NCQA Corrections, Clarifications and Policy Changes to the 2020 UM-CR-PN Standards and Guidelines

November 23, 2020

This document includes the corrections, clarifications and policy changes to the 2020 UM-CR-PN 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 UM-CR-PN 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.

Page	Standard/Element	Head/Subhead	Update	Type of Update	IRT Release Date
17	Policies and Procedures—Section 2: The Accreditation Process	Corrective Action	Replace the text with the following: 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. 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. 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**

<table>
<tr><th>Page</th><th>Standard/Element</th><th>Head/Subhead</th><th>Update</th><th>Type of Update</th><th>IRT Release Date</th></tr>
<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 Denied.</td></tr>
<tr><td>Does not complete the CAP after an extension, or
Is unwilling or unable to formulate a satisfactory CAP within the required time frame, or
Makes no attempt to complete an agreed-on CAP.</td><td>Issue a Denied Accreditation status.</td></tr>
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</td><td></td><td></td></tr>
<tr><td>64</td><td>UM 2, Element B</td><td>Look-back period</td><td>Revise the text for Initial Surveys to read:
For Initial Surveys: 24 months for factor 1 and 6 months for factor 2.</td><td>CO</td><td>11/23/20</td></tr>
<tr><td>70</td><td>UM 4, Element B</td><td>Explanation</td><td>Revise the text to read:
For specialty organizations where the practitioner type is not listed above, (e.g., vision only or hearing only organizations), the organization must determine whether a practitioner (e.g., optometrist, audiologist) is appropriate for denials pertaining to a type of specialty service.</td><td>CL</td><td>11/23/20</td></tr>
<tr><td>125</td><td>UM 8, Element A</td><td>Explanation—Factors 7-9: Appeal decisions</td><td>Add a second sentence in the seventh paragraph:
Organizations that do not handle admissions, continued stays or emergency services (e.g., PBMs) may instead outline services for which they grant expedited review.</td><td>CL</td><td>11/23/20</td></tr>
<tr><td>128</td><td>UM 8, Element B</td><td>Scope of review</td><td>Replace “First” with “Initial” to read:
For Initial Surveys: NCQA reviews the most recent distribution of external review rights to members.</td><td>CL</td><td>11/23/20</td></tr>
<tr><td>137, 138</td><td>UM 9, Elements E, F</td><td>Scope of review</td><td>Remove the following text:
The score for the element is the average of the scores for all files.</td><td>CO</td><td>11/23/20</td></tr>
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153, 155	UM 12, Elements A, B	Explanation—Factor 6: Securing system data	Revise the fourth subbullet of the third bullet under *Factor 6: Securing system data* to read: Change passwords when requested by staff or if passwords are compromised. ***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**	**11/3/20**
182	CRA 3, Element D	Factor 2: Intermittent password changes	Revise factor 2 to read: 2. Password changes.	**CL**	**11/3/20**
183	CRA 3, Element D	Explanation—Factor 2: Intermittent password changes	Revise the factor 2 subhead and text to read: ***Factor 2:*** **Password changes** The organization's policies and procedures describe requirements to change passwords when requested by staff or if passwords are compromised. ***Note:*** *NCQA scores this factor "Yes" if the organization's policies and procedures state that it follows the National Institute of Standards and Technology guidelines.*	**CL**	**11/3/20**
194	CR 1, Element C	Explanation— Factor 4: Securing information	Revise the fourth subbullet under the third bullet of *Factor 4: Securing information* to read: – Change passwords when requested by staff or if passwords are compromised. ***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**
200	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: ***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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13	Policies and Procedures—Section 1: Eligibility and the Application Process	Organization Obligations	Add the following as the fourth bullet: • Bring through all lines of business for which it performs UM functions.	**CL**	**3/30/20**
22	Policies and Procedures—Section 2: The Accreditation Process	Must-Pass Elements and Corrective Action Plan	Replace "UM 5: Timeliness of UM Decisions, Elements A–F" in the second bullet with "UM 5: Timeliness of UM Decisions, Elements A–C."	**CL**	**3/30/20**
70	UM 4, Element B	Explanation	Add the following text above the factor 1 subhead: For practitioner types not specified above (e.g., optometrist, audiologist), the organization must verify with NCQA whether the practitioner is appropriate for the UM denial decision.	**CL**	**7/27/20**
76	UM 4, Element F	Exception	Add the following as the last sentence: Network practitioners are not considered part of the organization.	**CL**	**7/27/20**
76	UM 4, Element F	Examples—Factors 1, 2: Use of board-certified consultant	Remove "or in its network" so the text reads: An attending physician believes a newborn is suffering from a neurological disorder. The physician requests approval for the infant to be treated by a pediatric neurologist. The organization does not have a pediatric neurologist on staff, but it does have access to a board-certified pediatric neurologist through a consulting firm. The organization collects the necessary clinical information and sends it to the consulting neurologist, who replies with a recommendation for authorization to an out-of-network pediatric neurologist within 24 hours.	**CL**	**7/27/20**
81, 86, 93	UM 5, Elements A-C	Related information—Extension conditions	Revise the bullets under "Factor 1: Urgent concurrent requests for commercial and Exchange product lines" to read: • 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.	**CL**	**3/30/20**

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			• 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.		
81, 86, 93	UM 5, Elements A-C	Related information—Factors 2, 3: Urgent concurrent and urgent preservice requests for Medicare and Medicaid product lines Factors 1, 2: Urgent concurrent and urgent preservice requests for Medicare and Medicaid product lines.	Revise the bullets under the factors 2, 3 subhead in Elements A and B and the factors 1, 2 subhead in Element C to read: *For Medicare,* the organization may extend the timeframe once, by up to 14 calendar days, under the following conditions: • The member requests an extension, ***or*** • The organization needs additional information, ***and*** – The organization documents that it made at least one attempt to obtain the necessary information. – The organization notifies the member or the member's authorized representative of the delay. 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. *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. The organization notifies the member or the member's authorized representative of its decision, but no later than the expiration of the extension.	**CL**	**7/27/20**
81, 86, 93	UM 5, Elements A-C	Related information—Extension conditions	Revise the second bullet under the factors 2, 3 subhead in Elements A, B and the factors 1, 2 subhead in Element C to read: • 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	**CL**	**3/30/20**

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			expeditiously as the member's health condition requires, but no later than the expiration of the extension.		
124	UM 8, Element A	Explanation—Factor 5: Person or people deciding the appeal	Revise the text to read: Appeal policies and procedures specify who in the organization decides appeals. 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. 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. NCQA considers the following practitioner types to be appropriate for review of the specified UM denial decisions: • *Physicians, all types:* Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials. • *Nurse practitioners*:* Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials. • *Doctoral-level clinical psychologists or certified addiction-medicine specialists:* Behavioral healthcare denials. • *Pharmacists:* Pharmaceutical denials. • *Dentists:* Dental denials. • *Chiropractors:* Chiropractic denials. • *Physical therapists:* Physical therapy denials. • *Doctoral-level board-certified behavioral analysts:* Applied behavioral analysis denials. *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.	**CL**	**7/27/20**

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124	UM 8, Element A	Explanation— Factor 6: Same-or-similar specialist review	Revise the text to read: 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. 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. 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. To be considered a same-or-similar specialist, the reviewing specialist's training and experience must meet the following criteria: Includes treating the condition. Includes treating complications that may result from the service or procedure. Is sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate. "Training and experience" refers to the practitioner's clinical training and experience. 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. 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	**CL**	**7/27/20**

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			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. 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. 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. 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.		
125	UM 8, Element A	Explanation— Factor 13: Titles and qualifications	Revise the text to read: 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. For each individual, the notice includes: • *For a benefit appeal*: The title (position or role in the organization).	**CL**	**7/27/20**

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			• *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). The organization is not required to include individuals' names in the written notification.		
124	UM 8, Element A	Explanation— Factor 6: Same-or-similar specialist review	Revise the text to read: 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. 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. 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. To be considered a same-or-similar specialist, the reviewing specialist's training and experience must meet the following criteria: • Includes treating the condition. • Includes treating complications that may result from the service or procedure. • Is sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate. "Training and experience" refers to the practitioner's clinical training and experience. When reviewing appeal files, NCQA reviews whether the specialist's training and experience aligns with the condition,	**CL**	**7/27/20**

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			service or procedure in question, as opposed to requiring an exact match to the referring or treating practitioner type or specialty. 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. 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. 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. 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.		
126	UM 8, Element A	Explanation	Revise the text that follows *"Medicare appeals for factors 7–13"* to read: The organization's policies and procedures describe its process for sending an upheld denial to MAXIMUS.	**CL**	**3/30/20**

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127, 132	UM 8, Element A UM 9, Element B	Related information—Verbal notification	Revise the third paragraph regarding Medicaid appeals to read: 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**
131	UM 9, Element B	Explanation—Factors 1-3: Timeliness of appeal process	Revise the third paragraph to read: 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**
133	UM 9, Element C	Explanation	Add a subhead and text above the Exceptions that read: **Person or people deciding the appeal** 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. 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. NCQA considers the following practitioner types to be appropriate for review of the specified UM denial decisions: • *Physicians, all types:* Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials. • *Nurse practitioners*:* Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials. • *Doctoral-level clinical psychologists or certified addiction-medicine specialists:* Behavioral healthcare denials.	**CL**	**7/27/20**

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			• *Pharmacists:* Pharmaceutical denials. • *Dentists:* Dental denials. • *Chiropractors:* Chiropractic denials. • *Physical therapists:* Physical therapy denials. • *Doctoral-level board-certified behavioral analysts:* Applied behavioral analysis denials. *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.		
133	UM 9, Element C	Explanation	Add a subhead and text above the Exceptions that read: **Same-or-similar specialist review** 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. 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. 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. To be considered a same-or-similar specialist, the reviewing specialist's training and experience must meet the following criteria: • Includes treating the condition. • Includes treating complications that may result from the service or procedure.	**CL**	**7/27/20**

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			• Is sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate. "Training and experience" refers to the practitioner's clinical training and experience. 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. 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. 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. 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. 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		

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			or specialties may be considered same-or-similar specialist reviewers.		
135	UM 9, Element D	Explanation—Factor 1: The appeal decision	Add the following text as the last paragraph: 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**
136	UM 9, Element D	Explanation—Factor 5: Titles and qualifications	Revise the text to read: 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. For each individual, the notice includes: • *For a benefit appeal:* The title (position or role in the organization). • *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). The organization is not required to include individuals' names in the written notification.	**CL**	**7/27/20**
152, 154	UM 12, Elements A, B	Scope of review	Replace the second sentence with the following paragraph: 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	**CL**	**7/27/20**

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			documentation and each external entity's documentation must meet the factor.		
153, 155	UM 12, Elements A, B	Explanation— Factor 6: Securing system data	Replace the last paragraph with the following: 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**	**7/20/20**
184	CRA 3, Element E	Data source	Add "reports" as a data source.	**CL**	**7/27/20**
184	CRA 3, Element E	Scope of review	Revise the first paragraph to read: NCQA reviews the organization's policies and procedures that are in place throughout the look-back period and the mechanisms the organization uses to protect and recover credentials data.	**CL**	**7/27/20**
184	CRA 3, Element E	Explanation—Factor 2: Back-ups at predetermined intervals	Revise the text to read: The organization has policies and procedures for periodic back-up of data to ascertain that data are not lost if: • Computer systems are disabled or destroyed. • Files are corrupted. • Files are accidentally deleted. Back-up reports show that data are backed up at specific intervals.	**CL**	**7/27/20**
189	CR 1, Element A	Related information	Add the following text as the second sentence after the "Automated credentialing system" subhead: 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**

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189	CR 1, Element A	Related information—Use of web crawlers	Revise the second sentence to read: 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**
193	CR 1, Element C	Scope of review	Replace the second sentence with the following paragraph: 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 to meet factor 4, the organization's documentation and each external entity's documentation must meet the factor.	**CL**	**7/27/20**
194	CR 1, Element C	Explanation— Factor 4: Securing information	Replace the last paragraph with the following: 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**
195	CR 2, Element A	Scope of review	Revise the text to read: NCQA reviews Credentialing Committee meeting minutes from three different meetings within the look-back period. 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**
3-10	Appendix 3	Table 1: Automatic credit for health plans delegating to an organization with NCQA Accreditation in UM, CR or PN	Revise footnote 12 to read: For UM 5, Element D, automatic credit is available if the delegate is accredited under the 2016 standards and beyond.	**CL**	**3/30/20**