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

March 31, 2025

This document includes the corrections, clarifications and policy changes to the 2020 Case Management standards and guidelines. NCQA has identified the appropriate page number in the publication and the standard/element head and 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.
- A ***regulatory change (RC)*** is a new requirement or a modification of an existing requirement to align with federal regulations.

An organization undergoing a survey under the 2020 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
26	Policies and Procedures—Section 2: The Accreditation Process	Responsible Use of Artificial Intelligence	Revise the "Responsible Use of Artificial Intelligence" text to read: NCQA supports the use of technological advancements that improve the quality and equity of health care operations and delivery. Artificial intelligence may be useful in this regard, but there are risks to consider and mitigate. Many AI frameworks have been established to address these risks. NCQA expects organizations that use AI to implement a framework and policies that are fair and equitable to members. Although NCQA does not mandate use of a specific AI framework, the NIST AI Risk Management Framework may be helpful. The Coalition for Health AI is also a useful resource. NCQA may consider use of AI in determining Accreditation/Certification status, even though current NCQA standards do not specifically address AI. For example, with regard to utilization management, NCQA standards require appropriately licensed professionals (not AI) to make medical necessity denial decisions. Other activities that require human decision making, and where AI is used, may be an area for NCQA to consider.	**CL**	**3/31/25**
105	CM 7, Element E	Explanation—Licensure	Replace the last paragraph in the *Licensure* subsection in the explanation to read: The organization must verify clinical staff licenses in all states where clinical staff provide services to patients.	**CL**	**3/31/25**

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March 31, 2025

Page	Standard/Element	Head/Subhead	Update	Type of Update	IRT Release Date
PREVIOUSLY POSTED UPDATES					
11	Policies and Procedures —Section 1: Eligibility and the Application Process	Eligibility for Accreditation— Eligibility for international organizations	Revise the second paragraph to read: NCQA limits evaluation to organizations that operate in and outside the United States, and limits award of NCQA status to an organization's U.S. operations. Organizations that do not operate in the United States (i.e., conduct no activities in the U.S., including in states and territories; conduct no operations for U.S. members and clients) or have no members, patients or clients in the United States are not eligible for NCQA Case Management Accreditation. NCQA does not evaluate operations of organizations that do not operate in the United States, or that do not have U.S. members, patients or clients.	**CL**	**3/25/24**
11	Policies and Procedures —Section 1: Eligibility and the Application Process	Eligibility for Accreditation	Add the following as the fourth bullet: • Does not delegate more than 50 percent of CM functions to another entity to perform on its behalf. – If the organization provides nonbehavioral health and behavioral health CM functions, it may delegate up to 100 percent of behavioral health CM functions to another entity to perform on its behalf. ***Note:*** *If the organization only performs behavioral health CM functions, it may not delegate more than 50 percent of its CM functions to another entity to perform on its behalf.*	**PC**	**11/22/21**
11	Policies and Procedures —Section 1: Eligibility and the Application Process	Eligibility for Accreditation	Add the following new subhead and text at the end of "Eligibility for Accreditation." **Eligibility for international organizations** NCQA standards evaluate performance of U.S. health care organizations and their U.S. operations only. Organizations that apply for and participate in an NCQA Survey must agree to comply with all applicable U.S. federal, state and other applicable laws, and must agree that the use of NCQA products and services shall for all purposes be governed, interpreted, construed and enforced solely and exclusively in accordance with U.S. laws and regulations, without regard to conflicts of law provisions thereof. NCQA limits evaluation to organizations that operate in and outside the United States, and limits award of NCQA status to an organization's U.S. operations. Organizations that do not operate in the United States (i.e., conduct all activities in the U.S., including in states and territories; conduct operations for U.S. members and clients) or have members, patients or clients in the United States are not eligible for NCQA Case Management Accreditation. NCQA does not evaluate operations of organizations that	**CL**	**11/14/22**

Page	Standard/Element	Head/Subhead	Update	Type of Update	IRT Release Date
PREVIOUSLY POSTED UPDATES					
			do not operate in the United States, or that do not have U.S. members, patients or clients. When determining eligibility of an organization with both U.S. and foreign operations, NCQA applies the following criteria: 1. The applicant organization must be the accountable (responsible) entity for performing NCQA-reviewed functions, and must describe how it meets NCQA's definition of an accreditable, certifiable or eligible entity. A parent, holding or shell company may not be eligible to apply. 2. The applicant organization must be a U.S. company, or be owned by a U.S. company, and provide services in the United States. An applicant organization that is not a U.S. company, but is owned by a U.S. company, must be domiciled in the United States by holding a business license or registration in at least one U.S. state or territory. The organization must submit evidence to reflect incorporation, registration or licensure to satisfy this criterion. 3. To be listed on NCQA's public report card, the applicant organization must have a United States address for a facility, business office or administrative location. NCQA does not allow organizations to list an address of a personal residence or U.S. statutory agent unless the organization conducts NCQA-reviewed functions from the address. 4. If any function to be reviewed is performed outside the United States, the organization must have the capability to complete the onsite survey (and/or any tour) virtually, and to present all required files electronically. Because NCQA does not travel outside the country for onsite reviews, the applicant organization must coordinate a virtual review to satisfy onsite requirements, which may include staff interviews or site tours, as described in NCQA standards. All virtual reviews must be conducted in English or with English translations for the NCQA survey team. 5. The applicant organization must meet all other eligibility criteria specified in the preceding section. Any organization with U.S. and foreign operations that meets the criteria above may apply for an NCQA Survey, and may include functions performed outside the United States in its NCQA Survey.		

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
13	Policies and Procedures —Section 1: Eligibility and the Application Process	Organization Obligations	Add the following as the fourth bullet: • Bring through the entire population for any program included in the survey.	**CL**	**7/27/20**
17	Policies and Procedures —Section 2: The Accreditation Process	Option to decline Accreditation status	Revise section head “Option to decline Accreditation status” to “Option to decline Accreditation status (applicable only to Introductory Initial Survey Evaluation Option); revised the text to read: Organizations surveyed under the Introductory Initial Survey Evaluation Option may select one of the following options: 1. Accept the resulting Accreditation status. 2. Decline the resulting Accreditation status (without penalty and undergo an Introductory Follow-Up Survey within 12 months of receipt of the final survey report). • An organization that declines Accreditation status under the Introductory Initial Survey Evaluation Option may accept the scores for specific elements that received a score of 80% or 100% and apply them toward an Introductory Follow-Up Accreditation Survey on the remaining elements within 12 months of receipt of the final survey report. If an organization has reason to believe that the scoring of any standard does not accurately reflect its survey performance, the organization may request Reconsideration. If the organization decides to request Reconsideration, it must do so before sending notice to NCQA of a decision to decline its status. Refer to *Reconsideration.* The organization may accept or decline the resulting Reconsideration status decision. If the organization decides to decline the status, it must undergo an Introductory Follow-Up Survey within 12 months. Organizations have 30 calendar days from receipt of the results to reply to NCQA with their decision to accept, decline or request Reconsideration of the resulting status.	**CL**	**7/29/24**
17	Policies and Procedures —Section 2: The Accreditation Process	Introductory Follow-Up Survey	Replace “effective date” with "expiration date" in the second paragraph to read: The expiration date of the Accreditation status is the same date specified in the Introductory Initial Survey decision that precipitated the Follow-Up Survey.	**CL**	**7/29/24**
18	Policies and Procedures —Section 2: The Accreditation Process	Add-On Survey	Replace “effective date” with “expiration date” in the last paragraph to read: The expiration date of the Accreditation status is the date specified for the current Accreditation status.	**CL**	**7/29/24**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
18	Policies and Procedures—Section 2: The Accreditation Process	Corrective Action	Replace the text with the following: In certain circumstances, NCQA may require corrective action and submission of a corrective action plan (CAP) by the organization. Corrective actions are steps taken to improve performance when an organization does not meet specific NCQA Accreditation requirements. Failure to timely comply with requested corrective action may result in a lower score or reduction or loss of Accreditation status. A CAP is considered complete when NCQA notifies the organization that all identified deficiencies are resolved and corrective actions have been implemented. If the CAP is not completed within the agreed-on time frame, the organization must notify NCQA of the reason. The ROC determines completion of the CAP. If the CAP is considered incomplete, the ROC may extend the CAP, reduce the organization's status or issue a Denied Accreditation status as specified below.	**CL**	**11/23/20**
20	Policies and Procedures—Section 2: The Accreditation Process	Corrective Action	Revise the first paragraph to read: In certain circumstances, NCQA may require the organization to take corrective actions and submit a CAP. **Corrective actions** are steps taken to improve performance when specific NCQA Accreditation requirements are not met. Corrective action requests are not specific to failed must-pass elements, which are also addressed during the CAP Survey process. Specific to interrater reliability (IRR) issues during the survey process, if an organization is found to be noncompliant during its survey, and the issue was not identified during a previous survey where the same requirement was reviewed and evaluated with evidence provided by the organization that was the same as or similar to the evidence provided previously, NCQA may require the organization to submit a corrective action plan addressing the noncompliant requirement. In most cases, this will not adversely impact the organization's Accreditation status. Failure to timely comply with requested corrective action requests may result in a lower score, or reduction or loss of Accreditation status. Refer to *Interrater Reliability* in	**CL**	**3/27/23**
			Section 5: Additional Information for the definition and information about interrater reliability.		
21	Policies and Procedures—Section 2: The Accreditation Process	A Standard's Structure—Look-back period	Add the following text as the last paragraph: The look-back period for a new program does not precede its implementation date.	**CL**	**3/30/20**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
22	Policies and Procedures —Section 2	A Standard's Structure—Look-back period	Add the following subhead and text immediately below ***Meeting the look-back period for records or files***: ***Expanding the look-back period for records and files*** For Renewal Surveys, if the organization has fewer than 40 files when it submits its completed survey tool, NCQA expands the look-back period in 6-month increments to allow more files to be included in the file universe. (This extension is optional for Initial Surveys.) The extension does not go past the date when the organization completed its last survey. • If the extension yields a file universe of fewer than 8 files, all files are reviewed, results are documented in the survey tool as a comment or issue and file review elements are scored NA. • If the extension yields a file universe of at least 8 files but fewer than 40, the normal 8/30 file review process applies. • If the extension yields a file universe of fewer than 30 files and the first 8 files do not meet the requirements, all files are reviewed. File review element scores are scored based on file review results.	**CL**	**3/29/21**
23	Policies and Procedures —Section 2: The Accreditation Process	Expanding the look-back period for records and files	Revise the bullets under "Expanding the look-back period for records and files" to read: • If the extension yields a file universe of at least 30 files but fewer than 40, the file review process of reviewing a minimum of 30 files applies. Refer to "File Review Universe" in Section 3 of the Policies and Procedures below. • If the extension yields a file universe of fewer than 8 files, all files are reviewed, results are documented in the survey tool as a comment or issue and file review elements are scored NA.	**PC**	**11/22/21**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
26	Policies and Procedures —Section 2: The Accreditation Process	Other Information NCQA May Consider	Add the following new section head and text between "Other Information NCQA May Consider" and "Notification to Regulatory Agencies." **Responsible Use of Artificial Intelligence** NCQA supports the use of technological advancements that improve the quality and equity of health care operations and delivery. Artificial intelligence may be useful in this regard, but there are risks to consider and mitigate. Many AI frameworks have been established to address these risks. The White House also issued an executive order with broad guiding principles, and specific health care industry roles, for the Department of Health and Human Services. NCQA expects organizations that use AI to implement a framework and policies that are fair and equitable to members. Although NCQA does not mandate use of a specific AI framework, the NIST AI Risk Management Framework, a key reference in the executive order, may be helpful. The Coalition for Health AI is also a useful resource. NCQA may consider use of AI in determining Accreditation/Certification status, even though current NCQA standards do not specifically address AI. For example, with regard to utilization management, NCQA standards require appropriately licensed professionals (not AI) to make medical necessity denial decisions. Other activities that require human decision making, and where AI is used, may be an area for NCQA to consider.	**CL**	**7/29/24**
29	Policies and Procedures — Section 2: The Accreditation Process	Offsite survey	Revise the section to read: The organization must submit a complete survey tool (including self-assessed scores and supporting evidence) to NCQA on the scheduled survey start date (submission date). The survey team conducts an initial review of all information and evidence submitted, and documents findings and questions in the survey tool. During a survey conference call with the survey team, the organization has the opportunity to address surveyor questions and initial findings. The organization may also submit additional supporting evidence, if needed to resolve outstanding issues. Any additional supporting evidence must be submitted by the due date for submitting responses to the survey team's outstanding questions and initial findings. The organization may not introduce new evidence after this point in the survey process.	**CL**	**7/29/24**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
			The organization should not attach documents to the survey tool that contain protected health information (PHI) or other personal identifiable information (PII), as defined by the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations. If original documentation contains PHI or PII, the organization must de-identify the information prior to submission. All documentation provided to NCQA during the survey process must be in English, or with English translation.		
29	Policies and Procedures — Section 2: The Accreditation Process	Documents dated after submission	Revise the section to read: The organization may only submit information that existed at the time of the original survey submission; it may not introduce information that did not exist at the time of the original survey submission. Evidence submitted in response to the survey team's initial questions and findings must have existed at survey submission. The organization may not alter or update evidence to address an issue, but may bookmark or highlight this information.	**CL**	**7/29/24**
29	Policies and Procedures — Section 2: The Accreditation Process	Onsite survey	Revise the section to read: The onsite review date is usually scheduled for 7 weeks after submission of the survey tool. The onsite review is primarily a file review, but might also require review of additional information, staff interviews or system queries. The onsite survey can be conducted either in person or virtually, depending on the organization's preferences and ability to present files electronically. The onsite review must be conducted in English, and all records or files that are part of the review must be provided in English, or with English translation.	**CL**	**7/29/24**
29	Policies and Procedures —Section 3: The Survey Process	File Review Results	Add the following section before "File Review Results": **File review universe** For surveys starting July 1, 2022, NCQA will review a minimum of 30 files. The organization submits a random selection of 40 files (30 file sample + 10 oversample). If an organization has fewer than 30 files, an expansion to the look-back period may be warranted. Refer to the "Expanding the look-back period for records and files" section above for more information.	**PC**	**11/22/21**
29	Policies and Procedures —Section 3: The Survey Process	File review universe	Revise the second sentence to read: The organization submits a full universe of its files, and NCQA randomly selects 40 files (a 30-file sample and a 10-file oversample).	**CL**	**11/14/22**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
30	Policies and Procedures —Section 3: The Survey Process	Comments about errors or omissions	Revise the section to read: NCQA gives the organization access to preliminary survey results in the IRT for review and comment. The organization has 10 calendar days to submit comments regarding factual errors or omissions before the survey report is sent to the Review Oversight Committee (ROC) for the final status decision. The organization comment process is not an opportunity to introduce new supporting evidence that was not included in the survey submission or provided in response to initial survey team issues. NCQA only considers comments and supporting evidence that are related to factual errors or omissions in the preliminary report and based on information and evidence presented during the survey.	**CL**	**7/29/24**
31	Policies and Procedures —Section 3: The Survey Process	Survey process results	Revise the first and second paragraphs to read: Preliminary results received or generated for a survey readiness evaluation are preliminary and do not constitute a final score for NCQA Accreditation/ Certification. NCQA notifies the organization when the ROC determines the organization's Accreditation/Certification status. The organization may only use results from the readiness evaluation for internal business purposes (to examine, review and otherwise analyze its business operations), and may not use, disclose, represent or otherwise communicate these results to any third party for any other purpose. The ROC reviews the preliminary results with all relevant information to determine Accreditation/ Certification. NCQA does not allow release of preliminary results to third parties as representative of survey results or findings presented in the final report. The organization may not use reports or numeric results to represent that it is NCQA Accredited/Certified without a final NCQA Accreditation/Certification decision, as described above.	**CL**	**11/18/24**
32	Policies and Procedures —Section 3: The Survey Process	Materials not accepted during Reconsideration	Revise the section to read: To protect the integrity of the Accreditation process, NCQA does not accept materials during Reconsideration that did not exist at the time of the original completed survey tool submission. The organization may not submit—and the Reconsideration Committee	**CL**	**7/29/24**
			does not consider—documentation that represents actions taken by the organization after it submitted the survey tool. The organization may not introduce new or additional supporting evidence that was not available during the survey (i.e., with original submission of evidence, or in response to the survey team's questions and initial findings).		

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
37	Policies and Procedures—Section 5: Additional Information	Notifying NCQA of Reportable Events	Add the following as a new third bullet: • Self-identification of systemic issues affecting 5% or more of eligible case management files.	**CL**	**7/25/22**
37	Policies and Procedures—Section 5: Additional Information	Notifying NCQA of Reportable Events	Add the following as a new second and third paragraph: Reporting obligations are effective upon issuance of the notice of sanctions, issuance of a fine or request for corrective action, or self-identification of issues. The notification requirement is not paused as a result of any appeal or negotiations with the applicable regulatory authority. All Reportable Events must be submitted through My NCQA (https://my.ncqa.org).	**CL**	**7/25/22**
37	Policies and Procedures—Section 5: Additional Information	Notifying NCQA of Reportable Events—Annual Attestation of Compliance With Reportable Events	Revise the information in this section to read: On an annual basis, the organization must also complete an attestation signed by an officer or other authorized signatory of the organization affirming that it has notified NCQA of all Reportable Events specified within NCQA policies and procedures. Failure to comply with Reportable Events submission or annual attestation requirements may result in suspension or revocation of Accreditation status. Annually, NCQA will send an email reminder to the designated Accreditation contact to complete the annual attestation on My NCQA (https://my.ncqa.org). The attestation must be completed within 30 days of the email notification.	**CL**	**7/25/22**
38	Policies and Procedures—Section 5: Additional Information		Add the following new section head and text between "Notifying NCQA of Reportable Events" and "Discretionary Survey." **Interrater Reliability** NCQA strives for consistency in the Accreditation/Certification process and across all surveys.	**CL**	**7/25/22**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
			NCQA defines "interrater reliability" (IRR) as the extent to which two or more independent surveyors produce similar results when assessing whether the same requirement is met—the level of confidence that similarly trained individuals would be likely to produce similar scores on the same standards for the same product when the same evidence is evaluated. To support consistency, NCQA will continue to clarify standards and educate surveyors. Organizations preparing for survey should also review all applicable standards, including changes between standards years and related NCQA corrections, clarifications, and policy changes, as well as FAQs, focusing on the standards' intent, scored elements and factors, explanations, and type of evidence (data sources) required to demonstrate that a requirement is met. **Reporting IRR Issues to NCQA** Report suspected IRR issues to NCQA during the following survey stages: • When the organization responds to initial issues (following the conference call with the surveyor and ASC). • During the organization review and comment stage (during the post-survey review process). • During a Reconsideration (after the survey is completed). Issues may be reported in the survey tool (IRT) or by submitting a case to My NCQA (https://my.ncqa.org). To protect the integrity of the Accreditation process, NCQA does not accept materials in an IRR report that did not exist at the time of the original completed survey tool submission. As a reminder, file review results may not be disputed or appealed once the onsite survey is complete, whether completed in-person or virtually. If you suspect an IRR issue related to a file review element, the issue should be reported during the onsite survey. NCQA performs an expedited review of reported IRR concerns on non-file review elements to ensure timely and accurate Accreditation/ Certification decisions. Based on review of a potential issue, NCQA may:		

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
			1. *If NCQA's scoring was inconsistent for non-file review elements,* issue a one-time exception for scoring of the standard, and require a Corrective Action Plan (CAP). NCQA reserves the right to determine if scoring was inconsistent. 2. *If no inconsistency is found,* maintain the standard score. NCQA analyzes IRR information to identify opportunities to clarify requirements or enhance surveyor education.		
41	Policies and Procedures —Section 5: Additional Information	Suspending Accreditation	Revise the first sentence under the "Grounds for immediate suspension" subhead to read: Grounds for recommending suspension of status include, but are not limited to:	**CL**	**7/25/22**
41	Policies and Procedures —Section 5: Additional Information	Suspending Accreditation	Add the following as a new sixth bullet under the "Grounds for immediate suspension" subhead: • Failure to comply with Reportable Events submission or annual attestation completion requirements.	**CL**	**7/25/22**
41	Policies and Procedures —Section 5: Additional Information	Revoking Accreditation	Revise the sixth bullet under "Grounds for revocation" to read: • The organization violates other published NCQA policies, including failure to submit Reportable Events or completion of annual attestation.	**CL**	**7/25/22**
37	Policies and Procedures —Section 5: Additional Information	Mergers and Acquisitions	Revise the email address in the third paragraph to read: SIG@ncqa.org	**CO**	**3/28/22**
46	Policies and Procedures — Section 6: Long-Term Services and Supports Distinction	Offsite survey	Revise the section to read: The organization must submit a complete survey tool (including self-assessed scores and supporting evidence) to NCQA on the scheduled survey start date (submission date). The survey team conducts an initial review of all information and evidence submitted, and documents findings and questions in the survey tool. During a survey conference call with the survey team, the organization has the opportunity to address surveyor questions and initial findings. The organization may also submit additional supporting evidence, if needed to resolve outstanding issues. Any additional supporting evidence	**CL**	**7/29/24**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
			must be submitted by the due date for submitting responses to the survey team's outstanding questions and initial findings. The organization may not introduce new evidence after this point in the survey process. The organization should not attach documents to the survey tool that contain protected health information (PHI) or other personal identifiable information (PII), as defined by the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations. If original documentation contains PHI or PII, the organization must de-identify the information prior to submission. Refer to "de-identify" in *Appendix 4: Glossary.* All documentation provided to NCQA during the survey process must be in English, or with English translation.		
46	Policies and Procedures — Section 6: Long-Term Services and Supports Distinction	Onsite survey	Revise the section to read: The onsite review date is usually scheduled for 7 weeks after submission of the survey tool. The onsite review is primarily a file review, but might also require review of additional information, staff interviews or system queries. The onsite survey can be conducted either in person or virtually, depending on the organization's preferences and ability to present files electronically. The onsite review must be conducted in English, and all records or files that are part of the review must be provided in English, or with English translation.	**CL**	**7/29/24**
47	Policies and Procedures —Section 6: Long-Term Services and Supports Distinction	Documents dated after submission	Revise the section to read: The organization may only submit information that existed at the time of the original survey submission; it may not introduce information that did not exist at the time of the original survey submission. Evidence submitted in response to the survey team's initial questions and findings must have existed at survey submission. The organization may not alter or update evidence to address an issue, but may bookmark or highlight this information.	**CL**	**7/29/24**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
49	CM 1, Element B	Explanation—Factor 1: Evidence used to develop the program	Remove the second paragraph under this section, which reads: If the organization's program is based on evidence set by the state or other purchaser, it is not required to ensure that the state or purchaser has reviewed the evidence. In these situations, the organization validates that its operations are current with the state or purchaser requirements.	**CL**	**3/29/21**
49	CM 1, Element B	Explanation—Exceptions	Add a third bullet to the Exceptions that reads: • If the organization's program is based on evidence or standards set by the state or another purchaser.	**CL**	**3/29/21**
50	CM 1, Element C	Look-back period	Revise the look-back period for Renewal Surveys to read: *For Renewal Surveys:* At least once during the prior 24 months.	**CL**	**7/25/22**
51	CM 1, Element C	Explanation	Add the following subhead and text below the Exceptions: **Related information** If the organization's program is based on evidence or standards set by the state or another purchaser, the organization validates that its operations are current with state or purchaser requirements and provides evidence of its review as it relates to factors 1-4.	**CL**	**3/29/21**
52	CM 2, Element A	Factor 1: Characteristics and needs of populations	Revise the first sentence and add the following note: The organization identifies the eligible population's characteristics and needs and, if applicable, reviews the characteristics and needs of relevant subpopulations, using available data and information. ***Note:*** *For surveys on or after July 1, 2021, the organization must identify the population's characteristics and needs based on the patient's eligibility. For surveys prior to July 1, 2021, the organization may identify these components based on the patient's enrollment status.*	**CO**	**3/29/21**
55	CM 2, Element B	Factor 9: Practitioner data	Revise the text to read: The organization uses data provided by practitioners, such as electronic health record (EHR) data or Health Information Exchange data (HIE), if available.	**CL**	**3/29/21**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
58, 63	CM 2, Elements D, E	Assessment and Evaluation	Add the following as the second sentence under "Assessment and evaluation" and the "Note" as the last paragraph: If the organization's CM system automatically generates suggestions, the case manager or other individual must still document their own conclusions. ***Note:*** *Organizations whose case management systems automatically generate answers will be surveyed on this requirement on or after 7/1/2021.*	**CL**	**11/23/20**
58, 64	CM 2, Elements D, E	Explanation—Factor 2: Documentation of clinical history	Add the following as the last sentence of the second paragraph: If dates are not present in the file, NCQA reviews the organization's complex case management policies and procedures. If the organization has a process for collecting dates as part of the clinical history, NCQA assumes the file does not include dates because the member or other individual giving information did not provide dates. The requirement is not met if the organization does not have a process for collecting dates as part of the clinical history.	**CL**	**11/23/20**
58, 64	CM 2, Elements D, E	Explanation—Factor 2: Documentation of clinical history	Add the following text as the last paragraph: Factor 2 does not require assessment or evaluation.	**CL**	**3/30/20**
63, 72	CM 2, Element E CM 4, Element B	Look-back period	Revise the text for Renewal Surveys to read: *For Renewal Surveys:* 6 months for surveys between July 1, 2020, and June 30, 2021, and 12 months for surveys effective July 1, 2021.	**CO**	**7/27/20**
63	CM 2, Element E	Explanation—Files excluded from review	Revise the first subbullet under the first bullet to read: Telephone. Text messaging is an acceptable form of member contact and counts as one contact attempt by telephone	**CL**	**7/29/24**
64, 73	CM 2, Element E CM 4, Element B	Explanation—Files excluded from review	Revise the subbullet under the second bullet to read: – The organization provides evidence of the patient's identification date and that the patient was in case management for less than 60 calendar days during the look-back period.	**CL**	**7/27/20**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
72	CM 4, Element B	Assessment	Add the following as the second sentence under "Assessment" and the "Note" as the last paragraph: If the organization's CM system automatically generates suggestions, the case manager or other individual must still document their own conclusions ***Note:*** *Organizations whose case management systems automatically generate answers will be surveyed on this requirement on or after 7/1/2021.*	**CL**	**11/23/20**
77	CM 5, Element A	Explanation	Revise the second paragraph to read: Factor 7 is a critical factor; if this critical factor is scored "no" the organization's score cannot exceed 50% for the element.	**CL**	**7/25/22**
82	CM 5, Element C	Summary of changes	Revise the first SOC to read: Revised the Renewal Survey look-back period from "At least once during the prior year" to "24 months."	**CL**	**11/20/23**
85	CM 6, Element A	Explanation—Factor 1: Obtaining patient feedback	Revise the text to read: ***Factor 1:*** **Obtaining feedback from patients** At least annually, the organization obtains feedback from patients through focus groups or experience surveys. Feedback is specific to the case management program submitted for Accreditation. To identify complaint patterns, the organization collects complaint data from the entire population of patients in the case management program, or draws statistically valid samples from the population. If the organization uses a sample, it describes the sample universe and the sampling methodology.	**CL**	**11/22/21**
85	CM 6, Element A	Explanation—Factor 2: Analyzing complaints from patients	Revise the text to read: The organization analyzes complaints to identify opportunities to improve individual experience with its case management program.	**CL**	**11/22/21**
			For initial measurement, the organization conducts quantitative and qualitative analysis of data. *For remeasurement,* the organization conducts quantitative analysis, and conducts qualitative analysis if quantitative analysis demonstrates that stated goals were not met.		
			Refer to *Appendix 4: Glossary* for the full definition of and requirements for quantitative analysis and qualitative analysis.		

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
87	CM 6, Element B	Explanation—Factor 1: Relevant process or outcome	Revise the first sentence to read: The organization selects process or outcome measures that have significant bearing on the case management program's population or on a defined subset of the population.	**CL**	**3/29/21**
88	CM 6, Element B	Explanation—Factor 5: Quantitative and qualitative analysis	Revise the factor 5 subhead and text to read: ***Factor 5:* Quantitative and qualitative analysis** *For initial measurement,* the organization conducts quantitative and qualitative analysis of data. *For remeasurement,* the organization conducts quantitative analysis, and conducts qualitative analysis if quantitative analysis demonstrates that stated goals were not met. Refer to *Appendix 4: Glossary* for the full definition of and requirements for quantitative analysis and qualitative analysis.	**CL**	**11/22/21**
93	CM 6, Element E	Related information	Add the following subhead and text under the explanation: **Related information** If the organization is required to use a regulatory agency's definition of "active participation" that is different from NCQA's, it may use the regulatory agency's definition if it also provides the definition to NCQA. NCQA will use the regulatory agency's definition to determine whether the organization's active participation is consistent with the definition.	**CL**	**7/25/22**
97	CM 7, Element A	Scope of review	Replace "policy and procedure" with "documented process" in the scope of review.	**CL**	**7/29/24**
98	CM 7, Element A	Examples	Remove the third bullet, "Job descriptions," from the factor 3 examples.	**CL**	**7/29/24**
104	CM 7, Element E	Explanation	Remove the second paragraph under "Appropriate documentation," which reads: A checklist with a single signature and a date for all verifications that has a statement confirming the signatory verified all of the credentials on that date and that includes for each verification: • The source used. The report date, if applicable.	**CL**	**7/29/24**
105	CM 7, Element E	Explanation—Appropriate documentation	Add the following text as the second sentence after the **Automated credentialing system** subhead: The organization provides its security and login policies and procedures to confirm the unique identifier and the signature can only be entered by the signatory.	**CL**	**3/30/20**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
116,119	CM 9, Elements B, D	NCQA-Accredited/ Certified delegates	Revise the first sentence of the Explanation to read: Automatic credit is available for this element if all delegates are NCQA-Accredited in Case Management, NCQA-Accredited PHP Organizations, NCQA-Prevalidated Health IT Solutions or are NCQA Certified in CVO, unless the element is NA.	**CL**	**11/23/20**
116,119	CM 9, Elements B, D	NCQA-Accredited/ Certified delegates	Add "NCQA-Prevalidated Health IT Solutions" to the first sentence so the text reads: Automatic credit is available for this element if all delegates are NCQA-Accredited in Case Management, NCQA-Prevalidated Health IT Solutions or are NCQA Certified in CVO, unless the element is NA.	**CL**	**7/27/20**
118	CM 9, Element C	NCQA-Accredited/ Certified delegates	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**	**7/27/20**
118	CM 9, Element C	NCQA-Accredited/ Certified delegates	Revise the third paragraph to read: Automatic credit is available for factor 3 if all delegates are NCQA-Prevalidated Health IT Solutions or NCQA-Accredited PHP Organizations, unless the element is NA.	**CL**	**11/23/20**
123	LTSS 1, Element A	Explanation	Revise the second paragraph to read: Factor 3 is a critical factor; if this critical factor is scored "no" the organization's score cannot exceed 20% for each program.	**CL**	**7/25/22**
127	LTSS 1, Element B	Look-back period	Revise the text to read: *For Renewal Surveys:* 24 months.	**CO**	**3/29/21**
127	LTSS 1, Element B	Explanation—Review of new evidence and professional standards	Remove the second paragraph under this section, which reads: If the organization's program is based on evidence or standards set by the state or other purchaser, it is not required to ensure that the state or purchaser has reviewed the evidence and professional standards. In these situations, the organization validates that its operations are current with the state or purchaser requirements.	**CL**	**3/29/21**
127	LTSS 1, Element B	Exceptions	Add a third bullet to the Exceptions that reads: • If the organization's program is based on evidence or standards set by the state or another purchaser.	**CL**	**3/29/21**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
129	LTSS 1, Element C	Explanation	Add the following subhead and text below the Exceptions: **Related information** If the organization's program is based on evidence or standards set by the state or another purchaser, the organization validates that its operations are current with state or purchaser requirements and provides evidence of its review as it relates to factors 1-4.	**CL**	**3/29/21**
130, 135, 138	LTSS 1, Elements D, E, F	Assessment	Add the following as the second sentence under "Assessment" and the "Note" as the last paragraph: If the organization's CM system automatically generates suggestions, the case manager or other individual must still document their own conclusions. ***Note:*** *Organizations whose case management systems automatically generate answers will be surveyed on this requirement on or after 7/1/2021.*	**CL**	**11/23/20**
131, 139	LTSS 1, Elements D, F	Explanation—Factor 2: Documentation of clinical history	Add the following as the last sentence of the second paragraph: If dates are not present in the file, NCQA reviews the organization's complex case management policies and procedures. If the organization has a process for collecting dates as part of the clinical history, NCQA assumes the file does not include dates because the member or other individual giving information did not provide dates. The requirement is not met if the organization does not have a process for collecting dates as part of the clinical history.	**CL**	**11/23/20**
131, 139	LTSS 1, Elements D, F	Explanation—Factor 2: Documentation of clinical history	Add the following text as the last paragraph: Factor 2 does not require assessment or evaluation.	**CL**	**3/30/20**
131	LTSS 1, Element D	Explanation—Factor 3: Assessment of activities of daily living	Revise the Explanation to read: Case management policies and procedures specify a process for assessing functional status related to activities of daily living, such as eating, bathing and mobility.	**CL**	**11/23/20**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
138, 148	LTSS 1, Element F LTSS 1, Element I	Look-back period	Revise the text for Renewal Surveys to read: *For Renewal surveys:* 6 months for surveys between July 1, 2020, and June 30, 2021, and 12 months for surveys effective July 1, 2021.	**CO**	**7/27/20**
138	LTSS 1, Element F	Explanation—Files excluded from review	Revise the subbullet under the second bullet to read: – The organization provides evidence of the individual's identification date and that the individual was in case management for less than 60 calendar days during the look-back period.	**CL**	**7/27/20**
142	LTSS 1, Element G	Explanation	Revise the second paragraph to read: Factors 1, 2 and 3 are critical factors; if one critical factor is scored "no" the organization's score cannot exceed 20% for the element. If two or more critical factors is scored "no," the organization's score cannot exceed 0% for the element.	**CL**	**7/25/22**
144	LTSS 1, Element H	Explanation	Revise the second paragraph to read: Factor 1 is a critical factor; if this critical factor is scored "no" the organization's score cannot exceed 20% for the element.	**CL**	**7/25/22**
148	LTSS 1, Element I	Scoring	Revise the 100% and 50% scoring categories to read: 100% = High (90-100%) on file review for 11-13 factors 50% = High (90-100%) or medium (60-89%) on file review for 7-8 factors and low (0-59%) on 1-6 factors or medium (60-89%) on file review for all 13 factors	**CO**	**3/29/21**
149	LTSS 1, Element I	Explanation—Files excluded from review	Add a subbullet under the second bullet that reads: – The organization provides evidence of the individual's identification date and that the individual was in case management for less than 60 calendar days during the look-back period.	**CL**	**7/27/20**
150	LTSS 1, Element I	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**	**7/27/20**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
150	LTSS 1, Element I	Explanation—Factor 12: Documentation of services received	Revise the explanation to read: The file or case record documents whether the individual received the services specified in the case management plan.	**PC**	**3/30/20**
153	LTSS 1, Element K	Explanation—Factors 2, 3: Background checks and additional screening tool for paid LTSS providers	Add the following as the last sentence of the first paragraph: NCQA does not consider it delegation if the organization uses another entity to conduct background checks.	**PC**	**3/30/20**
156	LTSS 2	Element stem	Revise the text to read: If the organization delegates LTSS activities, there is evidence of oversight of delegated activities.	**CL**	**7/27/20**
2-2	Appendix 2—Delegation and Automatic Credit Guidelines	Definitions	Add the following as a new definition: **Previously unidentified delegate** A contracted delegate identified during a survey that was not initially reported by the organization in the NCQA delegation worksheet.	**CL**	**3/28/22**
2-7	Appendix 2—Delegation and Automatic Credit Guidelines	How NCQA Evaluates Delegation—Delegation oversight—De facto delegation	Revise the following subhead and first paragraph to read: **Previously unidentified delegates and de facto delegation** If NCQA identifies previously unidentified delegates or de facto delegation at any point after selecting the delegates (including during the offsite survey), NCQA reserves the right to review oversight of the previously unidentified delegates or de facto delegates by selecting them at random to include up to two delegates in addition to the four originally selected.	**CL**	**3/28/22**

PREVIOUSLY POSTED UPDATES

Page	Standard/Element	Head/Subhead	Update	Type of Update	IRT Release Date
2-10	Appendix 2—Delegation and Automatic Credit Guidelines	Table 2: Health plan delegating to an NCQA-Accredited CM organization	Add PHM 2, Elements B and C to Table 2. **Standards and Elements — Interim — First — Renewal** **PHM 2: Population Identification** B Population Assessment — Y — Y — Y C Activities and Resources — Y — Y — Y **PHM 5: Population Health Management** A Access to Case Management — Y — Y — Y B Case Management Systems — Y — Y — Y C Case Management Process — Y — Y — Y D Initial Assessment — NA — Y — Y E Case Management—Ongoing Management — NA — Y — Y	**CL**	**7/26/21**
2-12	Appendix 2—Delegation and Automatic Credit Guidelines	ACO and PCMH Automatic Credit for CM File Review	Add references to "NCQA-Recognized PCSP" to this section to read: **ACO, PCMH and PCSP Automatic Credit for CM File Review** NCQA awards automatic credit for individual CM files selected for review when an organization's members are managed by an NCQA-Recognized PCMH practice, NCQA-Accredited ACO or a NCQA-Recognized PCSP practice and the organization tracks those members for inclusion on the file review worksheet for an Accreditation Survey. The table below outlines the requirements. Revise the second and third column headings in Table 6 to read: **Delegation to NCQA-Recognized PCMH, NCQA-Accredited ACO or NCQA-Recognized PCSP practice** — **Delegation to PCMHs/PCSPs Not Recognized or ACOs Not Accredited by NCQA**	**CL**	**7/27/20**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
2-12	Appendix 2—Delegation and Automatic Credit Guidelines	Automatic Credit for Delegating to an NCQA Accredited ACO or an NCQA-Recognized PCMH	Add references to "NCQA-Recognized PCSP" to the title of this section and the title of Table 7 to read: **Automatic Credit for Delegating to an NCQA-Accredited ACO, an NCQA-Recognized PCMH or an NCQA-Recognized PCSP** **Key: Y = Automatic credit available; N = No automatic credit; NA = Requirement does not apply to the Evaluation Option** ***Table 7: Automatic credit by Evaluation Option for delegating to an NCQA-Accredited ACO, an NCQA-Recognized PCMH or an NCQA-Recognized PCSP***	**CL**	**7/27/20**
2-12	Appendix 2—Delegation and Automatic Credit Guidelines	Automatic Credit for Delegating to an NCQA Prevalidated Health IT Solution	Add the following new section under table 7: **Automatic Credit for Delegating to an NCQA-Prevalidated Health IT Solution** Organizations that delegate CM functions to an NCQA-Prevalidated Health IT Solution 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. 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. ***Table 8: Automatic credit for delegating to an NCQA-Prevalidated Health IT Solution*** **CM Standards and Elements — Prevalidated Health IT Tool** **CM 2: Patient Identification and Assessment** A Population Assessment Y **CM 4: Care Monitoring** A Case Management Systems Y	**CL**	**7/27/20**

March 31, 2025

PREVIOUSLY POSTED UPDATES

Page	Standard/Element	Head/Subhead	Update	Type of Update	IRT Release Date
2-13 & 2-14	Appendix 2: Delegation and Automatic Credit Guidelines	Credit for CM 9 and LTSS 2 When Delegating to a PCMH	Add *Table 8: Credit for CM 9 when delegating to a PCMH* and *Table 9: Credit for LTSS 2 when delegating to a PCMH* to address scenarios where organizations delegate CM and LTSS functions to an NCQA-Recognized PCMH. See the updated Appendix 2: Delegation and Automatic Credit Guidelines posted in the IRT to view the tables.	**CL**	**3/29/21**
2-16	Appendix 2—Delegation and Automatic Credit Guidelines	Automatic Credit for Delegating to an NCQA-Accredited Population Health Program	Remove CM 4, Element A subhead and text from *Table 10: Automatic credit for delegating to an NCQA-Accredited Population Health Program*	**CO**	**11/14/22**
2-16	Appendix 2—Delegation and Automatic Credit Guidelines	Automatic Credit for Delegating to an NCQA-Accredited Population Health Program	Add a new main head and table 10 and renumber the subsequent tables. **CM** **Standard — Element — Initial Survey — Renewal Survey** CM 2 — A: Population Assessment — Y — Y ~~CM 4 — A: Case Management Systems — Y — Y~~ CM 8 — A: Patients' Rights Information, factors 1, 2, 4, 6–9 — Y — Y B: Expectations of Patients — Y — Y C: Handling Patient Complaints — Y — Y D: Resolving Complaints — Y — Y	**CL**	**7/25/22**
4-3	Appendix 4—Glossary		Add the following as a new definition: **de-identify:** Removal of individual identifiers. Under the HIPAA Privacy Rule, protected health information is de-identified if all individual identifiers are removed. There are 18 categories of identifiers that include name; street address and ZIP code; telephone and fax number; dates (except year) directly related to a person, including date of birth and dates of service; email address and URL; Social Security Number; medical record number and account number; vehicle identifiers, including license plate number; device identifiers and serial number; and any other unique identifying number, characteristic or code.	**CL**	**11/18/24**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
4-5	Appendix 4—Glossary		Add the following as a new definition: **interrater reliability:** The extent to which two or more independent surveyors produce similar results when assessing whether the same requirement is met—the level of confidence that similarly trained individuals would be likely to produce similar scores on the same standards for the same product when the same evidence is evaluated.	**CL**	**7/25/22**
4-6	Appendix 4—Glossary		Revise the definition of "qualitative analysis" to read: An examination of the underlying reason for or cause of results, including deficiencies or processes that may present barriers to improvement or cause failure to reach a stated goal. Qualitative analysis must draw conclusions about why the results are what they are and involves staff responsible for executing a program or process. Also called a *causal, root cause* or *barrier* analysis.	**CL**	**11/22/21**
4-6	Appendix 4—Glossary		Revise the definition of "quantitative analysis" to read: A comparison of numeric results against a standard or benchmark, trended over time. Quantitative analysis must draw conclusions about what results mean. Unless specified, tests of statistical significance are not required, but may be useful when analyzing trends. NCQA does not require that results be trended for First Surveys.	**CL**	**11/22/21**
4-7	Appendix 4—Glossary		Update the definition of "usual care providers" to read: Case management providers, LTSS providers, primary care practitioners or specialists responsible for the patient's care.	**CL**	**11/18/24**