

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

July 27, 2020

This document includes the corrections, clarifications and policy changes to the 2020 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 2020 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
161, 165	PHM 5, Elements D and E	Explanation—Files excluded from review	Revise the subbullet under the second bullet to read: — The organization provides evidence of the member’s identification date and that the member was in complex case management for less than 60 calendar days during the look-back period.	CL	7/27/2020
168	PHM 6, Element A	Summary of Change	Revise the fifth bullet to read: • Clarified that complaint data may be used to supplement an analysis of member experience, in addition to surveys or focus groups.	CO	7/27/2020
175,178	PHM 7, Elements B and D	NCQA-Accredited/Certified delegates	Add “NCQA-Prevalidated Health IT Solutions” to the sentence so the text reads: Automatic credit is available for this element if all delegates are NCQA-Accredited health plans, MBHOs or CMOs, NCQA-Accredited/Certified DMOs, or are NCQA-Prevalidated Health IT Solutions, unless the element is NA.	CL	7/27/2020
177	PHM 7, Element C	Explanation	Add the following text as the third paragraph: Automatic credit is available for factor 3 if all delegates are NCQA-Prevalidated Health IT Solutions, unless the element is NA.	CL	7/27/2020
222	NET 5, Element H	Exception	Revise the language to read: Corresponding factors marked “No” in Element F are scored NA in this element.	CO	7/27/2020

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260	UM 4, Element F	Exception	Add the following as the last sentence: Network practitioners are not considered part of the organization.	CL	7/27/2020
260	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	7/27/2020
265, 271, 277, 285	UM 5, Elements A-C, E	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 factors 2, 3 subhead in Elements A, B, E and the factors 1, 2 subhead in Element C to read: <i>For Medicare</i> , the organization may extend the timeframe once, by up to 14 calendar days, under the following conditions: <ul style="list-style-type: none"> • The member requests an extension, or • The organization needs additional information, and <ul style="list-style-type: none"> – 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. <p>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.</p> <p><i>For Medicaid</i>, 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.</p> <p>The organization notifies the member or the member’s authorized representative of its decision, but no later than the expiration of the extension.</p>	CL	7/27/2020

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298	UM 7, Element C	Scoring	Revise the text for Partially Met to read: Medium (60-89%) on file review for all 4 factors.	CO	7/27/2020
317	UM 8, Element A	Explanation— Factor 5: Person or people deciding the appeal	<p>Revise the text to read:</p> <p>Appeal policies and procedures specify who in the organization decides appeals.</p> <p>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.</p> <p>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.</p> <p>NCQA considers the following practitioner types to be appropriate for review of the specified UM denial decisions:</p> <ul style="list-style-type: none"> • <i>Physicians, all types</i>: Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials. • <i>Nurse practitioners*</i>: Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials. • <i>Doctoral-level clinical psychologists or certified addiction-medicine specialists</i>: Behavioral healthcare denials. • <i>Pharmacists</i>: Pharmaceutical denials. • <i>Dentists</i>: Dental denials. • <i>Chiropractors</i>: Chiropractic denials. • <i>Physical therapists</i>: Physical therapy denials. • <i>Doctoral-level board-certified behavioral analysts</i>: Applied behavioral analysis denials. <p>*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.</p>	CL	7/27/2020

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317	UM 8, Element A	Explanation—Factor 6: Same-or-similar specialist review	<p>Revise the text to read:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>To be considered a same-or-similar specialist, the reviewing specialist's training and experience must meet the following criteria:</p> <ul style="list-style-type: none"> • 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. <p>“Training and experience” refers to the practitioner’s clinical training and experience.</p> <p>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.</p> <p>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</p>	CL	7/27/2020

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			<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>		
318	UM 8, Element A	Explanation— Factor 13: Titles and qualifications	<p>Revise the text to read:</p> <p>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.</p> <p>For each individual, the notice includes:</p> <ul style="list-style-type: none"> • <i>For a benefit appeal:</i> The title (position or role in the organization). • <i>For a medical necessity appeal:</i> 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). <p>The organization is not required to include individuals' names in the written notification.</p>	CL	7/27/2020
326	UM 9, Element C	Explanation	<p>Add a subhead and text above the Exceptions that read:</p> <p>Person or people deciding the appeal</p> <p>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.</p>	CL	7/27/2020

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			<p>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.</p> <p>NCQA considers the following practitioner types to be appropriate for review of the specified UM denial decisions:</p> <ul style="list-style-type: none"> • <i>Physicians, all types</i>: Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials. • <i>Nurse practitioners*</i>: Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials. • <i>Doctoral-level clinical psychologists or certified addiction-medicine specialists</i>: Behavioral healthcare denials. • <i>Pharmacists</i>: Pharmaceutical denials. • <i>Dentists</i>: Dental denials. • <i>Chiropractors</i>: Chiropractic denials. • <i>Physical therapists</i>: Physical therapy denials. • <i>Doctoral-level board-certified behavioral analysts</i>: Applied behavioral analysis denials. <p>*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.</p>		
326	UM 9, Element C	Explanation	<p>Add a subhead and text above the Exceptions that read:</p> <p>Same-or-similar specialist review</p> <p>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.</p> <p>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.</p> <p>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</p>	CL	7/27/2020

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			<p>in limited situations and therefore are not considered same-or-similar specialists for the purposes of deciding appeals.</p> <p>To be considered a same-or-similar specialist, the reviewing specialist's training and experience must meet the following criteria:</p> <ul style="list-style-type: none"> • 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. <p>"Training and experience" refers to the practitioner's clinical training and experience.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>		

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			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.		
329	UM 9, Element D	Explanation— Factor 5: Titles and qualifications	<p>Revise the text to read:</p> <p>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.</p> <p>For each individual, the notice includes:</p> <ul style="list-style-type: none"> • <i>For a benefit appeal:</i> The title (position or role in the organization). • <i>For a medical necessity appeal:</i> 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). <p>The organization is not required to include individuals' names in the written notification.</p>	CL	7/27/2020
345, 347	UM 12, Elements A, B	Scope of review— Documentation	<p>Replace the second sentence with the following paragraph:</p> <p>For factor 6, if the organization contracts with external entities, NCQA also reviews contracts from up to four randomly selected external entities, or reviews all external entities if the organization has fewer than four. If factor 6 is not addressed in a contract, the organization may present the external entity's policies and procedures for review. In order to meet factor 6, the organization's documentation and each external entity's documentation must meet the factor.</p>	CL	7/27/2020
346, 348	UM 12, Elements A, B	Explanation— Factor 6: Securing system data	<p>Replace the last paragraph with the following:</p> <p>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.</p>	CL	7/27/2020

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365	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	7/27/2020
369	CR 1, Element C	Scope of review— Documentation	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	7/27/2020
370	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	7/27/2020
371	CR 2, Element A	Scope of review— Documentation	Revise the text to read: <i>For Interim Surveys</i> , NCQA reviews Credentialing Committee minutes from three different meetings or the Credentialing Committee charter, and reviews a timeline for operationalizing the committee if the committee has not met. If the required meeting minutes are not available for review, NCQA reviews the meeting minutes that are available within the look-back period. <i>For First Surveys and Renewal Surveys</i> , 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	7/27/2020
441	ME 6, Element D	Explanation	Add the following as the second paragraph: Although the intent of the element is to provide an electronic customer service function via email, if the organization does not provide this email function but uses a member portal to communicate with members instead, it	CL	7/27/2020

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			may opt to have NCQA review and score the portal functions. Services provided by the portal must meet all requirements in Element D.		
479, 491	LTSS 1, Element D LTSS 1, Element G	Look-back period	Revise the text for Renewal Surveys to read: <i>For Renewal surveys:</i> 6 months.	CO	7/27/2020
480, 491	LTSS 1, Element D LTSS 1, Element G	Explanation—Files excluded from review	Revise the subbullet under the second bullet to read: – The organization provides evidence of the member’s identification date and that the member was in case management for less than 60 calendar days during the look-back period.	CL	7/27/2020
493	LTSS 1, Element G	Explanation—Factor 10: Follow-up and communication with LTSS providers	Revise the explanation to read: The file or case record documents the roles and responsibilities of LTSS providers, case management plan details and the follow-up schedule that are communicated to providers.	CL	7/27/2020
523	LTSS 4	Element stem	Revise the text to read: If the organization delegates LTSS activities, there is evidence of oversight of delegated activities.	CL	7/27/2020
2-18	Appendix 2	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	Revise the text for footnote 20 to read: For NET 2, Element B, factor 4 and NET 3, Element A, factor 4 automatic credit is available if the MBHO is accredited under 2018 standards and beyond.	CL	7/27/2020
2-23	Appendix 2	Automatic Credit for Delegating to an NCQA-PHM Prevalidated Vendor for Health IT Solution	Replace “NCQA-Prevalidated Vendor for Health IT Solution” with “NCQA-Prevalidated Health IT Solution.”	CL	7/27/2020
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5	Overview	Changes to the Policies and Procedures—Section 2	Remove the third subbullet under the third bullet that reads: An organization that does not score “Met” on three or more must-pass elements could undergo a Resurvey at the Review Oversight Committee’s (ROC) discretion.	CL	3/30/2020
16	Policies and Procedures—Section 1: Eligibility and the Application Process	Evaluation Options—Table 1: Summary of Evaluation Options’ eligibility, status duration and HEDIS reporting and scoring	Replace the last sentence in the last column of each row that reads “Refer to HEDIS Reporting in Accreditation” with the following: <i>Refer to Health Plan Ratings and Accreditation.</i>	CO	3/30/2020
19	Policies and Procedures—Section 1: Eligibility and the Application Process	How NCQA Defines an Accreditable Entity—6. Product/product line	Replace “Exchange” with “Off-Exchange” in the second paragraph so it reads: Off-Exchange products must include this membership in the commercial product line.	CL	11/25/2019
20	Policies and Procedures—Section 1: Eligibility and the Application Process	How NCQA Defines an Accreditable Entity—HEDIS/CAHPS reporting unit	Remove the last sentence that reads: Refer to <i>HEDIS Reporting for Accreditation</i> , below, for the definition of “reporting unit.”	CO	3/30/2020

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28	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Accreditation Status	<p>Add a subhead and text immediately above table 4 that reads: <u>Statutes and Scoring Thresholds by Evaluation Option</u> The table below shows scoring ranges and statuses by evaluation option. Modify the first row in the table to read: Table 4: Scoring ranges for Accreditation statuses</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th></th> <th style="text-align: center;">Interim</th> <th style="text-align: center;">First and Renewal (Standards Only)</th> <th style="text-align: center;">First and Renewal (With HEDIS/CAHPS)</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">Accredited with a Star Rating, if applicable</td> <td style="text-align: center;">NA</td> <td colspan="2">At least 80% of applicable points in each category of standards (QI, PHM, NET, UM, CR, ME)</td> </tr> </tbody> </table>		Interim	First and Renewal (Standards Only)	First and Renewal (With HEDIS/CAHPS)	Accredited with a Star Rating, if applicable	NA	At least 80% of applicable points in each category of standards (QI, PHM, NET, UM, CR, ME)		CO	11/25/2019
	Interim	First and Renewal (Standards Only)	First and Renewal (With HEDIS/CAHPS)										
Accredited with a Star Rating, if applicable	NA	At least 80% of applicable points in each category of standards (QI, PHM, NET, UM, CR, ME)											
31	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	How Standards are Scored—Scope of review	<p>Revise the third bullet on the left to read:</p> <ul style="list-style-type: none"> • PHM 6, Elements A, B. 	CL	11/25/2019								
32	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	How Standards Are Scored—Look-back period	<p>Revise the last sentence to read:</p> <p>For example, for most non-file review elements, if the look-back period is 24 months and the survey date is July 10 of the current year, the organization must show evidence that requirements were met at all times, from the survey date back to any date in July two years ago.</p>	CL	11/25/2019								
34	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Must-Pass Elements and Corrective Action Plan	<p>Add the following bullet immediately above the last bullet in the “Note”:</p> <ul style="list-style-type: none"> • If an organization does not score “Met” in three or more must-pass elements, it receives Provisional Accreditation status and must undergo a Resurvey within 6-9 months to confirm completion of the CAP. <p>Note: This is a correction to the 11/25/19 update that inadvertently omitted text about Provisional Accreditation status.</p>	CO	3/30/2020								

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34	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Must-Pass Elements and Corrective Action Plan	<p>Revise the second paragraph to read:</p> <p>Note: <i>The must-pass threshold for all must-pass elements is “Met.”</i></p> <ul style="list-style-type: none"> • <i>If an organization does not score “Met” in any must-pass element:</i> <ul style="list-style-type: none"> – <i>It must submit a Corrective Action Plan (CAP) to NCQA within 30 calendar days.</i> – <i>It must undergo a CAP Review on the affected elements to confirm completion of the Corrective Action Plan.</i> – <i>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.</i> • <i>If an organization does not score “Met” in three or more UM must-pass timeliness elements (UM 5, Elements A–C and UM 9, Element B), the ROC may issue a Denied Accreditation status.</i> <p>Note: <i>Updated on 3/30/20 to reinstate text about Provisional status.</i></p>	CL	11/25/2019																
38	Policies and Procedures—Section 3: The Survey Process	About the Survey Process	<p>Add a checkmark and asterisk in the “Interim Evaluation Option” column and the “Health Plan Ratings” row and revise the asterisked note so the table reads as follows:</p> <p>Table 6: Survey component occurrences by Evaluation Option</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;">Components of Accreditation Survey</th> <th style="text-align: center;">Interim Evaluation Option</th> <th style="text-align: center;">First Evaluation Option (HEDIS/CAHPS scored)</th> <th style="text-align: center;">Renewal Evaluation Option (HEDIS/CAHPS scored)</th> </tr> </thead> <tbody> <tr> <td>Offsite Survey</td> <td style="text-align: center;">✓</td> <td style="text-align: center;">✓</td> <td style="text-align: center;">✓</td> </tr> <tr> <td>Onsite Survey</td> <td style="text-align: center;">✓</td> <td style="text-align: center;">✓</td> <td style="text-align: center;">✓</td> </tr> <tr> <td>Health Plan Ratings</td> <td style="text-align: center;">✓*</td> <td style="text-align: center;">✓</td> <td style="text-align: center;">✓</td> </tr> </tbody> </table>	Components of Accreditation Survey	Interim Evaluation Option	First Evaluation Option (HEDIS/CAHPS scored)	Renewal Evaluation Option (HEDIS/CAHPS scored)	Offsite Survey	✓	✓	✓	Onsite Survey	✓	✓	✓	Health Plan Ratings	✓*	✓	✓	CL	11/25/2019
Components of Accreditation Survey	Interim Evaluation Option	First Evaluation Option (HEDIS/CAHPS scored)	Renewal Evaluation Option (HEDIS/CAHPS scored)																		
Offsite Survey	✓	✓	✓																		
Onsite Survey	✓	✓	✓																		
Health Plan Ratings	✓*	✓	✓																		

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			*Optional for the first year for the Interim and First Evaluation Options.		
44	Policies and Procedures—Section 4: Reporting Results	Releasing information	Revise the first paragraph to read: 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
81	QI 1, Element A	Explanation—Factor 5: QI Committee oversight	Add the following under the first bullet of the factor 5 explanation: Note: <i>Participating practitioners are external to the organization and part of the organization's network.</i>	CL	11/25/2019
87	QI 1, Element D	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: <i>Participating practitioners are external to the organization and part of the organization's network.</i>	CL	11/25/2019
123	PHM 1, Element A	Scope of review—Documentation	Add the following as the last sentence: The organization may use a single document to describe a strategy that applies across all product lines if the document also describes differences in strategy to support different populations, by product line.	CL	3/30/2020
125	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

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139	PHM 3, Element A	Explanation—Factor 4: Comparative quality and cost information on selected specialties	<p>Add the following as the first sentence under the explanation for factors 4 and 5:</p> <p>Factor 4: Comparative quality and cost information on selected specialties</p> <p>The organization provides comparative quality and, if available, cost information to practitioners or providers to help them make referral decisions.</p> <p>Factor 5: Comparative pricing information for selected services</p> <p>The organization provides comparative pricing information to practitioners or providers to help them make referral decisions.</p>	CL	11/25/2019
139	PHM 3, Element A	Explanation—Factor 4: Comparative quality and cost information on selected specialties	<p>Add the following note after the third paragraph:</p> <p>Note: For this factor, “specialties” and “specialty” refers to nonprimary care (i.e., specialties other than pediatrics, internal medicine and general or family medicine).</p>	CL	11/25/2019
142	PHM 3, Element B	Scope of review—Documentation	<p>Revise the text to read:</p> <p><i>For First Surveys and Renewal Surveys:</i> NCQA reviews the VBP worksheet to demonstrate that the organization has VBP arrangements in each product line. Worksheets reflect a continuous 12-month period within the look-back period.</p>	PC	3/30/2020
143	PHM 3, Element B	Explanation	<p>Revise the third paragraph in the explanation to read:</p> <p>The organization demonstrates that it has at least one VBP arrangement by reporting the percentage of total payments made to providers and practitioners associated with each type of VBP arrangement for a continuous 12-month period within the look-back period.</p>	PC	3/30/2020
143	PHM 3, Element B	Explanation	<p>Revise the explanation under “Calculating VBP reach” to read:</p> <p>The percentage of payments is calculated by:</p> <ul style="list-style-type: none"> • Numerator: The value-based payments <i>divided by</i>, • Denominator: All payments (including fee-for-service). 	PC	3/30/2020

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			The percentage of payments reflects 12 months of payment within the look-back period and can be based on allowed amounts, actual payments or forecasted payments.		
153	PHM 5, Element C	Explanation— Assessment and evaluation	<p>Revise the section to read:</p> <p>Assessment and evaluation each require the case manager or other qualified individual to draw and document a conclusion about data or information collected. It is not sufficient to just have raw data or answers to questions. Policies describe the process to both collect information and document a summary of the meaning or implications of that data or information to the member’s situation, so that it can be used in the case management plan.</p> <p>The organization must draw a conclusion for each factor (unless otherwise stated in the explanation). This may be in separate summaries for each factor or in a combined summary, or in a combination of these.</p> <p>Complex case management policies and procedures state why an assessment might not be appropriate for a factor (e.g., life-planning activities, in pediatric cases). The organization records the specific factor and the reason in the case management system and file.</p>	CL	3/30/2020
153, 159	PHM 5, Elements C, D	Summary of Changes	<p>Revise the first bullet in the summary of changes to read:</p> <p>Added a second paragraph to the explanation of Factor 2.</p>	CL	3/30/2020
154, 161	PHM 5, Elements C, D	Explanation—Factor 2: Documentation of clinical history	<p>Add the following text as the last paragraph:</p> <p>Factor 2 does not require assessment or evaluation.</p>	CL	3/30/2020
160	PHM 5, Element D	Explanation— Assessment and evaluation	<p>Add the following as a second paragraph:</p> <p>The organization must draw a conclusion for each factor (unless otherwise stated in the explanation). This may be in separate summaries for each factor or in a combined summary, or in a combination of these.</p>	CL	3/30/2020

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164	PHM 5, Element E	Scope of review— Documentation	Revise the second sentence to read: Files are selected from active or closed cases that were identified during the look-back period and remained open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management.	CL	11/25/2019
168	PHM 6, Element A	Explanation—Factor 1: Quantitative results	Revise the second bullet under the summary of changes to read: • Clarified in the factor 1 explanation what is included in quantitative results.	CL	11/25/2019
168	PHM 6, Element A	Scope of review— Documentation	Revise the section to read: <i>For First Surveys:</i> NCQA reviews the organization’s plan for annual comprehensive analysis of its PHM strategy impact or the organization’s most recent annual comprehensive analysis of PHM strategy impact. <i>For Renewal Surveys:</i> NCQA reviews the organization’s most recent annual comprehensive analysis of PHM strategy impact.	PC	11/25/2019
169	PHM 6, Element A	Explanation— <i>Experience</i>	Revise the second paragraph to read: The organization may supplement analysis of member survey or focus group data with member complaint data.	CL	3/30/2020
171	PHM 6, Element B	Scope of review— Product lines	Revise the first sentence to read: <i>This element applies to Renewal Surveys for all product lines.</i>	PC	11/25/2019
171	PHM 6, Element B	Look-back period	Revise the text to read: <i>For Renewal Surveys:</i> At least once during the prior year.	PC	11/25/2019
183	NET 1, Element A	Look-back period	Revise the text for Renewal Surveys to read: <i>For Renewal Surveys:</i> 24 months.	CL	11/25/2019
202	NET 3, Element A	Explanation—Factor 3: Nonbehavioral requests for and utilization of out-of-network services	Add the following as the last sentence of the first paragraph: The organization reports data per thousand members at the product-line level.	CL	3/30/2020

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204	NET 3, Element B	Factor 1	Revise the factor language to read: Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements A, B and C), accessibility (NET 2, Elements A and C) and member experience accessing the network (NET 3, Element A, factors 1 and 3).	CO	11/25/2019						
205	NET 3, Element C	Factor 1	Revise the factor language to read: Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements A and D), accessibility (NET 2, Element B) and member experience accessing the network (NET 3, Element A, factors 2 and 4).	CO	11/25/2019						
229	NET 6, Element B	Look-back period	Revise the look-back period for Renewal Surveys to read: 12 months.	CL	3/30/2020						
231	NET 6, Element C	Scope of review—Documentation	Remove the second paragraph, which reads: For Interim Surveys, NCQA reviews the organization's evaluation of the delegate's network management procedures (factor 1).	CL	3/30/2020						
231	NET 6, Element C	Exceptions	Remove the last paragraph that reads: Factors 2 and 3 are NA for Interim Surveys.	CL	3/30/2020						
241	UM 1, Element A	Explanation—File review universe	Add the following as the last paragraph: <i>Organization employees and their dependents:</i> The organization may exclude employees and their dependents from the denial and appeal file universe.	CL	11/25/2019						
250	UM 3, Element A	Scoring	Revise the scoring set up in the IRT Standards and Guidelines to reflect the hardcopy publication so that it reads: <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th style="text-align: center;">Met</th> <th style="text-align: center;">Partially Met</th> <th style="text-align: center;">Not Met</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">The organization meets 4-5 factors</td> <td style="text-align: center;">The organization meets 3 factors</td> <td style="text-align: center;">The organization meets 0-2 factors</td> </tr> </tbody> </table>	Met	Partially Met	Not Met	The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 0-2 factors	CO	11/25/2019
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			<i>Note: This issue is specific to the standards and guidelines in the IRT. The language is correct in the printed and electronic publications.</i>		
265, 271, 277, 284	UM 5, Elements A-C, E	Related information	<p>Revise the bullets under <i>Factor 1: Urgent concurrent requests for commercial and Exchange product lines</i> to read:</p> <ul style="list-style-type: none"> • 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. • The organization may extend the decision notification time frame if the request to approve additional days for urgent concurrent care is related to care not previously approved by the organization and the organization documents that it made at least one attempt and was unable to obtain the needed clinical information within the initial 24 hours after the request for coverage of additional days. In this case, the organization has up to 72 hours to make the decision. 	CL	3/30/2020
265, 271, 277, 285	UM 5, Elements A-C, E	Related information	<p>Revise the second bullet under the <i>factors 2, 3</i> subhead in Elements A, B, E and the <i>factors 1, 2</i> subhead in Element C to read:</p> <ul style="list-style-type: none"> • The organization may extend the time frame by up to 14 calendar days if it needs additional information and notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension. 	CL	3/30/2020
277, 278	UM 5, Element C	Related information	<p>Revise the subheads under <i>Extension conditions</i> to read as follows:</p> <p>Replace the subhead that reads "Factors 2, 3: Urgent concurrent and urgent preservice requests for Medicare and Medicaid product lines" with "Factors 1, 2: Urgent concurrent and urgent preservice requests for Medicare and Medicaid product lines."</p> <p>Replace the subhead that reads "Factor 3: Urgent preservice requests" with "Factor 2: Urgent preservice requests for commercial and Exchange product lines."</p>	CL	3/3/2020

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			Replace the subhead that reads “Factors 4, 5: Nonurgent preservice and postservice requests” with “Factors 3, 4: Nonurgent preservice and postservice requests.”		
299, 306, 313	UM 7, Elements C, F, I	Explanation—Factor 2: Right to representation and appeal time frames	<p>Revise the second bullet to read:</p> <ul style="list-style-type: none"> • Provides contact information for the state Office of Health Insurance Consumer Assistance or ombudsman, if applicable. <p>Note: <i>This is not required for members covered by the Federal Employee Health Benefits (FEHB) program.</i></p>	CL	11/25/2019
319	UM 8, Element A	Explanation	<p>Revise the text that follows <i>Medicare appeals for factors 7–13</i> to read:</p> <p>The organization’s policies and procedures describe its process for sending an upheld denial to MAXIMUS.</p>	CL	3/30/2020
320, 325	UM 8, Element A UM 9, Element B	Related information— Verbal notification	<p>Revise the third paragraph regarding Medicaid appeals to read:</p> <p>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.</p>	CL	3/30/2020
324	UM 9, Element B	Explanation—Factors 1-3: Timeliness of appeal process	<p>Revise the third paragraph to read:</p> <p>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.</p>	CL	3/30/2020
328	UM 9, Element D	Explanation—Factor 1: The appeal decision	<p>Add the following text as the last paragraph:</p> <p>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</p>	CL	3/30/2020

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			decision must address whether or not the requested service can be obtained within the organization’s accessibility standards).								
343	UM 11, Element E	Scoring	Revise the “Not Met” scoring to read: <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th style="text-align: center;">Met</th> <th style="text-align: center;">Partially Met</th> <th style="text-align: center;">Not Met</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">The organization meets 4-5 factors</td> <td style="text-align: center;">The organization meets 3 factors</td> <td style="text-align: center;">The organization meets 0-2 factors</td> </tr> </tbody> </table>	Met	Partially Met	Not Met	The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 0-2 factors	CO	11/25/2019
Met	Partially Met	Not Met									
The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 0-2 factors									
346, 348	UM 12, Elements A and B	Factor 6: Securing System Data	Add the following as the first two sentences: This factor applies to all UM system data. It is not limited to the dates specified in factors 1-5.	CL	11/25/2019						
347	UM 12, Element B	Scope of review—Documentation	Add the following text as the second sentence: If the organization outsources storage of UM information to an external entity, NCQA also reviews the contract between the organization and the external entity.	CL	3/30/2020						
348	UM 12, Element B	Explanation—Factor 6: Securing system data	Revise the last paragraph to read: If the organization contracts with an external entity to outsource storage of UM data, the contract describes how the contracted entity ensures the security of the data.	CL	3/30/2020						
365	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	3/30/2020						
375	CR 3, Element A	Look-back period	Add the following as the last paragraph: <i>For all surveys:</i> For credentialing files where verification of DEA or CDS is before June 1, 2020, and a practitioner who is DEA- or CDS- eligible does not have a DEA or CDS certificate, NCQA accepts either the verification process required in the 2020 standards or the applicable prior year’s standards, which state, “If a qualified practitioner does not have a valid DEA	PC	11/25/2019						

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			or CDS certificate, the organization notes this in the credentialing file and arranges for another practitioner to fill prescriptions.”		
376	CR 3, Element A	DEA- and CDS- eligible practitioners who do not have a certificate	<p>Revise the text to read:</p> <p>The organization verifies that all DEA- and CDS-eligible practitioners who do not have a valid DEA/CDS certificate, and for whom prescribing controlled substance is in the scope of their practice, have in place a designated practitioner to write prescriptions on their behalf. The organization documents the practitioner’s lack of DEA/CDS certificate in the credentialing file and obtains the name of a designated alternate prescriber from the practitioner. If the alternate prescriber is a practice rather than an individual, the file may include the practice name. The organization is not required to arrange an alternate prescriber.</p> <p>If the practitioner states in writing that they do not prescribe controlled substances and that in their professional judgment, the patients receiving their care do not require controlled substances, they are therefore not required to have a DEA/CDS certificate, but must describe their process for handling instances when a patient requires a controlled substance. The organization includes the practitioner’s statement and process description in the credentialing file.</p>	CL	11/25/2019
379	CR 3, Element A	Examples	<p>Replace “None.” with the following:</p> <p>DEA- and CDS-eligible practitioners who do not have a certificate</p> <p><i>Practitioner’s statement.</i> I do not prescribe controlled substances for my patients. If I determine that a patient may require a controlled substance, I refer the patient to their PCP or to another practitioner for evaluation and management.</p>	CL	11/25/2019
393	CR 7, Element A	Explanation—Factor 2: Confirmation of review and approval by an accrediting body	<p>Revise the third bullet to read:</p> <ul style="list-style-type: none"> • Copies of credentials (e.g., accreditation report, certificate or decision letter) from the provider. 	CL	11/25/2019
413	ME 2, Element A	Look-back period	<p>Revise the text following “For Renewal Surveys:” to read:</p> <p>At least once during the prior year for factor 15; 24 months for all other factors.</p>	CL	3/30/2020

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434	ME 5, Element D	Explanation— Exceptions	Remove the first paragraph, which reads: This element is NA for Renewal Surveys for the commercial, Medicare, Medicaid and Exchange product lines.	CL	11/25/2019
443	ME 7, Element A	Explanation	Revise the second paragraph of the explanation to read: This element applies to all complaints that do not become requests for coverage or requests to overturn a decision.	CL	11/25/2019
449	ME 7, Element D	Explanation	Add the following as the first paragraph: This element may not be delegated.	CL	3/30/2020
472, 476	LTSS 1, Elements B, C	Explanation— Assessment	Revise the section to read: Assessment requires the case manager or other qualified individual to reach and document a conclusion about data or information collected. It is not sufficient to just have raw data or answers to questions. Policies describe the process to both collect information and document a summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan. The organization must reach a conclusion for each factor (unless otherwise stated in the explanation). This may be in separate summaries for each factor or in a combined summary, or in a combination of these. Case management policies and procedures state why an assessment might not be appropriate for a factor (e.g., life-planning activities, in pediatric cases). The organization records the specific factor and the reason in the case management system and file.	CL	3/30/2020
472, 481	LTSS 1, Elements B, D	Explanation—Factor 2: Documentation of clinical history	Add the following as the last paragraph: Factor 2 does not require assessment or evaluation.	CL	3/30/2020
479, 491	LTSS 1, Elements D, G	Scope of review— Documentation	Revise the section to read: NCQA reviews assessments in a random sample of up to 40 case management files. Files are selected from active or closed cases that were identified during the look-back period and remained open for at least 60	CL	11/25/2019

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			calendar days during the look-back period, from the date when the member was identified for case management. The organization must provide the identification date for each case in the file universe		
479, 491	LTSS 1, Elements D, G	Explanation—HEDIS LTSS measures	Revise the first sentence to read: Organizations may submit performance results on the Comprehensive Assessment and Update (LTSS-CAU) measure instead of completing the file review.	CL	11/25/2019
480	LTSS 1, Element D	Explanation—Assessment	Add the following as the third paragraph: The organization must reach a conclusion for each factor (unless otherwise stated in the explanation). This may be in separate summaries for each factor or in a combined summary, or in a combination of these.	CL	3/30/2020
491	LTSS 1, Element G	Explanation—Assessment	Add the following as the second paragraph: The organization must reach a conclusion for each factor (unless otherwise stated in the explanation). This may be in separate summaries for each factor or in a combined summary, or in a combination of these.	CL	3/30/2020
493	LTSS 1, Element G	Explanation—Factor 12: Documentation of services received	Revise the text to read: The file or case record documents whether the individual received the services specified in the case management plan.	PC	3/30/2020
497	LTSS 1, Element I	Explanation—Factors 2, 3: Background checks and additional screening tool	Add the following as the last sentence of the first paragraph: NCQA does not consider it delegation if the organization uses another entity to conduct background checks.	PC	3/30/2020

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1-1– 1-11	Appendix 1		Replace the points under “Partially Met” with “NA” as follows: <i>For QI</i> <ul style="list-style-type: none"> • 1B, 5C, under Interim Survey, First Survey and Renewal Survey • 1C, 3D under First Survey and Renewal Survey <i>For PHM</i> <ul style="list-style-type: none"> • 1B, 2D, 3A under Interim Survey, First Survey and Renewal Survey • 3B under First Survey and Renewal Survey • 4A under First Survey <i>For NET</i> <ul style="list-style-type: none"> • 4A, 5B, 5D, 5G under First Survey and Renewal Survey <i>For UM</i> <ul style="list-style-type: none"> • 12A, 12B under Interim Survey, First Survey and Renewal Survey • 1B, 9F under First Survey and Renewal Survey <i>For CR</i> <ul style="list-style-type: none"> • 1B, 1C, 2A under Interim Survey, First Survey and Renewal Survey • 7D, 7E under First Survey and Renewal Survey <i>For ME</i> <ul style="list-style-type: none"> • 1A, 2B under Interim Survey, First Survey and Renewal Survey • 5D, 7C under First Survey and Renewal Survey <i>For LTSS</i> <ul style="list-style-type: none"> • 2F 	CO	11/25/2019

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2-13 2-20	Appendix 2	<p>Table 2: Automatic credit by Evaluation Option for delegating to an NCQA-Accredited health plan</p> <p>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</p>	<p>Replace “NA” with “Y” for UM 5, Element D as follows:</p> <ul style="list-style-type: none"> Under the Renewal Survey column in Table 2. <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 5%;"></th> <th style="width: 45%;"></th> <th style="width: 15%;">Interim</th> <th style="width: 15%;">First</th> <th style="width: 20%;">Renewal</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">D</td> <td>UM Timeliness Report¹⁵</td> <td style="text-align: center;">NA</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> </tr> </tbody> </table> <ul style="list-style-type: none"> Under Accredited MBHO and Accredited UM-CR-PN columns in Table 3. <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2" style="width: 5%;"></th> <th rowspan="2" style="width: 15%;"></th> <th colspan="3" style="text-align: center;">Accredited MBHO</th> <th colspan="3" style="text-align: center;">Accredited in UM, CR or PN</th> </tr> <tr> <th style="width: 10%;">Interim</th> <th style="width: 10%;">First</th> <th style="width: 10%;">Renewal</th> <th style="width: 10%;">Interim</th> <th style="width: 10%;">First</th> <th style="width: 10%;">Renewal</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">D</td> <td>UM Timeliness Report²⁶</td> <td style="text-align: center;">NA</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">NA</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> </tr> </tbody> </table>			Interim	First	Renewal	D	UM Timeliness Report ¹⁵	NA	Y	Y			Accredited MBHO			Accredited in UM, CR or PN			Interim	First	Renewal	Interim	First	Renewal	D	UM Timeliness Report ²⁶	NA	Y	Y	NA	Y	Y	CO	11/25/2019
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		Interim	First	Renewal	Interim	First	Renewal																														
D	UM Timeliness Report ²⁶	NA	Y	Y	NA	Y	Y																														
2-23	Appendix 2	Automatic Credit for Delegating to an NCQA-Prevalidated Vendor for Health IT Solution	<p>Replace the first paragraph with the following text:</p> <p>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 Eligibility for documentation. The organization is responsible for providing documentation that states the name and the version of the health IT solution the organization is using and the date when it was licensed or implemented by the organization. Documentation may include a contract, agreement, purchase order or other document that states the name and version of the health IT solution and the date when it was licensed or implemented.</p>	CL	3/30/2020																																
6-2	Appendix 6	Section 2: Accreditation Scoring and Status Requirements	<p>Remove the third subbullet under the third bullet that reads:</p> <p>— An organization that does not score “Met” on three or more must-pass elements could undergo a Resurvey at the Review Oversight Committee’s (ROC) discretion.</p>	CO	3/30/2020																																

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6-11	Appendix 6	Other Modifications and Revisions for 2020 by Standard Category and Element	Revise the first bullet of the PHM 5, Elements C, D summary of changes to read: <ul style="list-style-type: none"> • Added a second paragraph to the explanation of Factor 2. 	CL	3/30/2020
7-10	Appendix 7	MEMBER EXPERIENCE—ME 1: Statement of Members' Rights and Responsibilities	For row ME 1, Element A: Rights and Responsibilities Statement, delete the check mark (✓) from the Renewal column under Commercial, Medicare and Exchange.	CL	11/25/2019