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

December 3, 2018

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	ISS Release Date
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**
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**
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**
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**
78, 80, 81	QI 3, Elements A-C	Look-back period	Revise the first paragraph to read:	**CL**	**12/3/2018**

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Page	Standard/Element	Head/Subhead	Update	Type of Update	ISS Release Date
			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."*		
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**
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**
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**
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**
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**

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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**
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**
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**
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**

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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>ISS Release Date</th></tr>
<tr><td>226</td><td>NET 4, Element C</td><td>Examples—Table 3: Factor 2—Out-of-network services data collection</td><td>Revise the first column title to read:
Previous Year Out-of-Network Requests, Total</td><td>CO</td><td>12/3/2018</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>
<tr><td>314, 321, 327</td><td>UM 7, Elements B, E, H</td><td>Explanation—Factor 1: Reason for denial</td><td>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.</td><td>CL</td><td>12/3/2018</td></tr>
<tr><td>317, 324, 329</td><td>UM 7, Elements C, F and I</td><td>Scope of review</td><td>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.</td><td>PC</td><td>12/3/2018</td></tr>
<tr><td>319, 325, 331</td><td>UM 7, Elements C, F, I</td><td>Related information</td><td>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.</td><td>PC</td><td>12/3/2018</td></tr>
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Page	Standard/Element	Head/Subhead	Update	Type of Update	ISS 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 organization upheld the appeal decision and have enough information to file the next level of appeal.	**CL**	**12/3/2018**

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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>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>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><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>479, 486</td><td>LTSS 1, Elements D, G</td><td>Look-back period</td><td>Revise the Renewal Survey look-back period to read:
For Renewal Surveys: 12 months.</td><td>CO</td><td>12/3/2018</td></tr>
<tr><td>569</td><td>MED 11, Element A</td><td>Explanation—Factor 1: Continued coverage pending the outcome</td><td>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.</td><td>CL</td><td>12/3/2018</td></tr>
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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**
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** **Factors 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** **Factors 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**

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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**
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 in QI and NET** 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. The delegate's documentation to meet 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**
5-3	Appendix 5	About Delegation—Structural Requirements	Add footnote 2 to PHM 6 so the bullet reads: • PHM 6: PHM Impact, Elements A and B.[2]	**CL**	**12/3/2018**

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5-8	Appendix 5	Delegating to NCQA-Accredited/Certified or NCQA-Recognized Organizations—General Requirements	Add the following as the last sentence of the fourth bullet: If there are two or more delegates, "70 percent" is cumulative.	**CL**	**12/3/2018**
5-36	Appendix 5	Activities That May Not Be Delegated	Remove the following from the list: MED 14: Practitioner and Provider Directories	**CL**	**12/3/2018**

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