NCQA Corrections, Clarifications and Policy Changes to the 2019 HP Standards and Guidelines

March 30, 2020

This document includes the corrections, clarifications and policy changes to the 2019 HP 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 2019 HP 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
285, 291, 305	UM 5, Elements A, C, H	Explanation—Factors 2, 3: Medicare and Medicaid urgent concurrent and urgent preservice	Revise the language to read: The organization must make a decision and must notify the member **or** the member's authorized representative, as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request. Notification may be orally or in writing. If the decision is a denial, the organization must mail written notification of its decision within 3 calendar days after providing oral notification.	**CL**	**3/30/2020**
287, 292, 306	UM 5, Elements A, C, H	Related information	Revise the language under *Factors 2, 3: Urgent concurrent and urgent preservice requests for Medicare and Medicaid* to read: For Medicare and Medicaid, the organization may extend the urgent concurrent and urgent preservice time frame once due to lack of information, for up to 14 calendar days, if the member requests the extension. The organization may extend the time frame by up to 14 calendar days if it needs additional information but 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.	**CL**	**3/30/2020**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
	Policies and Procedures and applicable Appendices		NCQA improved the methodology to evaluate and communicate health plan accreditation and performance on clinical (HEDIS) and patient experience (CAHPS) measures. Beginning July 1, 2020, all Excellent and Commendable accreditation statuses will be replaced with Accredited along with the Health Plan Rating (for organizations required to report HEDIS/CAHPS); Provisional, Interim and Denied statuses will remain. ***Note:*** *NCQA will not change all references to the Excellent and Commendable statuses in the HPA 2019 publication.*	**PC**	**7/29/2019**
	Multiple		Refer to the memo to review requirements that were eliminated for the 2020 Standards Year and will be scored NA for the 2019 Standards Year.	**PC**	**7/29/2019**
15	Policies and Procedures—Section 1: Eligibility and the Application Process	Product/product line	Replace the last paragraph with the following: Because HEDIS reporting must match the product line for which an organization seeks Accreditation, an organization with a CHIP population includes those members in its Medicaid product line for NCQA HEDIS reporting and Accreditation even if it needs separate HEDIS submissions for other purposes such as state reporting.	**PC**	**3/25/2019**
23	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Follow-Up Survey *(applies to First Evaluation Option)*	Add the following as the last sentence in the last paragraph: The effective date of the accreditation status is the same date specified in the Full Survey decision that precipitated the Follow-Up Survey.	**CL**	**7/29/2019**
23	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Resurvey *(applies to First and Renewal Evaluation Options)*	Add the following as the last sentence in the second paragraph: The effective date of the accreditation status is the same date specified in the Full Survey decision that precipitated the Resurvey.	**CL**	**7/29/2019**
23	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Add-On Survey *(applies to First and Renewal Evaluation Options)*	Add the following as the fourth paragraph: The effective date of the accreditation status is the date specified for the currently accredited product/product line.	**CL**	**7/29/2019**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
27	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Accreditation Status—Corrective Action	Revise the text to read: In certain circumstances, NCQA may require corrective action by the organization. Corrective action are steps taken to improve performance when an organization does not meet specific NCQA accreditation requirements. Failure to comply timely with requested corrective action may result in a lower score or reduction or loss of accreditation status.	**CL**	**7/29/2019**
33	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Must-Pass Elements and Corrective Action Plan (CAP)	Revise the second bullet under the **Note** to read: • *If an organization does not meet the must-pass threshold for any must-pass element, a status modifier of "Under Corrective Action" will be displayed after the applicable accreditation status (e.g., Accredited—Under Corrective Action) until NCQA confirms that the organization has completed the CAP.*	**CL**	**12/3/2018**
33	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Must-Pass Elements and Corrective Action Plan (CAP)	Revise the third bullet under the **Note** to read: • *If an organization does not meet the must-pass threshold for 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.* ***Note: This issue is specific to the IRT. The language is correct in the printed publication.***	**CO**	**3/25/2019**
33	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Must-Pass Elements and Corrective Action Plan (CAP)	Update the bulleted text under the note as follows: • *If an organization does not meet the must-pass threshold for any must-pass element:* • *It must submit a Corrective Action Plan to NCQA within 30 calendar days.* • *It must undergo a CAP Review on the affected elements to confirm completion of the Corrective Action Plan.* • *A status modifier of "Under Corrective Action" will be displayed after the applicable accreditation status (e.g., Accredited—Under Corrective Action) until NCQA confirms that the organization has completed the CAP.*	**CL**	**11/25/2019**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
			• *If an organization does not meet the must-pass threshold for 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.* • *If an organization does not meet the must-pass threshold for three or more UM must-pass timeliness elements (UM 5, Elements A–F and UM 9, Element B), the ROC may issue a Denied Accreditation status.*		
38	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Annual Reevaluation	Add the following subhead and text after the second paragraph under "Annual Reevaluation": **New Annual Reevaluation Using Health Plan Ratings beginning July 1, 2020** Beginning July 1, 2020, evaluation of HEDIS/CAHPS performance scoring will be replaced by Health Plan Ratings for all accredited organizations regardless of standards year. The 50/50 scoring method where accreditation standards are worth 50 points and HEDIS/CAHPS are worth 50 points will no longer exist. In addition, Excellent and Commendable accreditation statuses will be changed to Accredited; Provisional, Interim or Denied statuses will remain and will be displayed along with Health Plan Ratings on the NCQA Report Card. In addition to Accreditation status as noted above, the HPR result will be displayed on the NCQA Report Card as the indicator of HEDIS/CAHPS performance. Based on the updated methodology, organizations earn a star rating of 0–5 stars (in half-star increments) for the HEDIS/CAHPS portion of Accreditation. The methodology includes a distinct set of measures for each product line. Each measure is classified in one of three categories: • Process measures, which have a weight of 1. • Outcome measures, which have a weight of 3. • Patient experience measures, which have a weight of 1.5. The overall rating is the weighted average of an organization's HEDIS and CAHPS measure ratings, plus Accreditation bonus points (if the organization is Accredited by NCQA), rounded to the nearest half point.	**PC**	**7/29/2019**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
			Overall performance is measured in three subcategories (displayed as stars and scored 0–5 in half point increments): 1. **Consumer Satisfaction:** Patient-reported experience of care, including experience with doctors, services and customer service (measures in the Consumer Satisfaction category). 2. **Rates for Clinical Measures:** The proportion of eligible members who received preventive service (prevention measures) and the proportion of eligible members who received recommended care for certain conditions (treatment measures). 3. **NCQA Accreditation Standards Score:** For an organization with an Accredited or Provisional status, 0.5 points (displayed as stars) are added to the overall rating. An organization with an Interim status receives one-third of the 0.5 bonus points (displayed as stars). ***Note:*** *If an organization chooses to publicly report performance data on the HEDIS Attestation, it is scored on the data submitted and receives the Accreditation bonus points (displayed as stars). If an organization Accredited on standards only chooses not to publicly report performance data, it will not be scored based on performance measurement results and will not be awarded the Accreditation bonus points.* Refer to the *Reports* section at https://www.ncqa.org/hedis/reports-and-research/ for the detailed HPR methodology and the list of required measures. Refer to the *General Guidelines* section of the *HEDIS Volume 2: Technical Specifications* for additional reporting requirements.		
46	Policies and Procedures—Section 4: Reporting Results	Releasing information	Remove the reference to the First Evaluation Option from the first paragraph so the text reads: NCQA releases Accreditation Survey results to the public, unless an organization going through the Interim Evaluation Option is denied Accreditation based on standards performance.	**CL**	**11/25/2019**
47	Policies and Procedures—Section 4: Reporting Results	Reporting Accreditation Status to the Public—Right to release and publish	Revise the last paragraph to read: NCQA publicly reports Denied Accreditation status for one year for First surveys (unless the organization declines its accreditation status) or Renewal surveys or until the status is replaced as the result of another	**CL**	**7/29/2019**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
			survey. An organization that dissolves or ceases to exist is removed from public reporting.		
48	Policies and Procedures—Section 4: Reporting Results	NCQA Health Plan Report Card—Under Corrective Action	Revise the text to read: NCQA requires the organization to complete corrective actions. Failure to comply timely with requested corrective action may result in a lower score or reduction or loss of accreditation status.	**CL**	**7/29/2019**
55	Policies and Procedures—Section 6: LTSS Distinction	Eligibility for LTSS Distinction	Add as a new paragraph directly above the **Note:** Organizations that manage their LTSS populations differently are required to contact NCQA via My.NCQA (https://my.ncqa.org) to determine the appropriate survey option (HPA with LTSS Distinction or CM-LTSS) to pursue. Examples of when an organization may manage requirements differently include delegated populations or dual-eligible populations whose LTSS services are not covered under the organization's medical benefit.	**CL**	**12/3/2018**
58	Policies and Procedures—Section 7: Medicaid Module	NCQA Health Plan-Medicaid Module: Value	Revise the third sentence of the last paragraph to read: Twenty-six states require NCQA Accreditation; an additional 5 mandate accreditation and accept NCQA Accreditation.	**CL**	**7/29/2019**
60	Policies and Procedures—Section 7: Medicaid Module	NCQA Health Plan-Medicaid Module Survey—Medicaid Module Standards	Revise the note to read: *For a complete list of elements eligible for nonduplication, refer to the Medicaid Managed Care Toolkit, which can be downloaded from the NCQA Store (http://store.ncqa.org/index.php/other-products/medicaid-managed-care-toolkits.html) for free. This includes specific references to the federal regulation that aligns with each standard and element in the NCQA Health Plan Accreditation Standards and Medicaid Module, ultimately comprising nonduplication.*	**CL**	**7/29/2019**
60	Policies and Procedures—Section 7: Medicaid Module	Eligibility for the Medicaid Program and State Oversight Relief	Remove the subhead and text that reads: **Nonduplication of Oversight in Applicable States** If an organization operates in a state that allows the use of accreditation to streamline organization oversight review (i.e., nonduplication), then a	**PC**	**7/29/2019**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
			Medicaid organization that undergoes an NCQA Medicaid Module Survey must meet all the following requirements: • Be awarded any Medicaid accreditation status after completing the Health Plan Accreditation Survey. • Achieve a score of 80% or higher for each federally defined nonduplication Medicaid element in the HP Accreditation Survey. • Achieve a score of Met for at least 80 percent of the elements in the Medicaid Module. NCQA includes a letter in the Medicaid survey results stating that the organization achieved the listed items.		
62	Policies and Procedures—Section 7: Medicaid Module	Survey Results and Scoring—Preliminary review results	Remove the last two bullets, which read: • A chart of the eligible health plan accreditation standards and the Medicaid Module standards at the element level. • NCQA recommendations to the Medicaid organization about its survey.	**CL**	**7/29/2019**
62	Policies and Procedures—Section 7: Medicaid Module	Survey Results and Scoring—HP Accreditation findings	Revise the section to read: For each federally defined nonduplication Medicaid element in the Health Plan Accreditation Survey, accreditation scores of less than 100% are equivalent to a Medicaid score of Not Met for purposes of implementing a Corrective Action Plan (CAP). Refer to *CAP Process,* below.	**PC**	**7/29/2019**
62	Policies and Procedures—Section 7: Medicaid Module	Survey Results and Scoring—Survey results	Revise the fourth paragraph to read: An organization that earns a performance score of Not Met for one or more elements in the Health Plan-Medicaid Module Survey may elect to come through the CAP process. If the organization elects to come through the CAP process, it may implement a CAP for any or all deficient elements elected to be reviewed through the CAP process. NCQA includes a notice of Corrective Actions Required (CAR) with the report for each element that is "Not Met". Even though NCQA uses the regulatory terminology "required" for the CAR notice, organizations are not required to implement a CAP for deficient elements noted in the CAR	**PC**	**7/29/2019**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
			notice, but may elect to do so for purposes of the Health Plan-Medicaid Module Survey. Refer to *CAP Process,* below.		
63	Policies and Procedures—Section 7: Medicaid Module	The Medicaid Program CAP Process	Revise the subhead and first paragraph to read: **The Medicaid Program Voluntary CAP Process** NCQA monitors the CAP process for organizations participating in the NCQA Medicaid program on a voluntary basis. An organization that scores Not Met on any federally defined nonduplication Medicaid element in the Health Plan Accreditation Survey or NCQA Medicaid Module Survey can elect to come through the NCQA Medicaid program CAP process to address any or all cited deficiencies. Any state requiring an organization to come through the NCQA Medicaid Module Survey has the discretion to require the organization to undergo a CAP by NCQA. An organization that receives a performance score of Not Met for any element in the Medicaid Module Survey Results may implement a CAP for any deficient element elected to be reviewed through the CAP process. A CAP is considered complete when NCQA notifies the organization that all corrective actions have been implemented.	**PC**	**7/29/2019**
63	Policies and Procedures—Section 7: Medicaid Module	The Medicaid Program CAP Process—CAR notice	Revise the section to read: NCQA initiates the CAP process by sending the organization a CAR notice with the Medicaid Module Survey Results. The CAR identifies each element that has a performance score of Not Met for which the organization may submit a CAP.	**PC**	**7/29/2019**
63	Policies and Procedures—Section 7: Medicaid Module	The Medicaid Program CAP Process—CAP	Revise the section to read: The organization may elect to complete a CAP during the post-survey process for each element with a performance score of Not Met. Within 30 calendar days of receipt of the final results, the organization must provide NCQA with either: • The CAP ***or*** • Notice that the organization is opting not to pursue the CAP process for any deficient requirement.	**PC**	**7/29/2019**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
			For each element with a performance score of Not Met, the organization prepares a CAP that: • Addresses all findings in the CAR. • Details the steps to be taken to resolve the deficiency. • Provides a time frame for completing the CAP.		
63	Policies and Procedures—Section 7: Medicaid Module	The Medicaid Program CAP Process—CAP review and implementation	Remove the third paragraph that reads: The Medicaid organization may seek Reconsideration of the Medicaid Survey findings to modify the performance score for any Medicaid, federal nonduplication eligible element contained in the HP Accreditation or Medicaid Module. The Medicaid organization may seek Reconsideration if NCQA determines that a CAP is deficient.	**CL**	**7/29/2019**
64	Policies and Procedures—Section 7: Medicaid Module	The Medicaid Program CAP Process—Final approval of CAP	Revise the note to read: *NCQA Health Plan Accreditation performance scores and status are not affected by the results of the CAP process for Medicaid Module specific requirements.*	**CL**	**7/29/2019**
64	Policies and Procedures—Section 7: Medicaid Module	Reconsideration	Revise the section to read: The Medicaid organization may seek Reconsideration to modify the performance score for any Medicaid federal nonduplication eligible element contained in the: • Health Plan Accreditation Survey. • Medicaid Module Survey. If the Medicaid organization submits a federally defined nonduplication Medicaid element from the Health Plan Accreditation Survey for Reconsideration, any change in the performance score for that element applies to Health Plan Accreditation score. For example, if the organization submits a survey element that is also a federally defined nonduplication Medicaid element and the Reconsideration Committee changed the element score from Not Met to Met, the new score applies to the Health Plan Accreditation Survey score. The organization may also submit for Reconsideration a performance score of Not Met received on any element in the Medicaid Module. The	**CL**	**7/29/2019**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
			Reconsideration policies, procedures and time frames described in Section 3 of these policies and procedures apply to Medicaid Module Survey Reconsiderations. ***Note:*** *The Medicaid organization may not request Reconsideration of its CAP performance.*		
70	QI 1, Element A	Explanation—Factor 5: QI Committee oversight	Add the following under the first bullet of the factor 5 explanation: ***Note:*** *Participating practitioners are external to the organization and part of the organization's network.*	**CL**	**11/25/2019**
75	QI 2, Element A	Explanation—Factor 3: Practitioner participation	Revise the factor 3 explanation to read: The QI Committee facilitates participating practitioner involvement in the QI program activities through attendance and discussion in relevant QI committee or QI subcommittee meetings or on ad hoc task forces. Participating practitioners represent a broad range of specialties, as needed. If participating practitioners are not members of the QI committee, they are involved in a clinical subcommittee or relevant ad hoc task force. ***Note:*** *Participating practitioners are external to the organization and part of the organization's network.*	**CL**	**11/25/2019**
78, 80	QI 3, Elements A, B	Scope of review	Revise the second paragraph to read: *For Interim Surveys:* NCQA reviews one primary care contract and one specialist contract. The contracts do not need to be executed. ***Note: This edit is being made because in the hard copy publication only, the scope of review listed "First Surveys" twice and omitted "Interim."***	**CL**	**12/3/2018**
78, 80, 81	QI 3, Elements A-C	Look-back period	Revise the first paragraph to read: *For Interim Surveys:* Prior to the survey date. ***Note: This edit is being made because in the hard copy publication only, the look-back period listed "First Surveys" twice and omitted "Interim."***	**CL**	**12/3/2018**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
81	QI 3, Element C	Scope of review	Revise the second paragraph to read: *For Interim Surveys:* NCQA reviews one hospital contract and one contract from another provider type. The contracts do not need to be executed. ***Note: This edit is being made because in the hard copy publication only, the scope of review listed "First Surveys" twice and omitted "Interim."***	**CL**	**12/3/2018**
87	QI 4, Element C	Examples- Attitude and Service	Add the following as the third and fourth bullets: • A member complained about the tone and attitude of the customer service representative. • A member complained that a customer service representative provided inaccurate information.	**CL**	**7/29/2019**
107	QI 6, Element A	Explanation—Factor 5: Prevention programs for behavioral healthcare	Revise the explanation under the subhead to read: The organization collects data on issues that could be preventable if appropriate primary or secondary programs were developed and implemented. The organization identifies the programs that the collaboration deems most appropriate, but is not required to implement the program to meet the element.	**CL**	**12/3/2018**
109	QI 6, Element A	Examples—Factor 4	Add a fifth bullet that reads: Results of the HEDIS measure Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD).	**CL**	**7/29/2019**
116 187 249 405 429 460	QI 7, Element A PHM 7, Element A NET 7, Element A CR 8, Element A RR 5, Element A MEM 5, Element A	Explanation—Factor 1: Mutual agreement	Add the following after the first paragraph: NCQA considers the effective date specified in the delegation agreement as the mutually agreed-upon effective date. The effective date may be before or after the signature date on the agreement. If the agreement has no effective date, NCQA considers the signature date (meaning the date of last signature) as the mutually agreed upon effective date.	**CL**	**3/25/2019**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
516 595	LTSS 4, Element A MED 15, Element A		NCQA may accept other evidence of the mutually agreed-upon effective date: a letter, meeting minutes or other form of communication between the organization and the delegate that references the parties' agreement on the effective date of delegated activities. NCQA requires submitted evidence for all other delegation factors to consider the same mutually agreed-upon date as the effective date for the delegate's performance of delegated activities.		
117 188 250 363 429 461	QI 7, Element A PHM 7, Element A NET 7, Element A UM 12, Element A RR 5, Element A MEM 5, Element A	Explanation—Factor 5: Providing member and clinical data	Revise the first sentence to read: The organization's delegation agreement specifies that the organization will provide the following data when requested: Add the following as the last paragraph: The organization may provide the delegate with the data upon request or on an ongoing basis.	**CL**	**3/25/2019**
126	PHM 1, Element A	Explanation	Add the following text immediately before the subhead ***Factor 3:*** **Activities that are not direct member interventions:** ***Factor 2:*** **Programs and services** Programs and services offered to the organization's members align with its comprehensive strategy and the areas of focus in factor 1. NCQA does not prescribe a specific number of programs or services that must be offered to members, nor does it require all programs and services to be included or limited to each focus area in factor 1. The organization must include a description of the programs and services that align with the goals in its comprehensive PHM strategy. This may include programs and services involving any level of member interactive contact.	**CL**	**3/25/2019**
126	PHM 1, Element A	Explanation—Factor 5: Informing members	Remove the last sentence of the second paragraph, which reads: If the organization posts the information on its website, it uses alternative methods to notify members that the information is available online.	**CL**	**11/25/2019**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
126	PHM 1, Element A	Explanation—Factor 3: Activities that are not direct member interventions to read:	Revise the text under the subhead for factor 3 to read: The organization describes the activities it offers in its PHM strategy, including activities not directed at individual members. The organization has at least one activity in place that supports the PHM strategy. An activity may be specific to one area of focus or apply to more than one area of focus. NCQA does not prescribe a specific number of activities that must be offered to members, nor does it require all activities unrelated to the PHM strategy to be included or limited to each focus area in factor 1. The organization must include a description of all activities that align with the goals in its comprehensive PHM strategy.	**CL**	**3/25/2019**
126	PHM 1, Element A	Explanation—Factor 5: Informing members	Add the following text as the second paragraph under the subhead for factor 5: The organization communicates the information to members by mail, telephone or in person. If the organization posts the information on its website, it uses alternative methods to notify members that the information is available online.	**CL**	**3/25/2019**
127	PHM 1, Element A	Examples	Revise the second bullet example under "Patient safety" to read: • Goal: Improve clinical safety by reducing hospital-acquired infection by 5% over 3 years. – *Target population:* Members receiving in-patient surgical procedures. – *Activity:* Distribute information to members that facilitates informed decisions regarding care, such as: ▪ Questions to ask surgeons before surgery. – *Activity:* Implement follow-up system to contact members after discharge to confirm receipt of care and post-surgical care instructions.	**CL**	**12/3/2018**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
130	PHM 1, Element B	Explanation—Interactive contact	Add the following text as the third bullet in the second paragraph: • Contact made to inform members of the availability of affinity programs (e.g., subsidized gym memberships, device purchases, discounted weight loss subscriptions).	**CL**	**3/25/2019**
130	PHM 1, Element B	Explanation	Add the following Related information section and text under the Exceptions section: **Related information** *Use of vendors for services or activities in the PHM strategy.* The organization may contract with a vendor to provide technology services. NCQA does not consider the relationship to be delegation, but evaluates the vendor's technology-supported processes against requirements. Refer to *Vendor Relationships* in Appendix 5. *Use of organizations that have interactive contact with members.* Arrangements with contracted organizations to administer programs within the scope of the PHM strategy are considered delegation.	**CL**	**3/25/2019**
132	PHM 2, Element A	Explanation—Factor 1: Claims or encounter data	Revise the second sentence under the factor 1 subhead to read: Behavioral claim data are not required if all purchasers of the organization's services carve out behavioral healthcare services.	**CL**	**12/3/2018**
132	PHM 2, Element A	Exceptions	Add the following under the Exceptions section: **Related information** The data sources that meet factors 1-6 may not be used to meet factor 7.	**CL**	**12/3/2018**
143	PHM 3, Element A	Examples—Factor 4	Replace the reference to "CAHPS measures" with "CAHPS Clinician and Group Survey."	**CL**	**7/29/2019**
166	PHM 5, Element C	Look-back period	Revise the look-back period for Renewal Surveys to read: For *Renewal Surveys*: 24 months; 12 months for factors 3, 5 and 11; 6 months for the "current medications, including schedules and dosages" aspect of factor 1 and all of factor 2.	**PC**	**12/3/2018**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
166	PHM 5, Element C	Explanation—Factor 1: Initial assessment of members' health status	Add a fourth bullet to the factor 1 explanation to read: • Current medications, including schedules and dosages.	**PC**	**12/3/2018**
166	PHM 5, Element C	Explanation—Factor 2: Documentation of clinical history	Revise the language to read: Complex case management policies and procedures specify the process for documenting clinical history, including: • Past hospitalization and major procedures, including surgery. • Significant past illnesses and treatment history. • Past medications.	**PC**	**12/3/2018**
173	PHM 5, Element D	Explanation—Factor 2: Documentation of clinical history	Replace the third bullet under "Factor 2: Documentation of clinical history" with: • Past medications.	**CL**	**12/3/2018**
182	PHM 6, Element A	Scope of review	Revise the second paragraph to read: *For First Surveys:* NCQA reviews the organization's plan for its annual comprehensive analysis of PHM strategy impact or its most recent analysis. *For Renewal Surveys:* NCQA reviews the organization's most recent annual comprehensive analysis of PHM strategy impact.	**PC**	**11/25/2019**
185	PHM 6, Element B	Scope of review	Revise the first two paragraphs to read: *This element applies to Renewal Surveys.* NCQA reviews the organization's most recent annual comprehensive analysis of PHM strategy impact.	**PC**	**11/25/2019**
185	PHM 6, Element B	Look-back period	Revise the text to read: *For Renewal Surveys:* At least once during the prior year.	**PC**	**11/25/2019**
185	PHM 6, Element B	Explanation—Factor 2: Act on opportunity for improvement	Revise the explanation to read: The organization acts on at least one identified opportunity for improvement.	**CO**	**12/3/2018**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
197	NET 1, Element A	Data source	Add "documented process" as a data source.	**CL**	**7/29/2019**
197	NET 1, Element A	Scope of review	Revise second paragraph to read: NCQA reviews the organization's data collection methodology (presented as a documented process or within the report), assessment of unmet member needs, characteristics of the practitioner network and documentation of any adjustments made in the network to meet identified needs at least once within the look-back period.	**CL**	**7/29/2019**
197	NET 1, Element A	Look-back period	Revise the text for Renewal Surveys to read: *For Renewal Surveys:* 24 months.	**CL**	**11/25/2019**
~~197~~	~~NET 1, Element A~~	~~Look-back period~~	~~Revise the look back period for Renewal Surveys to read:~~ ~~For Renewal Surveys: 24 months; at least once during the prior year for the "cultural" component of factor 1.~~ ***Updated the issue on November 25, 2019.***	~~**PC**~~	~~**7/29/2019**~~
197	NET 1, Element A	Explanation—Factor 1: Assessing members' needs	Revise the text to read: **Data collection** To assess the cultural, ethnic, racial and linguistic needs of its members relative to its network, the organization must first collect data on ethnic, racial and linguistic characteristics of its members. A separate source of data specific to cultural characteristics (e.g., employer demographics, member surveys or focus groups) is not required. **Assessment** The organization assesses the unmet needs of its members relative to its network. To meet the factor, the organization must address all four needs—cultural, ethnic, racial and linguistic. Cultural preferences and beliefs may be assessed from members (e.g. member surveys or focus groups) or other sources. If using other sources, aspects of culture can be initially inferred from ethnic, racial and linguistic characteristics but must also be supplemented with information about the cultural needs and preferences (e.g. religion,	**CL**	**7/29/2019**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
			family traditions, customs) of its population or populations with similar characteristics. The organization may use existing health services research.		
198	NET 1, Element A	Explanation—Factor 2: Practitioner Availability	Revise the text to read: In order to meet member needs, the organization assesses the applicable characteristics (i.e., culture, ethnicity, race, spoken language) of the network practitioners related to the needs identified in factor 1. The organization adjusts the practitioner network to provide the types and number of practitioners necessary to meet the cultural, ethnic, racial and linguistic needs of its members within defined geographical areas. Adjustment of the practitioner network may include requiring existing practitioners to complete cultural competency training, providing practitioners with culturally and linguistically appropriate health education materials, or recruiting practitioners whose cultural and ethnic backgrounds are similar to the underrepresented member population. The organization determines what adjustments are appropriate based on identified needs. The organization receives credit for factor 2 if it demonstrates that, based on its assessment of members' unmet needs and the applicable characteristics of the network, it is not necessary to adjust the practitioner network.	**CL**	**7/29/2019**
198	NET 1, Element A	Examples	Revise the text to read: **Five-step process for meeting the intent of this element** 1. Collect data on ethnic, racial and linguistic needs of members from U.S. Census and enrollment data. 2. Conduct research or review literature on cultural needs and preferences based on the characteristics of the organization's members. 3. Correlate data with members' preferences based on member feedback or complaint data.	**CL**	**7/29/2019**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
			4. Assess the cultural, ethnic, racial and linguistic characteristics of network practitioners to evaluate whether network practitioners meet members' needs. 5. Take action to adjust the practitioner network if it does not meet members' cultural, ethnic, racial and linguistic needs. **Data sources** • Data from survey questions or focus groups that identify the health-related preferences or beliefs from specific ethnic groups. • U.S. Census data on the racial/ethnic composition of the population within a service area or region. • Practitioner race, ethnicity and language data collected during the credentialing process. • Published health statistics, health services research, data provided by plan sponsors or government agencies. **Actions resulting from assessment** • Recruit, credential and contract with practitioners who speak a language that reflects members' linguistic needs. • Recruit, credential and contract with practitioners whose cultural and ethnic backgrounds are similar to the underrepresented member population. • Require practitioners to complete cultural competency training courses based on the racial/ethnic composition of the member population.		
208	NET 2, Element A	Explanation—Quantitative and qualitative analyses	Revise the second paragraph to read: The analysis may be conducted at the organizational level (i.e., primary care practitioners and practices may be grouped together), but if the analysis reveals issues, the organization conducts a practitioner-level analysis (by individual primary care practitioner) across all primary care practitioners and practices or from a statistically valid sample of them to determine if members are able to get an appointment to see a practitioner.	**CL**	**12/3/2018**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
210	NET 2, Element B	Explanation—Quantitative and qualitative analyses	Revise the second paragraph to read: The analysis may be conducted at the organizational level (i.e., behavioral healthcare practitioners and practices may be grouped together), but if the analysis reveals issues, the organization conducts a practitioner-level analysis (by individual behavioral healthcare practitioner) across all behavioral healthcare practitioners and practices or from a statistically valid sample of them to determine if members are able to get an appointment to see a practitioner.	**CL**	**12/3/2018**
211	NET 2, Element C	Explanation—Quantitative and qualitative analyses	Revise the second paragraph to read: The analysis may be conducted at the organizational level (i.e., specialists and specialty practices may be grouped together), but if the analysis reveals issues, the organization conducts a practitioner-level analysis (by individual specialist) across all affected high-volume and high-impact specialty practitioners and practices or from a statistically valid sample of them to determine if members are able to get an appointment to see a practitioner.	**CL**	**12/3/2018**
226	NET 4, Element C	Examples—Table 3: Factor 2—Out-of-network services data collection	Revise the first column title to read: **Previous Year Out-of-Network Requests, Total**	**CO**	**12/3/2018**
242	NET 6, Element G	Explanation	Add the following as the third and fourth paragraphs above the factor 1 subhead in the Explanation: A hospital is an institution that primarily provides diagnostic and therapeutic services to patients admitted for medical diagnosis, treatment and care of injured, disabled, or ill individuals by or under the supervision of a physician. This element is limited to acute care hospitals including specialty acute care such as children's hospitals or Veteran Affairs hospitals.	**CL**	**7/29/2019**

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<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>261</td><td>UM 1, Element A</td><td>Explanation—The scope of medical necessity review</td><td>Add the following as the last paragraph:
Organization employees and their dependents: The organization may exclude employees and their dependents from the denial and appeal file universe.</td><td>CL</td><td>11/25/2019</td></tr>
<tr><td>275</td><td>UM 4, Element B</td><td>Explanation</td><td>Add a new 8th bullet in the explanation that reads:
• Doctoral-level Board-Certified Behavioral Analysts: Applied behavioral analysis denials.</td><td>CL</td><td>3/25/2019</td></tr>
<tr><td>286, 292, 299</td><td>UM 5, Elements A, C, E</td><td>Related information—Extending time frames</td><td>Incorporate the sentence regarding the organization choosing to extend the decision time frame, under the “Extending time frames” subhead to the first sentence under the subhead “Factor 1: Urgent concurrent requests for commercial and Marketplace” to read:
The organization may extend the decision notification time frame if the request to extend urgent concurrent care was not made prior to 24 hours before the expiration of the prescribed period of time or number of treatments.</td><td>CL</td><td>7/29/2019</td></tr>
<tr><td>303</td><td>UM 5, Element G</td><td>Explanation</td><td>Add the following as the second paragraph to the factors 1-6 explanation:
Approval decisions must adhere to the timeliness requirements in UM 5 and must be included in factors 1, 3, and 5. However, the timeliness of notifications sent for approvals is not required to be included in factors 2, 4 and 6.</td><td>CL</td><td>3/25/2019</td></tr>
<tr><td>303</td><td>UM 5, Element G</td><td>Exceptions</td><td>Add the following as the first exception:
Factors 2, 4 and 6 are NA for notification of approval decisions.</td><td>CL</td><td>3/25/2019</td></tr>
<tr><td>304</td><td>UM 5, Element H</td><td>Scoring</td><td>Revise the scoring table to read:
<table>
<tr><th>100%</th><th>80%</th><th>50%</th><th>20%</th><th>0%</th></tr>
<tr><td>The organization meets all 5 factors</td><td>The organization meets 4 factors</td><td>The organization meets 3 factors</td><td>The organization meets 1-2 factors</td><td>The organization meets 0 factors</td></tr>
</table></td><td>CO</td><td>12/3/2018</td></tr>
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PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
314, 321, 327	UM 7, Elements B, E, H	Explanation—Factor 1: Reason for denial	Replace the first paragraph with the following text: The denial notification states the reason for the denial in terms specific to the member's condition or request and in language that is easy to understand, so the member and practitioner understand why the organization denied the request and have enough information to file an appeal. An appropriately written notification includes a complete explanation of the grounds for the denial, in language that a layperson would understand, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand. The organization is not required to spell out abbreviations/acronyms if they are clearly explained in lay language. To illustrate, for the acronym DNA, spelling out would be "a DNA (deoxyribonucleic acid)" whereas explaining would be "a DNA test is a test that looks at your genetic information." Denial notifications sent only to practitioners may include technical or clinical terms.	**CL**	**12/3/2018**
317, 324, 329	UM 7, Elements C, F, I	Scope of review	Add the following as the third paragraph in the scope of review: Organizations must implement the changes in factors 2 and 3 for files processed on or after 11/1/18.	**PC**	**12/3/2018**
318, 324, 330	UM 7, Elements C, F, I	Explanation—Factor 2: Right to representation and appeal time frames	Revise the second bullet to read: • Provides contact information for the state Office of Health Insurance Consumer Assistance or ombudsman, if applicable. ***Note:*** *This is not required for members covered by the Federal Employee Health Benefits (FEHB) program.*	**CL**	**11/25/2019**
319, 325, 331	UM 7, Elements C, F, I	Related information	Revise the last paragraph to read: *Medicare denials and Fully Integrated Dual Eligible (FIDE) denials.* CMS requires organizations to issue an Integrated Denial Notice (IDN) for non-inpatient medical service denials for Medicare and FIDE members. The IDN meets factors 1–3 for these members.	**PC**	**12/3/2018**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
334	UM 8, Element A	Explanation—Factors 7-9: Appeal decisions	Replace the first paragraph with the following text: Appeal policies and procedures specify that appeal decisions and notifications are timely. The appeal decision notification states the reason for upholding the denial in terms specific to the member's condition or request and in language that is easy to understand, so the member and practitioner understand why the organization upheld the appeal decision and have enough information to file the next level of appeal. An appropriately written notification includes a complete explanation of the grounds for the upheld appeal decision, in language that a layperson would understand, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand. The organization is not required to spell out abbreviations/acronyms if they are clearly explained in lay language. To illustrate, for the acronym DNA, spelling out would be "a DNA (deoxyribonucleic acid)" whereas explaining would be "a DNA test is a test that looks at your genetic information." Upheld appeal notifications sent only to practitioners may include technical or clinical terms.	**CL**	**12/3/2018**
336	UM 8, Element A	Related information—Extending the time frame to obtain additional information	Add "or" to the end of the first bullet so that it reads: • The member agrees to extend the appeal time frame, ***or***	**CL**	**12/3/2018**
337	UM 8, Element B	Scope of review	Replace the third paragraph with the following two paragraphs: *For First Surveys:* NCQA reviews the most recent distribution of external review rights to members. *For Renewal Surveys:* NCQA reviews the most recent and previous annual distribution of external review rights to members.	**CL**	**12/3/2018**
345	UM 9, Element D	Explanation—Factor 1: The appeal decision	Replace the explanation with the following text: The appeal decision notification states the reason for upholding the denial in terms specific to the member's condition or request and in language that is easy to understand, so the member and practitioner understand why the	**CL**	**12/3/2018**

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<tr><td></td><td></td><td></td><td>organization upheld the appeal decision and have enough information to file the next level of appeal.
An appropriately written notification includes a complete explanation of the grounds for the upheld appeal decision, in language that a layperson would understand, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand.
The organization is not required to spell out abbreviations/acronyms if they are clearly explained in lay language.
To illustrate, for the acronym DNA, spelling out would be “a DNA (deoxyribonucleic acid)” whereas explaining would be “a DNA test is a test that looks at your genetic information.”
Upheld appeal notifications sent only to practitioners may include technical or clinical terms.</td><td></td><td></td></tr>
<tr><td>346</td><td>UM 9, Element D</td><td>Related information—Medicare appeals</td><td>Revise the sentence to read:
For Medicare appeal files, factors 1–6 are met if there is evidence that the organization sent the upheld denial to MAXIMUS.</td><td>PC</td><td>7/29/2019</td></tr>
<tr><td>361</td><td>UM 12, Element A</td><td>Scoring</td><td>Revise the scoring table to read:<table><tr><th>100%</th><th>80%</th><th>50%</th><th>20%</th><th>0%</th></tr><tr><td>The organization meets all 6 factors</td><td>The organization meets 5 factors</td><td>The organization meets 3-4 factors</td><td>The organization meets 1-2 factors</td><td>The organization meets 0 factors</td></tr></table></td><td>CO</td><td>12/3/2018</td></tr>
<tr><td>362</td><td>UM 12, Element A</td><td>Explanation—Factor 1: Delegation agreement</td><td>Add the following after the first paragraph:
NCQA considers the effective date specified in the delegation agreement as the mutually agreed-upon effective date. The effective date may be before or after the signature date on the agreement. If the agreement has no effective date, NCQA considers the signature date (meaning the date of last signature) as the mutually agreed upon effective date.
NCQA may accept other evidence of the mutually agreed-upon effective date: a letter, meeting minutes or other form of communication between the</td><td>CL</td><td>3/25/2019</td></tr>
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<tr><td></td><td></td><td></td><td>organization and the delegate that references the parties' agreement on the effective date of delegated activities.
NCQA requires submitted evidence for all other delegation factors to consider the same mutually agreed-upon date as the effective date for the delegate's performance of delegated activities.</td><td></td><td></td></tr>
<tr><td>388</td><td>CR 3, Element C</td><td>Explanation—Factor 5: Current malpractice coverage</td><td>Revise the Explanation to read:
The application states the amount of a practitioner's current malpractice insurance coverage (even if the amount is $0) and the date when coverage expires.
If the practitioner's malpractice insurance coverage is current and is provided in the application, it must be current as of the date when the practitioner signed the attestation and include the amount of coverage the practitioner has on the date when the attestation was signed.
If the practitioner does not have current malpractice coverage, then it is acceptable to include future coverage with the effective and expiration dates.
Documentation of malpractice insurance coverage may also be a face sheet or a federal tort letter as an addendum to the application. In this case, the practitioner is not required to attest to malpractice coverage on the application. The face sheet or federal tort letter must include the insurance effective and expiration dates (the future effective date is acceptable).</td><td>CL</td><td>7/29/2019</td></tr>
<tr><td>408</td><td>CR 8, Element C</td><td>Look-back period</td><td>Revise the first sentence to read:
For Interim Surveys and *First Surveys*: At least once during the prior year.</td><td>CL</td><td>12/3/2018</td></tr>
<tr><td>428</td><td>RR 5, Element A</td><td>Scoring</td><td>Revise the scoring table to read:
<table>
<tr><th>100%</th><th>80%</th><th>50%</th><th>20%</th><th>0%</th></tr>
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PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
446 452	MEM 2, Element C MEM 3, Element C	Scope of review	Add the following note as the last paragraph: ***Note:*** *For the 2019 and 2020 Standards year only, NCQA will accept the following as quality assessments because they were examples in prior standards years:* • *Website:* – *Ease of use and navigation, including how easily members can find the information they need (e.g., number of clicks, intuitive properties).* – *Functionality (whether it produces a result, can answer questions in one attempt).* • *Telephone:* – *Quality of telephone interactions (e.g., audit components include appropriate greeting, HIPAA verification, tone and attitude).*	**CL**	**7/29/2019**
446 453	MEM 2, Element C MEM 3, Element C	Explanation—Factors 1, 2: Data collection and analysis	Revise the second sentence in the second paragraph to read: When the organization conducts a quality assessment, it measures or evaluates how useful or understandable the information provided is.	**CL**	**7/29/2019**
447 453	MEM 2, Element C MEM 3, Element C	Examples	Revise the examples after the examples for "Evidence of the QI process" to read: **Quality assessment—website** • How easily members can find the information they need. • How easy is the information to understand? • Member feedback on the usefulness or understandability of information (e.g., surveys, focus groups). **Quality assessment—telephone** • Quality assurance monitoring of telephone interactions (e.g., clarity of response to questions). • Member feedback on the usefulness or understandability of information (e.g., surveys, focus groups).	**CL**	**7/29/2019**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
			Accuracy assessment—website • For interactive components, is the correct information returned when data is entered (e.g., a member benefit search returned correct benefit information)? **Accuracy assessment—telephone** • Quality assurance monitoring of telephone interactions (e.g., correct greeting and member identification, HIPAA verification).		
479, 486	LTSS 1, Elements D, G	Look-back period	Revise the Renewal Survey look-back period to read: *For Renewal Surveys:* 12 months.	**CO**	**12/3/2018**
545	MED 4, Element C	Exception	Revise the exception to read: Factor 5 is NA for all surveys.	**PC**	**3/25/2019**
569	MED 11, Element A	Explanation—Factor 1: Continued coverage pending the outcome	Revise the language under the subhead to read: If a member requests continued coverage, the organization informs the member that benefits scheduled for reduction or termination will continue if the member files an appeal or requests a State Fair Hearing.	**CL**	**12/3/2018**
578	MED 12, Element E	Explanation	Revise the subhead titles for factors 1-4 to read: **Factor 1: Availability of the member handbook in regular and large print** **Factor 2: Availability of the member handbook in alternative formats** **Factor 3: Availability of the member handbook in other languages** **Factor 4: Availability of the member handbook with taglines in other languages**	**CL**	**12/3/2018**
579	MED 12, Element F	Element stem	Revise the element stem to read: Denial notifications sent by the organization to existing members are available:	**CL**	**12/3/2018**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
579-580	MED 12, Element F	Explanation	Revise the following Explanation factor titles to read: **Factor 1: Availability of denial notifications in regular and large print** **Factor 2: Availability of denial notifications in alternative formats** **Factor 3: Availability of denial notifications in other languages** **Factor 4: Availability of denial notifications with taglines in other languages**	**CL**	**12/3/2018**
580	MED 12, Element F	Explanation—Factor 2: Availability of denial notifications in alternative formats	Revise the explanation to read: Alternative formats, including auxiliary aids and services, must also be made available upon request of the member, free of charge.	**CL**	**12/3/2018**
580	MED 12, Element F	Exception	Revise the language to read: Factors 3 and 4 are NA if the organization can show that English is the principal spoken and written language of all members.	**CL**	**12/3/2018**
581	MED 12, Element G	Explanation	Revise the following Explanation factor titles to read: **Factor 1: Availability of the appeal and grievance notifications in regular and large print** **Factor 2: Availability of the appeal and grievance notifications in alternative formats** **Factor 3: Availability of the appeal and grievance notifications in other languages** **Factor 4: Availability of the appeal and grievance notifications with taglines in other languages**	**CL**	**12/3/2018**
589	MED 14, Element B	Explanation—Factor 1: Name	Revise the explanation to read: The directory includes the name of the pharmacy.	**CL**	**12/3/2018**
593	MED 14, Element D	Explanation—Factor 5: Accepting new patients	Revise the sentence under the Factor 5 subhead to read: The directory indicates whether providers are accepting new patients.	**CL**	**12/3/2018**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
3-8 to |3-11	Appendix 3—Points by Reporting Category for 2019	Medicaid HMO/POS/ PPO—Standard and Measure Points by Reporting Category	Revise the First Survey Points and Renewal Survey Points for all HEDIS measures with points noted as 1.9350 to 1.1935 in the Medicaid table.	**CO**	**3/25/2019**
4-7, 4-8, 4-9, 4-10, 4-11, 4-12	Appendix 4	Tables 3A–3D; 4A–4D; 5A–5D	Revise the language below Tables 3C, 3D, 4C, 4D, 5C, 5D to read as follows, and add the revised language below Tables 3A, 3B, 4A, 4B, 5A, 5B. An organization with more than 8 HEDIS measure NA or NB results is scored on standards and CAHPS only. An organization with more than 4 CAHPS NAs or that exceeds 10 NA or NB results between HEDIS and CAHPS for each product line, is scored on the standards only and the accreditation status is capped at "Accredited."	**CL**	**12/3/2018**
5-4	Appendix 5	Non-file review elements	Revise the subhead and the first paragraph as follows: **Non-file review elements <u>in QI and NET</u>** <u>If the organization delegates QI or NET functions (other than to an MBHO, PBM or DM organization) affecting 30 percent or more of its membership, NCQA evaluates applicable non-file-review elements for a sample of up to four delegates in addition to the organization.</u> The delegate's documentation <u>to meet</u> delegated functions should be included in the appropriate non-file-review elements.	**CL**	**12/3/2018**
5-1, 5-26	Appendix 5		Replace all references to "PHM" with the new name. • Page 5-1: Replace the 19th bullet text under the Summary of Changes with, "Automatic Credit for Delegating to an Accredited Population Health Program (PHP) Organization. • Page 5-26: Replace the subhead language at the top of the page with, "Automatic Credit for Delegating to an NCQA-Accredited PHP Organization." • Page 5-26: Replace the Table 6 title with "Automatic Credit by Evaluation Option for Delegating to an NCQA-Accredited PHP Organization" and replace footnote #36 with "For PHM 1, Element B, automatic credit is available if the delegate is accredited under the 2019 standards and beyond."	**CL**	**12/3/2018**

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<tr><td>5-3</td><td>Appendix 5</td><td>About Delegation—Structural Requirements</td><td>Add footnote 2 to PHM 6 so the bullet reads:
• PHM 6: PHM Impact, Elements A and B.[2]</td><td>CL</td><td>12/3/2018</td></tr>
<tr><td>5-8</td><td>Appendix 5</td><td>Delegating to NCQA-Accredited/Certified or NCQA-Recognized Organizations—General Requirements</td><td>Add the following as the last sentence of the fourth bullet:
• If there are two or more delegates, “70 percent” is cumulative.</td><td>CL</td><td>12/3/2018</td></tr>
<tr><td>5-8</td><td>Appendix 5—Delegation and Automatic Credit Guidelines</td><td>Delegating to NCQA-Accredited/Certified or NCQA-Recognized Organizations—General Requirements</td><td>Revise the second sentence of the fourth bullet as follows:
If there are two or more delegates, “70 percent” is cumulative for the same delegated function. If the organization has two or more product lines and manages them the same, 70% is cumulative across all product lines. If the organization manages the product lines differently (e.g., delegating the activity for the commercial product line and not for Medicaid or Medicare product lines), 70% is calculated by product line.
Note: 70% is cumulative across product lines in 2019 Standards Year as updated above. NCQA is evaluating this policy for the 2020 Standards Year.</td><td>CL</td><td>3/25/2019</td></tr>
<tr><td>5-18</td><td>Appendix 5—Delegation and Automatic Credit Guidelines</td><td>Table 3: Automatic credit by Evaluation Option for delegating to an NCQA-Accredited MBHO, or a delegate that is NCQA-Accredited in UM, CR or PN or an NCQA-Certified CVO</td><td>Replace “Factor 5” with “Factor 4” to read:
<table><tr><th colspan="2">QI 1: Program Structure</th></tr><tr><td>A</td><td>QI Program Structure[18]
Factor 2: Behavioral healthcare aspects
Factor 4: Involvement of a behavioral healthcare practitioner</td></tr></table></td><td>CO</td><td>7/29/2019</td></tr>
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<tr><td>5-21</td><td>Appendix 5—Delegation and Automatic Credit Guidelines</td><td>Table 3: Automatic credit by Evaluation Option for delegating to an NCQA-Accredited MBHO, or a delegate that is NCQA-Accredited in UM, CR or PN or an NCQA-Certified CVO</td><td>Add UM 4, Element G under the UM, CR, or PN column as follows:
<table>
<tr><th rowspan="2"></th><th rowspan="2"></th><th colspan="3">Accredited in UM, CR or PN</th></tr>
<tr><th>Interim Survey</th><th>First Survey</th><th>Renewal Survey</th></tr>
<tr><td>G</td><td>Affirmative Statement About Incentives</td><td>Y</td><td>Y</td><td>Y</td></tr>
</table></td><td>CL</td><td>3/25/2019</td></tr>
<tr><td>5-25</td><td>Appendix 5—Delegation and Automatic Credit Guidelines</td><td>Automatic Credit for Delegating to an NCQA-Prevalidated Vendor for Health IT Solution</td><td>Revise the language to read:
Organizations that delegate PHM functions to a NCQA-Prevalidated Vendor for the Health IT solutions that receive the designation “eligible for automatic credit” present the Letter of Implementation for documentation. The vendor is responsible for providing the Letter of Implementation 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.
To receive automatic credit,
• The license or implementation date must be at or prior to the start of the lookback period, and;
• The version of the health IT solution must be validated prior to the start of the organization’s survey.</td><td>CL</td><td>3/25/2019</td></tr>
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<tr><th colspan="6">PREVIOUSLY POSTED UPDATES</th></tr>
<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>5-31</td><td>Appendix 5—Delegation and Automatic Credit Guidelines</td><td>Table 15: Automatic credit for CCM for using an NCQA-Accredited ACO</td><td>Revise the 2nd and 3rd column headers so the table reads:<table><tr><th>Requirements</th><th>Delegation to NCQA-Accredited ACO</th><th>Delegation to Organization Not Recognized by NCQA</th></tr><tr><td>File inclusion criteria</td><td>Member in the case management program for >60 days if tracked by the health plan.</td><td>Member in the case management program for >60 days if tracked by the health plan.</td></tr><tr><td>Automatic credit</td><td>Yes</td><td>No</td></tr></table></td><td>CO</td><td>7/29/2019</td></tr>
<tr><td>5-36</td><td>Appendix 5</td><td>Activities That May Not Be Delegated</td><td>Remove the following from the list:
MED 14: Practitioner and Provider Directories</td><td>CL</td><td>12/3/2018</td></tr>
</table>