NCQA Corrections, Clarifications and Policy Changes to the 2016 HP Standards and Guidelines

July 29, 2019

This document includes the corrections, clarifications and policy changes to the 2016 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 2016 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	Head/Subhead	Update	Type of Update	IRT Release Date
	Policies and Procedures and applicable Appendices		NCQA improved the methodology to evaluate and communicate health plan accreditation and performance on clinical (HEDIS) and patient experience (CAHPS) measures. Beginning July 1, 2020, all Excellent and Commendable accreditation statuses will be replaced with Accredited along with the Health Plan Rating (for organizations required to report HEDIS/CAHPS); Provisional, Interim and Denied statuses will remain. ***Note****: NCQA will not change all references to the Excellent and Commendable statuses in the HPA 2016 publication.*	**PC**	**7/29/2019**
31	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Annual Reevaluation	Add the following subhead and text after the second paragraph under "Annual Reevaluation": **New Annual Reevaluation Using Health Plan Ratings beginning July 1, 2020** Beginning July 1, 2020, evaluation of HEDIS/CAHPS performance scoring will be replaced by Health Plan Ratings for all accredited organizations regardless of standards year. The 50/50 scoring method where accreditation standards are worth 50 points and HEDIS/CAHPS are worth 50 points will no longer exist. In addition, Excellent and Commendable accreditation statuses will be changed to Accredited; Provisional, Interim or Denied statuses will remain and will be displayed along with Health Plan Ratings on the NCQA Report Card. In addition to Accreditation status as noted above, the HPR result will be displayed on the NCQA Report Card as the indicator of HEDIS/CAHPS performance. Based on the updated methodology, organizations earn a star rating of 0–5 stars (in half-star increments) for the HEDIS/CAHPS portion of Accreditation. The methodology includes a distinct set of measures for each product line. Each measure is classified in one of three categories:	**PC**	**7/29/2019**

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			• Process measures, which have a weight of 1. • Outcome measures, which have a weight of 3. • Patient experience measures, which have a weight of 1.5. The overall rating is the weighted average of an organization's HEDIS and CAHPS measure ratings, plus Accreditation bonus points (if the organization is Accredited by NCQA), rounded to the nearest half point. Overall performance is measured in three subcategories (displayed as stars and scored 0–5 in half point increments): 1. **Consumer Satisfaction:** Patient-reported experience of care, including experience with doctors, services and customer service (measures in the Consumer Satisfaction category). 2. **Rates for Clinical Measures:** The proportion of eligible members who received preventive service (prevention measures) and the proportion of eligible members who received recommended care for certain conditions (treatment measures). 3. **NCQA Accreditation Standards Score:** For an organization with an Accredited or Provisional status, 0.5 points (displayed as stars) are added to the overall rating. An organization with an Interim status receives one-third of the 0.5 bonus points (displayed as stars). ***Note:*** *If an organization chooses to publicly report performance data on the HEDIS Attestation, it is scored on the data submitted and receives the Accreditation bonus points (displayed as stars). If an organization Accredited on standards only chooses not to publicly report performance data, it will not be scored based on performance measurement results and will not be awarded the Accreditation bonus points.* Refer to the *Reports* section at https://www.ncqa.org/hedis/reports-and-research/ for the detailed HPR methodology and the list of required measures. Refer to the *General Guidelines* section of the *HEDIS Volume 2: Technical Specifications* for additional reporting requirements.		
22	Policies and Procedures—Section 2	Calculating scores	Add the following as the first sentence of the first paragraph: NCQA calculates one standards score, even if multiple product lines are brought forward for accreditation.	**CL**	**11/21/2016**
42	Policies and Procedures—Section 5	Discretionary Survey	Revise the Discretionary Survey section to read: NCQA may survey an organization while an accreditation status is in effect or if the organization's HEDIS results change significantly during the annual HEDIS	**PC**	**11/21/2016**

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			reevaluation. This survey is called a **Discretionary Survey** and its purpose is to validate the appropriateness of the organization's ongoing accreditation. **Structure** NCQA determines the scope and content of Discretionary Surveys, which may consist of one or more of the following: • An offsite document review. • An onsite survey. • A teleconference. **Target** Discretionary Surveys address issues regarding the organization's continued performance against NCQA's standards and other considerations that may pose an imminent threat to members. During a discretionary review, an accredited organization will be reviewed under the NCQA standards in effect at the time of the discretionary review. The Discretionary Survey may include file review (encompassing a sample of denial, appeal, credentialing and recredentialing and case management files, as appropriate) and interviews with organization staff. Any relevant look-back period for file review standards will be determined at the time of the Discretionary Survey and may or may not reflect the full look-back period identified in the standards. **Time frame** The Discretionary Survey is generally conducted within 60 calendar days of notification by NCQA of its intent to conduct a Discretionary Survey. Discretionary Survey costs are borne by the organization and correspond to the complexity and scope of the Discretionary Survey and NCQA pricing policies in effect at the time of the Discretionary Survey. **Change in status** When NCQA notifies the organization in writing of its intent to conduct a Discretionary Survey, the organization's existing accreditation status is listed with the notation "Under Review by NCQA.".		

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			NCQA may suspend the organization's accreditation status pending completion of a Discretionary Survey. Upon completion of the Discretionary Survey and after the ROC's decision, the organization's status may change. The organization has the right to Reconsideration if its accreditation status changes because of the Discretionary Survey		
65	QI 4, Element A	Explanation—Data collection methods	Remove the second sentence in the second paragraph that reads: If the organization collects data using surveys, it supplements the data with an analysis of complaints regarding access. ***This update is a correction to a previously posted update on November 16, 2015.***	**CL**	**11/21/2016**
123	QI 8, Element C	Related Information—Collaborative activities	Add the following as the first sentence: An organization receives credit in Element C for use of a PCMH initiative, for the conditions for which it received credit in Elements A and B.	**CL**	**11/21/2016**
154	NET 2, Element B	Scope of review	Add the following as the fourth and fifth paragraphs of the scope of review: During the most recent year of the look-back period, the organization analyzes and stratifies data by behavioral healthcare practitioner prescribers versus nonprescribers for each factor. During the previous year of the look-back period, the organization analyzes data across all behavioral healthcare practitioners or by prescribers versus nonprescribers.	**CL**	**11/21/2016**
158	NET 3, Element A	Exceptions	Add as the second sentence of the last paragraph: However, an organization that wants to be eligible for Commendable or Excellent accreditation status may opt to submit HEDIS/CAHPS results; such optional CAHPS results are included in the analysis for this element. ***See previously posted update on November 16, 2015.***	**CL**	**11/21/2016**

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158,159	NET 3, Elements B and C	Data source	Add "materials" as a data source.	**CL**	**11/21/2016**
158	NET 3, Element B	Scope of review	Revise the scope of review to read: *This element applies to First Surveys and Renewal Surveys for commercial, Medicare and Medicaid product lines only.* For factor 1: NCQA reviews the organization's most recently completed report. For factors 2 and 3, for surveys before July 1, 2017, the organization presents a plan (documented process) for implementing interventions and measuring effectiveness. Alternatively, for factor 2, the organization presents a documented process, reports or materials, depending on the action taken to address identified opportunities, if the organization has implemented interventions. ***This update is a correction to a previously posted update on July 25, 2016.***	**CO**	**11/21/2016**
159	NET 3, Element C	Scope of review	Add as the last paragraph: Alternatively, for factor 2, the organization presents a documented process, reports or materials, depending on the action taken to address identified opportunities, if the organization has implemented interventions. ***See previously posted update on November 16, 2015.***	**CL**	**11/21/2016**
174	NET 6, Element C	Explanation—Factor 4: Awareness of physician's participation in the organization's networks	Remove the second bullet that reads: • Contracts match directory information.	**CO**	**11/21/2016**
182	NET 6, Element J	Explanation	Revise the first bullet in the second paragraph to read: • Allows searches by zip code.	**CO**	**11/21/16**
201	UM 1, Element A	Examples—Medical necessity determinations	Revise the second sub-bullet of the second bullet to read: – Use of out-of-network practitioner if no in-network practitioner has the appropriate clinical expertise, because the organization is deciding if it is or is not medically necessary for the member to receive care out of network.	**CL**	**11/21/2016**

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216, 217, 218	UM 4, Elements C, D and E	Explanation	Revise the second paragraph for the following elements to read: **Element C:** This element applies to all nonbehavioral healthcare UM denials that are directly related to requests by members, or by their authorized representatives, for authorization or payment for health care services that are based on medical necessity. **Element D:** This element applies to all behavioral healthcare UM denials that are directly related to requests by members, or by their authorized representatives, for authorization or payment for health care services that are based on medical necessity. **Element E:** This element applies to all pharmacy UM denials that are directly related to requests by members, or by their authorized representatives, for authorization or payment for pharmaceuticals that are based on medical necessity.	**CL**	**11/21/2016**
222	UM 4, Element H	Scope of review	Add the following as the third paragraph: For the 2016 standards year, NCQA evaluates and scores the UM 4, Element H file review as normal during the onsite survey. NCQA will adjust the final score, after the onsite survey, to 100% if the organization includes all denials required by UM 4, Element H in the file review universe. If the organization does not include all denials in the file review universe, NCQA will adjust the organization's final score to 50% for the 2016 standards year and 0% thereafter.	**CL**	**11/21/2016**
250, 255, 260	UM 7, Elements A, D and G	Explanation—Opportunity to discuss denial decisions	Add the following as the last sentence in the last paragraph: For the Medicare product line, the organization may provide the treating practitioner with an opportunity to discuss a UM request with a physician or other appropriate reviewer prior to the decision to meet the intent of this element. The organization must provide documentation in the denial file.	**CL**	**11/21/2016**
374, 375, 376	RR 5, Elements A-C	Exceptions	Remove "Medicaid" from the first sentence and add the following as the second exception: This element is NA for the Medicaid product line if: • The organization has no control over its marketing materials, ***or*** • The organization does not communicate with or market to prospective members and does not submit information to a centralized location for prospective members to compare plans. The organization must provide documentation of the restriction or a policy stating that it does not market to prospective members.	**CL**	**11/21/2015**

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5-9	Appendix 5	General Requirements	Add the following subhead and text immediately above "CR files" **Complex case management and UM files** If the organization delegates 100% of CM or UM activities to an NCQA accredited/certified delegate, NCQA gives automatic credit to delegated file-review elements. NCQA does not review the delegate's files during the survey. Consequently, the organization does not need to include such files in the file universe but must complete the "100% AC" tab of the UM File Submissions Instructions workbook. If the organization delegates less than 100% of CM or UM activities to an NCQA accredited/certified delegate, the organization must include its files and the delegate's files in the file review universe.	**CL**	**11/21/2016**
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	Multiple		Refer to the memo to review requirements that were eliminated for the 2017 Standards Year and will be scored NA for the 2016 Standards Year.	**PC**	**7/25/2016**
10	Policy	Marketplace Measure Reporting and Scoring Policy for Accreditation	Revise the paragraph to read: For Renewal Surveys and applicable First Surveys, NCQA will continue to score the Marketplace product line on accreditation standards only, and will evaluate whether the organization continues to be a Qualified Health Plan under CMS requirements. If the organization did not submit Quality Rating System (QRS) measures to CMS and is not listed on Healthcare.gov, NCQA will not accredit the Marketplace product line or, if the organization is accredited, will revoke its accreditation status. If the organization is not required by CMS to report QRS measures but is listed on Healthcare.gov, NCQA will discuss the issue with the organization before revoking accreditation status.	**PC**	**3/28/2016**
12	Policy	7. Geographic unit	Add EPO to the second paragraph to read: Organizations with HMO, POS and EPO products—which are generally incorporated locally and regulated individually by states—the size of the geographic unit is determined by the legal entity.	**CL**	**11/16/2015**
30	Policies and Procedures—Section 2	Scoring CAHPS	Add "Coordination of Care" after "Customer Service" in Table 6.	**CL**	**7/25/2016**

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49	QI 1, Element A	Scope of review	Replace the second and third paragraphs as follows: For *Interim Surveys and First Surveys*, NCQA reviews the organization's QI program description that is in place throughout the look-back period and the annual work plan. For *Renewal Surveys*, NCQA reviews the organization's QI program description that is in place throughout the look-back period and the most recent and the previous year's annual work plans.	**CL**	**11/16/2015**
64	QI 4	Summary of Changes	Replace the fifth bullet with the following: • Elements C–F were formerly QI 6, Elements A-D.	**CO**	**11/16/2015**
65	QI 4, Element A	Explanation—Data collection methods Quantitative and qualitative analyses Access to Member Services by telephone	Revise the three subheads and associated text as follows: **Access to Member Services by telephone** The organization has standards for timely access to Member Services. Organizations typically set telephone standards for: • Percentage of members' complaints concerning access to Member Services. **Data collection methods** The organization determines its data collection methodology. The data collection methodology allows identification of issues at the organizational level. The organization may collect data across the entire member population or from a statistically valid sample. ~~If the organization collects data using surveys, it supplements the data with an analysis of complaints regarding access.~~ **Quantitative and qualitative analyses** The organization annually conducts quantitative analysis of its performance against its accessibility standards and a qualitative analysis of the performance results. ***Corrected by an update issued on November 21, 2016.***	**CO**	**11/16/2015**

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67	QI 4, Element C	Scope of review	Revise the text to read: *This element applies to First Surveys and Renewal Surveys.* NCQA reviews this element for each product line brought forward for accreditation. *For First Surveys*, NCQA reviews the organization's most recent annual data collection and evaluation report. *For Renewal Surveys*, NCQA reviews the organization's most recent and previous year's annual data collection and evaluation report. The score for the element is the average of the scores for all product lines.	**CO**	**11/16/2015**
70	QI 4, Element E	Scope of review	Replace the language with the following: *This element applies to First Surveys and Renewal Surveys.* NCQA reviews this element for each product line brought forward for accreditation. *For First Surveys*, NCQA reviews the organization's most recent annual data collection and evaluation report. *For Renewal Surveys*, NCQA reviews the organization's most recent and the previous year's annual data collection and evaluation report. The score for the element is the average of the scores for all product lines.	**PC**	**3/28/2016**
~~70~~	~~QI 4, Element E~~	~~Scope of review~~	~~Replace the second paragraph with the following:~~ ~~*For First Surveys*, NCQA reviews the organization's most recent annual data collection, assessment and survey reports.~~ ~~*For Renewal Surveys*, NCQA reviews the organization's most recent and previous year's annual data collection, assessment and survey reports.~~ ***This update replaced by the one immediately above.***	~~**CO**~~	~~**11/16/2015**~~
72	QI 4, Element F	Scope of review— Look-back period	Replace the second paragraph of the scope of review with the following: NCQA reviews the organization's most recent and previous year's evaluation report, interventions and effectiveness evaluation. Replace the Renewal Survey look-back period with the following: *For Renewal Surveys:* 24 months.	**CO**	**11/16/2015**

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82	QI 5, Element D	Explanation/Factors 1-6	Replace the subhead and associated text with the following: ***Factors 1–4*** No additional explanation required. ***Factors 5, 6*** The organization communicates referral options to members (factor 5) and practitioners (factor 6).	**CO**	**7/25/2016**
82	QI 5, Element D	Exceptions	Revise the first Exception as follows: Factor 1 is NA: • For Interim Surveys. • If the organization does not maintain a health information line.	**PC**	**7/25/2016**
107	QI 6, Element H	Exceptions	Add as the second exception: Factor 1 is NA if the organization does not maintain a health information line.	**PC**	**7/25/2016**
120	QI 8, Element A	Related Information—Collaboration through patient-centered medical home (PCMH) initiative	Replace the text under the subhead with the following: The use of a medical home initiative is acceptable to meet one opportunity for QI 8, Element A if: • The initiative is a direct result of the data collected and the analysis performed in meeting factors 1 and 2. • The organization provides evidence of active support for the PCMH model during the previous 12 months. The organization may receive credit for a second or third opportunity, if the organization can provide evidence of analysis that the medical home initiatives can meet additional opportunities. NCQA defines "active support" as any of the following: • Helping with application fees for NCQA PCMH Recognition (beyond the NCQA program's sponsor discount). • Helping practices transform into a medical home. • Providing other incentives for NCQA PCMH Recognition, such as pay-for-performance. • Using NCQA PCMH Recognition as a criterion for inclusion in a restricted or tiered network. • Reporting recognition status in the physician directory. Automatic credit does not apply if the organization uses a medical home initiative to meet the requirements.	**CL**	**11/16/2015**

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122	QI 8, Element B	Related information—Collaboration through PCMH initiative	Replace the text under the subhead with the following: The use of a medical home initiative is acceptable to meet one opportunity for QI 8, Element B if: • The initiative is a direct result of the data collected and the analysis performed to meet Element A, factors 1 and 2. • The organization provides evidence of active support for the PCMH model during the previous 12 months. The organization may receive credit for a second or third opportunity, if the organization can provide evidence of analysis that the medical home initiatives can meet additional opportunities. NCQA defines "active support" as any of the following: • Helping with application fees for NCQA PCMH Recognition (beyond the NCQA program's sponsor discount). • Helping practices transform into a medical home. • Providing other incentives for NCQA PCMH Recognition, such as pay-for-performance. • Using NCQA PCMH Recognition as a criterion for inclusion in a restricted or tiered network. • Reporting recognition status in the physician directory. • Automatic credit does not apply if the organization uses a medical home initiative to meet the requirements.	**CL**	**11/16/2015**
128	QI 9, Element B	Scope of review	Add as the last paragraph: For factors 5 and 6, NCQA reviews a documented process, reports or materials, depending on the action taken to address identified opportunities.	**CL**	**7/25/2016**
128	QI 9, Element B	Data source	Add "documented process" and "materials" as data sources.	**CL**	**11/16/2015**
130	QI 9, Element C	Data source	Remove "documented process" as a data source.	**CL**	**11/16/2015**
133	QI 10, Element A	Examples—Factor 3: Reporting	Replace the examples with the following: None.	**CL**	**11/16/2015**
~~135, 189, 299, 345, 380, 435~~	~~QI 10, Element C, NET 7 Element C, UM 14 Element C, CR 9 Element B, RR 6 Element C, MEM 9 Element C~~	~~Explanation—Factor 4: Access to PHI~~	~~Replace the text under the subhead with the following:~~ ~~The delegation agreement includes procedures to receive, analyze and resolve members' requests for access to their PHI.~~ ***Replaced by an update issued on July 25, 2016.***	**~~CO~~**	**~~11/16/2015~~**

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135, 189, 299, 345, 380, 436	QI 10, Element C, NET 7, Element C, UM 14, Element C, CR 9, Element B, RR 6, Element C, MEM 9, Element C	Explanation—Factor 4: Access to PHI	Replace the text under the subhead with the following: No additional explanation required.	**CO**	**7/25/2016**
148	NET 1, Element C	Explanation—Factor 5: Performance analysis	Revise the second sentence to read: The analysis methodology allows direct measurement of performance against standards in factors 2-4.	**CO**	**7/25/2016**
154	NET 2, Element B, factor 4	Factors	Revise the factor to read: Follow-up routine care.	**CO**	**11/16/2015**
154	NET 2, Element B	Explanation—Factor 4: Follow-up routine care appointments	Revise the paragraph as follows: Follow-up routine care appointments are visits at later, specified dates to evaluate patient progress and other changes that have taken place since a previous visit.	**CL**	**11/21/2016**
155	NET 2, Element B	Explanation—Quantitative and qualitative analyses	Revise the first paragraph as follows: The organization annually conducts quantitative analysis to determine if members are receiving follow-up routine care within a reasonable timeframe as defined by the organization.	**CL**	**11/16/2015**
155	NET 2, Element B	Examples	Add the following subhead and examples: **Factor 4: Follow-up routine care** Timeliness Standards • 90 percent of sites report availability of slots for routine follow-up appointments within clinically reasonable timeframes. • 90 percent of members reported that they "always" or usually get a follow-up routine appointment as soon as they need it. Sources of data used to assess reasonable access to routine follow-up care • Average number of days between routine follow-up appointments for individuals with	**CL**	**11/16/2015**

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			a specific condition via claims data. Site-specific surveys regarding average number of days to next available appointment slot for a routine follow-up visit.		
158	NET 3, Element A	Explanation—Factors 1,2: Analysis of data from complaints and appeals	Revise the last sentence in the second paragraph to read: Analysis of complaints, appeals and experience related to network adequacy may be included in the overall analysis of member experience for QI 4, Elements C–E. However, the documentation must clearly reflect the results/analysis/opportunities by product line as evidence to meet NET 3, Element A.	**CO**	**11/16/2015**
158	NET 3, Element A	Exceptions	Add as the third paragraph: For First Surveys, for factor 1, the organization is not required to include CAHPS survey results in its analysis reports.	**CL**	**11/16/2015**
158	NET 3, Element B, factor 1	Factors	Revise the factor to read: Prioritizes opportunities for improvement identified from analyses of availability (NET 1), accessibility (NET 2) and CAHPS survey results and member complaints and appeals (NET 3 Element A, factor 1).	**CO**	**11/16/2015**
158	NET 3, Element B	Scope of review	Add as the first sentence under the heading: *This element applies to First Surveys and Renewal Surveys for commercial, Medicare and Medicaid products only.*	**CL**	**11/16/2015**
158	NET 3, Element B	Exceptions	Revise the exceptions to read: This element is NA for the Marketplace product line. Network adequacy for Marketplace products is assessed in NET 4, Element C (former QI 12). *For First Surveys:* Organizations are not required to include CAHPS in their analysis reports. However, an organization that wants to be eligible for Commendable or Excellent accreditation status may opt to submit HEDIS/CAHPS results; such optional CAHPS results are included in the analysis for this element.	**CL**	**11/16/2015**

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~~158, 159~~	~~NET 3, Elements B, C~~	~~Scope of review — NA~~	~~Replace the second and third paragraphs with the following:~~ ~~NCQA reviews the organization's most recently completed report.~~ ~~For factor 2, NCQA reviews a documented process, reports or materials, depending on the action taken to address identified opportunities.~~ ***Replaced by an update issued on November 21, 2016.***	~~**CL**~~	~~**7/25/2016**~~
159	NET 3, Element C	Factors, Look-back period, Scope of review, Exceptions	See the attached document for revisions to NET 3, Element C.	**CL**	**11/16/2015**
163	NET 4, Element B	Explanation— Related information	Revise the sentence to read: "Marketplace plans" refers to the individual health plans that organizations offer across all levels of coverage (i.e., Catastrophic, Bronze, Silver, Gold and Platinum).	**CO**	**11/16/2015**
170	NET 5, Element B	Examples	Replace the last bullet with the following: Contracts with practitioners include continued access for the periods specified in factors 1 and 2.	**CL**	**11/16/2015**
191	NET 7, Element E	Look-back period	Revise the **Look-back period for Interim Surveys and First Surveys** to read: *For Interim Surveys and First Surveys*: Once during the prior year.	**CO**	**7/25/2016**
191	NET 7, Element E	Explanation	Revise the second paragraph as follows: NCQA scores factor 2 "yes" if all delegates are NCQA-Accredited health plans, MBHOs or NCQA- Certified HIPs, unless the element is NA. NCQA-Certified HIPs must be certified in the activity being delegated by the organization.	**CO**	**7/25/2016**
~~191~~	~~NET 7, Element E~~	~~Explanation~~	~~Revise the text to read:~~ ~~NCQA scores factors 1 and 2 "yes" if all delegates are NCQA-Accredited health plans, MBHOs or NCQA-Certified HIPs unless the element is NA. NCQA-Certified HIPs must be certified in the activity being delegated by the organization.~~ ***Replaced by an update issued on July 25, 2016.***	~~**CO**~~	~~**11/16/2015**~~
192	NET 7, Element E	Exceptions	Revise the last sentence to read: Factors 2 and 3 are NA for Interim Surveys.	**CL**	**3/28/2016**

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198	UM 1	Table of Contents	Strike the table of contents on pg. 198.	**CO**	**11/16/2015**
208, 209	UM 2, Elements B, C	Explanation	Remove the first paragraph that reads: This element is a structural requirement. The organization must present its own documentation.	**CO**	**11/16/2015**
209	UM 2, Element C	Data source	Add "documented process" and "materials" as data sources.	**CL**	**11/16/2015**
~~216~~	~~UM 4, Element C~~	~~Explanation~~	~~Revise the second paragraph to read:~~ ~~This element applies to all nonbehavioral healthcare UM decisions, whether they are approvals or denials, that are directly related to requests by members, or by their authorized representatives, for authorization or payment for health care services that are based on medical necessity.~~ ***Replaced by an update issued on November 21, 2016.***	~~**CL**~~	~~**7/25/2016**~~
216, 218	UM 4, Elements C, E	Explanation	Remove the last sentence in the second paragraph that reads: Decisions about any services covered under member benefits are medical necessity determinations.	**CO**	**3/28/2016**
~~218~~	~~UM 4, Element E~~	~~Explanation~~	~~Revise the second paragraph to read:~~ ~~This element applies to all pharmacy UM decisions, whether they are approvals or denials, that are directly related to requests by members, or by their authorized representatives, for authorization or payment for pharmaceuticals that are based on medical necessity.~~ ***Replaced by an update issued on November 21, 2016.***	~~**CL**~~	~~**7/25/2016**~~
220	UM 4, Element F	Exceptions	Add as the second paragraph: Factor 2 is NA if the organization does not use board-certified consultants for medical necessity determinations because all specialties are available within the organization to assist with UM determinations.	**CL**	**7/25/2016**
222	UM 4, Element H	Look-back period	Revise the look-back period to read: *For First Surveys and Renewal Surveys:* From the survey submission date back to April 1, 2016, or 6 months, whichever is less.	**PC**	**3/28/2016**
222	UM 4, Element H	Entire element	See the attached document for revisions to UM 4, Element H.	**CO**	**11/16/2015**

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PREVIOUSLY POSTED UPDATES					
Page	**Standard**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
224	UM 5	Summary of change	Revise the first bullet under "Clarifications" as follows: Made Elements A-F must pass elements.	**CO**	**11/16/2015**
235-241	UM 5, Elements E, F		See the attached document for revisions to UM 5, Elements E and F.	**CO**	**11/16/2015**
240	UM 5, Element F	Related Information—Oral notification	Add as the last paragraph under the subhead: For Medicare Part D plans, initial oral notification of a decision may be made within the specified time frames. Written notification must be made no later than three calendar days after oral notification.	**CL**	**3/28/2016**
240	UM 5, Element F	Exceptions	Add as the second exception: This element is NA for pharmaceutical approvals made at the point of service (i.e., a pharmacy).	**CL**	**3/28/2016**
241	UM 5, Element G	Exceptions	Add as the first exception: Factor 6 is NA for pharmaceutical approvals made at the point of service (i.e., a pharmacy).	**CL**	**3/28/2016**
241	UM 5, Element G	Exceptions	Add the following to the Exceptions: Factors 3 and 4 are NA if all purchasers of the organization's services carve out or exclude behavioral healthcare. Factors 5 and 6 are NA if all purchasers of the organization's services carve out or exclude pharmaceutical management.	**CL**	**11/16/2015**
242	UM 5, Element G	Examples	Revise the title for the second example to read: Factor 2: Timeliness of notification of nonbehavioral UM decisions-commercial product line	**CO**	**11/16/2015**
250, 255, 260	UM 7, Elements A, D and G	Explanation—Opportunity to discuss denial decisions	Add the following as the last paragraph: For Medicare product lines, organizations may provide the opportunity for a physician or other appropriate reviewer to discuss a UM request with a treating practitioner prior to the decision to meet the intent of this element. The organization must provide documentation in the denial file.	**CL**	**11/16/2015**

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Page	**Standard**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
251, 253	UM 7, Elements B, C	Explanation	Replace the second paragraph under the subhead with the following: This element applies to all nonbehavioral healthcare UM denial decisions directly related to requests by members or by their authorized representatives for authorization or payment for health care services, whether requests are based on benefits or on medical necessity.	**CO**	**11/16/2015**
256, 258	UM 7, Elements E, F	Explanation	Replace the second paragraph under the subhead with the following: This element applies to all behavioral healthcare UM denial decisions directly related to requests by members or by their authorized representatives for authorization or payment for health care services, whether requests are based on benefits or on medical necessity.	**CO**	**11/16/2015**
261, 263	UM 7, Elements H, I	Explanation	Replace the second paragraph under the subhead with the following: This element applies to all pharmaceutical UM denial decisions directly related to requests by members or by their authorized representatives for authorization or payment for health care services, whether requests are based on benefits or on medical necessity.	**CO**	**11/16/2015**
269	UM 8, Element B	Scope of review	Replace the third and fourth paragraphs with the following: For *First Surveys and Renewal Surveys*, NCQA also reviews the most recent distribution of external review rights to members.	**CL**	**7/25/2016**
269	UM 8, Element A	Explanation— Related information	Revise the first sentence in the second paragraph to read: Medicare appeals and factors 7-13.	**CO**	**11/16/2015**
290, 294	UM 12, Element E, UM 13 Element B	Scope of review— Look-back period	Revise the first sentence of the **scope of review** to read: *This element applies to Interim Surveys, First Surveys and Renewal Surveys* Add the following as the first paragraph in the **look-back period**: *For Interim Surveys*: Prior to the survey date.	**CL**	**7/25/2016**
310	CR 1, Element A	Related information— Appropriate documentation	Add as following as the second sentence in the second paragraph: Faxed, digital, electronic, scanned or photocopied signatures are acceptable. Signature stamps are not acceptable.	**CL**	**11/16/2015**

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Page	**Standard**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
316	CR 3, Element A	Scope of review	Add the following subhead and language: **Scope of review** *This element applies to First Surveys and Renewal Surveys.* NCQA reviews verification of credentials within a random sample of up to 40 initial credentialing files and up to 40 recredentialing files from decisions made during the look-back period.	**CO**	**3/28/2016**
320	CR 3, Element A	Exceptions	Revise the second exception to read: A board-certified nurse practitioner or other health care professional, but the organization does not communicate board certification to members.	**CL**	**11/16/2015**
321	CR 3, Element B	Explanation—Factor 2: Sources for Medicare/Medicaid Sanctions	Add as the sixth bullet: • AMA Physician Master File.	**PC**	**7/25/2016**
342	CR 8, Element E	Scope of review	Revise the text to read: NCQA reviews evidence that the organization assessed the providers in Element C.	**CL**	**11/16/2015**
398	MEM 2, Element A	Explanation—Evidence-based information	Add as the second sentence: If the organization's materials do not cite recognized sources, NCQA also reviews the organization's documented process detailing sources used, and how they were used in developing the self- management tools.	**CL**	**11/16/2015**
411	MEM 4, Element C	Examples— Evidence of the QI process	Revise the first bullet to read: • Periodic audits of information provided via the organization's Web site and by telephone.	**CL**	**11/16/2015**
418	MEM 5, Element D	Look-back period	Revise the first sentence to read: *For First Surveys:* For factors 1-2, 6 months.	**CL**	**7/25/2016**

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<tr><th>Page</th><th>Standard</th><th>Head/Subhead</th><th>Update</th><th>Type of Update</th><th>IRT Release Date</th></tr>
<tr><td>438</td><td>MEM 9, Element E</td><td>Scope of review</td><td>Revise the fourth paragraph to read:
For Renewal Surveys for the commercial product line, NCQA reviews the most recent and previous performance evaluations and four semiannual evaluations.
For Renewal Surveys for the Medicare, Medicaid and Marketplace product lines, NCQA reviews the organization's most recent performance evaluation and semiannual report evaluation.</td><td>CL</td><td>7/25/2016</td></tr>
<tr><td>439</td><td>MEM 9, Element F</td><td>Scope of review</td><td>Revise the fourth paragraph to read:
For Renewal Surveys for the commercial product line, NCQA reviews the organization's most recent and previous year's annual reviews and follow-up on improvement opportunities.
For Renewal Surveys for the Medicare, Medicaid and Marketplace product lines, NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities.</td><td>CL</td><td>7/25/2016</td></tr>
<tr><td>All</td><td>Appendix 1</td><td></td><td>Add as the second footnote:
Because elements that are retired for 2017 will be scored NA for the 2016 standards year, points may not be used to calculate the actual score for affected standards. Use the ISS to determine the actual score.</td><td>CL</td><td>7/25/2016</td></tr>
<tr><td>1-1</td><td>Appendix 1</td><td>NET Category total—UM Category total</td><td>Revise the category totals for NET and UM as follows:
<table>
<tr><td>NET CATEGORY TOTAL</td><td>1.180</td><td>1.180</td><td>10.000</td><td>10.000</td><td>10.000</td><td>10.000</td><td>NA</td></tr>
<tr><td>UM CATEGORY TOTAL</td><td>15.100</td><td>15.100</td><td>10.000</td><td>10.000</td><td>10.000</td><td>10.000</td><td>NA</td></tr>
</table></td><td>CO</td><td>11/16/2015</td></tr>
</table>

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<tr><th>Page</th><th>Standard</th><th>Head/Subhead</th><th>Update</th><th>Type of Update</th><th>IRT Release Date</th></tr>
<tr><td>1-5</td><td>Appendix 1</td><td>NET 4: Marketplace Network Transparency and Experience</td><td>Revise the Interim Survey points to read:
<table>
<tr><th rowspan="2">Element, Standard</th><th colspan="2">Interim Survey</th></tr>
<tr><th>No Delegation</th><th>Delegation</th></tr>
<tr><td colspan="3">NET 4: MARKETPLACE NETWORK TRANSPARENCY AND EXPERIENCE</td></tr>
<tr><td>A: Network Design for Practitioners</td><td>0.590</td><td>0.531</td></tr>
<tr><td>B: Network Design for Hospitals</td><td>0.590</td><td>0.531</td></tr>
<tr><td>C: Marketplace Member Experience</td><td>NA</td><td>NA</td></tr>
<tr><td>STANDARD TOTAL</td><td>1.180</td><td>1.062</td></tr>
</table></td><td>CO</td><td>7/25/2016</td></tr>
<tr><td>2-1</td><td>Appendix 2</td><td>New HEDIS Measures</td><td>Add the following rates to AMR, PCR and
DDE: AMR (Total Rate)
PCR (Observed-to-Expected Ratio) DDE (Total Rate)</td><td>CL</td><td>3/28/2016</td></tr>
<tr><td>2-1</td><td>Appendix 2</td><td>New HEDIS Measures</td><td>Revise the product line entry for PCR as follows:
PRC Plan All-Cause Readmissions Commercial, Medicare</td><td>CO</td><td>11/16/2015</td></tr>
</table>

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<tr><td>2-3</td><td>Appendix 2</td><td>CAHPS 5.0H Measures Required For 2016 HP Accreditation—Commercial HMO/POS/PPO</td><td>CAHPS 5.0H MEASURES REQUIRED FOR 2016 HP ACCREDITATION—MEDICARE HMO/POS/PPO
<table><tr><th>Measure Description</th><th>Points</th><th>Reporting Category</th></tr><tr><td>Getting Care Quickly</td><td>1.6250</td><td>AS</td></tr><tr><td>Getting Needed Care</td><td>1.6250</td><td>AS</td></tr><tr><td>Coordination of Care (NEW)</td><td>1.6250</td><td>AS</td></tr><tr><td>Rating of Health Plan</td><td>3.2500</td><td>AS</td></tr><tr><td>Rating of All Health Care</td><td>1.6250</td><td>QP</td></tr><tr><td>Rating of Personal Doctor</td><td>1.6250</td><td>QP</td></tr><tr><td>Rating of Specialist Seen Most Often</td><td>1.6250</td><td>QP</td></tr><tr><td>MEDICARE CAHPS MEASURES = 8
(Rating of Health Plan Counts as 2)</td><td>13.000</td><td></td></tr></table>This update corrects (adds points back for Rating of Health Plan) the 11/16/15 entry below.</td><td>CO</td><td>3/28/2016</td></tr>
<tr><td>~~2-3~~</td><td>~~Appendix 2~~</td><td>~~CAHPS 5.0H MEASURES REQUIRED FOR 2016 HP ACCREDITATION—COMMERCIAL HMO/POS/PPO~~</td><td>~~Revise the table to read:~~
<table><tr><th>~~CAHPS 5.0H MEASURES REQUIRED FOR 2016 HP ACCREDITATION—MEDICARE HMO/POS/PPO~~</th><th></th><th></th></tr><tr><td>~~Measure Description~~</td><td>~~Points~~</td><td>~~Reporting Category~~</td></tr><tr><td>~~Getting Care Quickly~~</td><td>~~1.6250~~</td><td>~~AS~~</td></tr><tr><td>~~Getting Needed Care~~</td><td>~~1.6250~~</td><td>~~AS~~</td></tr><tr><td>~~Coordination of Care (NEW)~~</td><td>~~1.6250~~</td><td>~~AS~~</td></tr><tr><td>~~Rating of Health Plan~~</td><td></td><td>~~AS~~</td></tr><tr><td>~~Rating of All Health Care~~</td><td>~~1.6250~~</td><td>~~QP~~</td></tr></table></td><td>~~CO~~</td><td>~~11/16/2015~~</td></tr>
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<table>
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<tr><td>~~Rating of Specialist Seen Most Often~~</td><td>~~1.6250~~</td><td>~~QP~~</td></tr>
<tr><td>~~**MEDICARE CAHPS MEASURES = 8 (Rating of Health Plan Counts as 2)**~~</td><td>~~**13.000**~~</td><td></td></tr>
</table>
This update was replaced by one issued on 3/28/16.</td><td></td><td></td></tr>
<tr><td>4-7</td><td>Appendix 4</td><td>Table 3C: Commercial HMO/POS/PPO-HEDIS/CAHPS Point Allocation With a Reportable Rate on Rating of Health Plan</td><td>Revise the text under No NA or NB Measures for Below 25th Percentile to read:
<table>
<tr><th>Number of NA or NB Measures</th><th>Meets or Exceeds the 90th Percentile Benchmark Nationally</th><th>Meets or Exceeds the 75th Percentile Benchmark Regionally or Nationally</th><th>Meets or Exceeds the 50th Percentile Benchmark Regionally or Nationally</th><th>Meets or Exceeds the 25th Percentile Benchmark Regionally or Nationally</th><th>Falls Below the 25th Percentile Benchmark Regionally or Nationally</th><th>Receives NR on Audit</th></tr>
<tr><td>0</td><td>1.300</td><td>1.144</td><td>0.884</td><td>0.520</td><td>0.260</td><td>0.000</td></tr>
<tr><td>1</td><td>1.444</td><td>1.271</td><td>0.982</td><td>0.578</td><td>0.289</td><td>0.000</td></tr>
<tr><td>2</td><td>1.625</td><td>1.430</td><td>1.105</td><td>0.650</td><td>0.325</td><td>0.000</td></tr>
<tr><td>3</td><td>1.857</td><td>1.634</td><td>1.263</td><td>0.743</td><td>0.371</td><td>0.000</td></tr>
<tr><td>4</td><td>2.167</td><td>1.907</td><td>1.473</td><td>0.867</td><td>0.433</td><td>0.000</td></tr>
<tr><td>5-9</td><td colspan="6">Scored on standards only</td></tr>
</table></td><td>**CL**</td><td>**11/16/2015**</td></tr>
<tr><td>5-9</td><td>Appendix 5</td><td>Table 2: Automatic credit by Evaluation Option for delegating to an NCQA- Accredited Health Plan</td><td>Replace “QI 5, Element F, Case Management Process” with “Element G, Initial Assessment.”</td><td>**CO**</td><td>**3/28/2016**</td></tr>
</table>

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<tr><td>5-17</td><td>Appendix 5</td><td>Table 3: Automatic credit by Evaluation Option for delegating to an NCQA- Accredited MBHO, NCQA-Certified UM/CR or CVO</td><td>Add the following text to the table:
<table>
<tr><th colspan="2" rowspan="2"></th><th colspan="3">Accredited MBHO</th><th colspan="3">Certified UM/CR</th></tr>
<tr><th>Interim Survey</th><th>First Survey</th><th>Renewal Survey</th><th>Interim Survey</th><th>First Survey</th><th>Renewal Survey</th></tr>
<tr><td colspan="8">UM 2: Clinical Criteria for UM Decisions</td></tr>
<tr><td>B</td><td>Availability of Criteria</td><td>Y[3]</td><td>Y[3]</td><td>Y[3]</td><td>Y</td><td>Y</td><td>Y</td></tr>
<tr><td>C</td><td>Consistency in Applying Criteria</td><td>NA</td><td>Y[3]</td><td>Y[3]</td><td>NA</td><td>Y</td><td>Y</td></tr>
</table>
[3]Automatic credit is available for behavioral healthcare criteria.</td><td>CO</td><td>3/28/2016</td></tr>
<tr><td>5-25</td><td>Appendix 5</td><td>Table 7: Automatic credit by Evaluation Option for delegating to an organization with NCQA MHC Distinction</td><td>Revise the last row of Table 7 to read:
<table>
<tr><th colspan="6">RR 3: Subscriber Information</th></tr>
<tr><td>A</td><td>Subscriber Information, factor 5</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr>
</table></td><td>CO</td><td>7/25/2016</td></tr>
<tr><td>5-30</td><td>Appendix 5</td><td>QI 10: Delegation of QI</td><td>Replace the text under the “NCQA-Accredited ACO” column with the following:
Require proof that at least twice a year the organization sends a list of eligible patients to the ACOs for evaluation and engagement and expects feedback from the ACOs on whether they intend to engage the patients on the list.</td><td>CO</td><td>3/28/2016</td></tr>
<tr><td>All pages</td><td>Appendix 5</td><td></td><td>See the attached document for revisions to Appendix 5.</td><td>CO</td><td>11/16/2015</td></tr>
<tr><td>7-3</td><td>Appendix 7</td><td>MAC Evaluation and Outcomes</td><td>Revise the look-back period in the third sentence of the paragraph to 6 months as follows:
A look-back period of 6 months applies to each transaction, to determine if a serial merger or complete consolidation situation exists and to decide the type of survey that may be necessary.</td><td>PC</td><td>11/16/2015</td></tr>
</table>

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