace the second sentence with the following paragraph:<br>For factor 6, if the organization contracts with external entities, NCQA also reviews contracts from up to four randomly selected external entities, or reviews all external entities if the organization has fewer than four. If factor 6 is not addressed in a contract, the organization may present the external entity's policies and procedures for review. In order to meet factor 6, the organization's documentation and each external entity's documentation must meet the factor. | **CL** | **7/27/20** |
| 239, 241 | UM 11, Elements A, B | Explanation— Factor 6: Securing system data | Replace the last paragraph with the following:<br>NCQA includes external entities that store, create, modify or use UM data for any function covered by the UM standards on behalf of the organization in the scope of this factor, with the exception of organizations whose only UM service provided for the organization is to provide cloud-based data storage functions and not services that create, modify or use UM data. | **CL** | **7/27/20** |
| 256 | CR 1, Element A | Related information | Add the following text as the second sentence after the "Automated credentialing system" subhead:<br>The organization provides its security and login policies and procedures to confirm the unique identifier and the signature can only be entered by the signatory. | **CL** | **3/30/20** |
| 257 | CR 1, Element A | Related information— Use of web crawlers | Revise the second sentence to read:<br>The organization provides documentation that the web crawler collects information only from approved sources, and documents that staff reviewed the credentialing information. | **CL** | **7/27/20** |
| 260 | CR 1, Element C | Scope of review | Replace the second sentence with the following paragraph:<br>For factor 4, if the organization contracts with external entities, NCQA also reviews contracts from up to four randomly selected external entities, or reviews all external entities if the organization has fewer than four. If factor 4 is not addressed in a contract, the organization may present the external entity's policies and procedures for review. In order | **CL** | **7/27/20** |

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| | | | to meet factor 4, the organization's documentation and each external entity's documentation must meet the factor. | | |
| 261 | CR 1, Element C | Explanation—Factor 4: Securing information | Replace the last paragraph with the following:<br>NCQA includes external entities that store, create, modify or use CR data for any function covered by the CR standards on behalf of the organization in the scope of this factor, with the exception of organizations whose only CR service provided for the organization is to provide cloud-based data storage functions and not services that create, modify or use CR data. | **CL** | **7/27/20** |
| 262 | CR 2, Element A | Scope of review | Revise the text to read:<br>NCQA reviews Credentialing Committee meeting minutes from three different meetings within the look-back period.<br>If the required meeting minutes are not available for review, NCQA reviews the meeting minutes that are available within the look-back period. | **CL** | **7/27/20** |
| 277 | CR 5, Element A | Factor 2 | Revise the factor 2 language to read:<br>2. Collecting and reviewing sanctions and limitations on licensure. | **CL** | **3/30/20** |
| 312 | RR 4, Element C | Scope of review | Revise the scope of review to read:<br>*For Initial Surveys and Renewal Surveys:* NCQA reviews the organization's most recent annual data collection, assessment and analysis report. | **CL** | **3/30/20** |
| 314 | RR 4, Element D | Scope of review | Replace the first and second paragraph of the scope of review with the following:<br>*For Initial Surveys and Renewal Surveys:* NCQA reviews the organization's most recent annual report or dated policy and procedure showing actions taken. | **CL** | **3/30/20** |
| 318 | RR 4, Element H | Exception | Revise the language to read:<br>Factors marked "No" in Element F are scored NA in this element. | **CO** | **7/27/20** |

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| 336, 343 | LTSS 1, Elements B, D | Explanation—Factor 2: Documentation of clinical history | Add the following text as the last paragraph:<br>Factor 2 does not require assessment or evaluation. | **CL** | **3/30/20** |
| 342, 353 | LTSS 1, Element D<br>LTSS 1, Element G | Look-back period | Revise the text for Renewal Surveys to read:<br>*For Renewal Surveys:* 6 months. | **CO** | **7/27/20** |
| 343 | LTSS 1, Element D | Explanation—Files excluded from review | Revise the subbullet under the second bullet to read:<br>– The organization provides evidence of the member's identification date and that the member was in case management for less than 60 calendar days during the look-back period. | **CL** | **7/27/20** |
| 354 | LTSS 1, Element G | Explanation—Files excluded from review | Add a subbullet under the second bullet that reads:<br>– The organization provides evidence of the member's identification date and that the member was in case management for less than 60 calendar days during the look-back period. | **CL** | **7/27/20** |
| 355 | LTSS 1, Element G | Explanation—Factor 10: Follow-up and communication with LTSS providers | Revise the explanation to read:<br>The file or case record documents the roles and responsibilities of LTSS providers, case management plan details and the follow-up schedule that are communicated to providers. | **CL** | **7/27/20** |
| 355 | LTSS 1, Element G | Explanation—Factor 12: Documentation of services received | Revise the explanation to read:<br>The file or case record documents whether the individual received the services specified in the case management plan. | **PC** | **3/30/20** |
| 358 | LTSS 1, Element I | Explanation—Factors 2, 3: Background checks and additional screening tool for paid LTSS providers | Add the following as the last sentence of the first paragraph:<br>NCQA does not consider it delegation if the organization uses another entity to conduct background checks. | **CL** | **3/30/20** |
| 384 | LTSS 4 | Element stem | Revise the text to read:<br>If the organization delegates LTSS activities, there is evidence of oversight of delegated activities. | **CL** | **7/27/20** |

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| **Page** | **Standard/Element** | **Head/Subhead** | **Update** | **Type of Update** | **IRT Release Date** |
| 3-10 | Appendix 3 | Table 2: Automatic credit for a health plan delegating to an NCQA-Accredited MBHO | Revise the text for footnote 5 to read:<br>For NET 1, Element D, factors 1–3 and NET 2, Element B, factors 1–3 (structural requirements), if activities are delegated to an NCQA-Accredited MBHO, the organization is not required to provide its own documentation. For NET 2, Element B, factor 4, automatic credit is available if the MBHO is Accredited under 2018 standards or beyond. | **CL** | **7/27/20** |
| 3-10 | Appendix 3 | Table 2: Automatic credit for a health plan delegating to an NCQA-Accredited MBHO | Revise the text for footnote for 7 to read:<br>Automatic credit is available for behavioral health criteria and if the MBHO is Accredited under 2018 standards and beyond. | **CL** | **7/27/20** |
| 3-18 | Appendix 3 | Automatic Credit for Delegating to an NCQA-PHM Prevalidated Health IT Solutions | Rename the section to the following:<br>Automatic Credit for Delegating to an NCQA-PHM Prevalidated Vendor for Health IT Solutions | **CL** | **3/30/20** |
| 3-18 | Appendix 3 | Automatic Credit for Delegating to an NCQA-PHM Prevalidated Vendor for Health IT Solutions | Revise the first paragraph to read:<br>Organizations that delegate CCM functions to an NCQA-Prevalidated Vendor for health IT solutions that receive the designation "eligible for automatic credit" present the Letter of Eligibility for documentation. The organization is responsible for providing documentation that states the name and the version of the health IT solution the organization is using and the date when it was licensed or implemented by the organization. Documentation may include a contract, agreement, purchase order or other document that states the name and version of the health IT solution and the date when it was licensed or implemented. | **CL** | **3/30/20** |
| 3-19 | Appendix 3 | Automatic Credit for Delegating to an NCQA-PHM Prevalidated Vendor for Health IT Solutions | Replace "NCQA-Prevalidated Vendor for Health IT Solution" with "NCQA-Prevalidated Health IT Solution." | **CL** | **7/27/20** |