NCQA Corrections, Clarifications and Policy Changes to the 2018 HP Standards and Guidelines

July 29, 2019

This document includes the corrections, clarifications and policy changes to the 2018 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 2018 HP standards and guidelines must implement corrections and policy changes within 90 calendar days of the IRT release date, unless otherwise specified. The 90-calendar-day advance notice does not apply to clarifications or FAQs, because they are not changes to existing requirements.

Page	Standard/Element	Head/Subhead	Update	Type of Update	IRT Release Date
	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 2018 publication.*	**PC**	**7/29/2019**
35	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	**PC**	**7/29/2019**

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			methodology, organizations earn a star rating of 0–5 stars (in half-star increments) for the HEDIS/CAHPS portion of Accreditation. The methodology includes a distinct set of measures for each product line. Each measure is classified in one of three categories: • Process measures, which have a weight of 1. • Outcome measures, which have a weight of 3. • Patient experience measures, which have a weight of 1.5. The overall rating is the weighted average of an organization's HEDIS and CAHPS measure ratings, plus Accreditation bonus points (if the organization is Accredited by NCQA), rounded to the nearest half point. 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.		

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	Multiple		Refer to the memo to review requirements that were eliminated for the 2019 Standards Year and will be scored NA for the 2018 Standards Year.	**PC**	**7/30/2018**
NA	Policies and Procedures	Acknowledgments	Update the NCQA address on the page preceding the Acknowledgments page to read: 1100 13th Street NW, Third Floor Washington, DC 20005	**CL**	**11/20/2017**
8	Overview	Other NCQA Programs	Add the following as the last bullet under "NCQA offers the following accreditation programs": • Utilization Management, Credentialing and Provider Network (UM-CR-PN). • Delete the first bullet under "NCQA offers the following certification programs" that reads: • Accreditation in Utilization Management, Credentialing and Provider Network (UM-CR-PN).	**CL**	**11/20/2017**
13	Policies and Procedures—Section 1: Eligibility and the Application Process	Marketplace Measure Reporting and Scoring Policy for Accreditation	Add as the third paragraph: If an organization drops its Marketplace product line, the Marketplace accreditation status will be suspended. If the Marketplace product line is later reoffered again within the timeframe of the organization's Marketplace accreditation, NCQA may reinstate the organization's previous accreditation status until the expiration date of the organization's Marketplace accreditation. NCQA will allow the organization to come through another Interim Survey during the next accreditation cycle. NCQA may allow an organization to come through the First or Renewal Evaluation Option, depending on the organization's membership circumstances and whether the organization can meet the option's requirements (e.g., look-back periods).	**CL**	**3/26/2018**
20	Policies and Procedures—Section 1: Eligibility and Application Process	Organization Obligations	Add the following as sub-bullets after the first sentence of the last bullet: – An organization that ceases to do business and no longer has members before the end of its NCQA Accreditation cycle will be removed from the NCQA Health Plan Report Card.	**CL**	**7/30/2018**

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			– An organization that continues to have membership and elects to withdraw from accreditation and not continue to meet NCQA requirements before the end of its NCQA Accreditation cycle, will be reported as "Revoked" on the NCQA Health Plan Report Card.		
39	Policies and Procedures—Section 3: The Survey Process	About the Survey Process—File review results	Replace the first bullet with: • PHM 5.	**CO**	**3/26/2018**
40	Policies and Procedures—Section 3: The Survey Process	Reconsideration—Reconsideration request	Add the following as the last sentence: The request may be submitted via email to Reconsiderations@ncqa.org or mailed to: NCQA Office of Program Integrity 1100 13th Street NW, 3rd Floor Washington DC, 20005	**CL**	**7/30/2018**
41	Policies and Procedures—Section 3: The Survey Process	Reconsideration—Documentation That Supports Reconsideration	Delete the last sentence of the note, which reads: The organization must provide NCQA with 12 copies of materials.	**CL**	**7/30/2018**
44	Policies and Procedures—Section 4: Reporting Results	State Deeming Survey results	Replace the section with the following: For state Deeming Surveys, NCQA gives the appropriate state agency access to the organization's survey tool via "My.NCQA" (https://my.ncqa.org) to preview the final accreditation results and download the following documents: • The Medicaid Managed Care Results Summary Report. • The Standards score sheet. • The HEDIS score sheet. • The QI program description. • The QI work plan (if not included in the QI program description). • The QI program evaluation.	**CL**	**3/26/2018**

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			Note: *Per Federal Medicaid Rule: §438.332 – State review of the accreditation status, organizations must authorize NCQA as an independent accrediting entity to provide the State a copy of its most recent accreditation review. NCQA reserves the right to release to the State a copy of the accreditation review as required by the State, including: accreditation status, survey type and level (as applicable); accreditation results with recommended actions or improvements and corrective action plans required by NCQA for certain elements and standards where an organization's performance is determined to be noncompliant; expiration date of the accreditation. This rule applies to all organizations seeking NCQA Accreditation for their Medicaid product line, regardless of whether the organization undergoes an NCQA Medicaid Deeming Survey.*		
48	Policies and Procedures—Section 5: Additional Information	Notifying NCQA of Reportable Events—Annual Attestation of Compliance With Reportable Events	Revise the last sentence in the third paragraph to read: Submit Reportable Events via email to ReportableEvents@ncqa.org and annual attestations electronically to Attestations@ncqa.org, by fax to 202-955-3599 or by mail to the address below:	**CL**	**7/30/2018**
48, 50	Policies and Procedures—Section 5: Additional Information	Annual Attestation of Compliance With Reportable Events & Mergers and Acquisitions and Changes to Operations	Update the NCQA address to read: National Committee for Quality Assurance 1100 13th Street NW, Third Floor Washington, DC 20005	**CL**	**11/20/2017**
55	Policies and Procedures—Section 6: LTSS Distinction	Applying for an NCQA Survey—Request an application	Remove the last sentence in the second paragraph that reads: http://www.ncqa.org/programs/accreditation/online-application-process information on NCQA's new application process.	**CL**	**11/20/2017**
56	Policies and Procedures		Click here for the *New Section 7: Medicaid Module,* policies and procedures.	**PC**	**3/26/2018**

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<tr><td>68, 71</td><td>QI 3, Elements A, C</td><td>Scope of review</td><td>Revise the second sentence of the third paragraph to read:
If the contracts do not address the factors, NCQA reviews a practitioner manual or the organization's policies and procedures as an extension of the contract in certain circumstances. Refer to Related information.</td><td>CL</td><td>11/20/2017</td></tr>
<tr><td>77</td><td>QI 4, Element C</td><td>Examples—Tables 1 and 2</td><td>Revise the tables to correctly reflect accurate calculations and read as follows:
Table 1: Complaint volume report
<table>
<tr><th>Category</th><th>Previous Year Complaints, Total</th><th>Previous Year Complaints per 1,000 Members (Total Members 300,000)</th><th>Current Measurement Year Complaints, Total</th><th>Current Measurement Year Complaints per 1,000 Members (Total Members 240,000)</th></tr>
<tr><td>Quality of Care</td><td>1,462</td><td>4.87</td><td>1,323</td><td>5.51</td></tr>
<tr><td>Access</td><td>1,075</td><td>3.58</td><td>1,416</td><td>5.90</td></tr>
<tr><td>Attitude/ Service</td><td>946</td><td>3.15</td><td>951</td><td>3.96</td></tr>
<tr><td>Billing/ Financial</td><td>817</td><td>2.72</td><td>785</td><td>3.27</td></tr>
<tr><td>Quality of Practitioner Office Site</td><td>431</td><td>1.44</td><td>413</td><td>1.72</td></tr>
<tr><td>Total/ Number per 1,000</td><td>4,731</td><td>15.77</td><td>4,888</td><td>20.37</td></tr>
</table></td><td>CL</td><td>7/30/2018</td></tr>
</table>

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<tr><td></td><td></td><td></td><td>Table 2: Appeal volume report
<table>
<tr><th>Category</th><th>Previous Year Appeals, Total</th><th>Previous Year Appeals per 1,000 Members (Total Members 300,000)</th><th>Current Measurement Year Appeals, Total</th><th>Current Measurement Year Appeals per 1,000 Members (Total Members 240,000)</th></tr>
<tr><td>Quality of Care</td><td>203</td><td>0.68</td><td>185</td><td>0.77</td></tr>
<tr><td>Access</td><td>121</td><td>0.40</td><td>98</td><td>0.41</td></tr>
<tr><td>Attitude/ Service</td><td>83</td><td>0.28</td><td>86</td><td>0.36</td></tr>
<tr><td>Billing/ Financial</td><td>91</td><td>0.30</td><td>78</td><td>0.33</td></tr>
<tr><td>Quality of Practitioner Office Site</td><td>68</td><td>0.23</td><td>63</td><td>0.26</td></tr>
<tr><td>Total/ Number per 1,000</td><td>566</td><td>1.89</td><td>510</td><td>2.13</td></tr>
</table></td><td></td><td></td></tr>
<tr><td>88</td><td>QI 5, Element A</td><td>Related information—Collaboration through patient-centered medical home (PCMH) initiative</td><td>Remove the reference to “QI 8” under Related information so the text reads:
Collaboration through patient-centered medical home (PCMH) initiative. The use of a medical home initiative meets one opportunity for Element A if:</td><td>CL</td><td>11/20/2017</td></tr>
<tr><td>90</td><td>QI 5, Element B</td><td>Related information—Collaboration through PCMH initiative</td><td>Remove the reference to “QI 8” under Related information so the text reads:
Collaboration through PCMH initiative: The use of a medical home initiative meets one opportunity for Element B if:</td><td>CL</td><td>11/20/2017</td></tr>
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92	QI 5, Element C	Related information	Add the following text as the last paragraph under Related information: *Intermediate measures.* The organization may evaluate effectiveness of an intervention by using the same measure specification used for the initial measurement to remeasure, or by conducting an intermediate measurement. An intermediate measurement can evaluate processes or outcomes related to the intervention. For example, if the goal of the organization's intervention is to increase a screening rate by encouraging members to schedule a screening appointment, its intermediate measurement of effectiveness might be to measure the rate of member contacts that resulted in scheduled appointments. The organization might wait to assess the intervention's success until the next annual measurement cycle.	**CL**	**11/20/2017**
98	QI 6, Element B	Explanation	Add the following *Related information* subhead and text as the last section of the Explanation: Related information *Collaboration through patient-centered medical home (PCMH) initiative* The use of a medical home initiative meets one opportunity for collaboration between medical care and behavioral healthcare in Element A if: • The initiative is a direct result of the data collected and the analysis performed to meet factors 1-2. • The organization provides evidence of active support for the PCMH model during the previous 12 months. The organization can receive credit for a second opportunity, if it can provide evidence of an 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 practice transform into a medical home. • Providing other incentives for NCQA PCMH Recognition, such as pay-for-performance.	**CL**	**7/30/2018**

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			• 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.		
100	QI 6, Element C	Related information	Add the following text as the last paragraph under "Related information": *Intermediate measures.* The organization may evaluate effectiveness of an intervention by using the same measure specification used for the initial measurement to remeasure, or by conducting an intermediate measurement. An intermediate measurement can evaluate processes or outcomes related to the intervention. For example, if the goal of the organization's intervention is to increase a screening rate by encouraging members to schedule a screening appointment, its intermediate measurement of effectiveness might be to measure the rate of member contacts that resulted in scheduled appointments. The organization might wait to assess the intervention's success until the next annual measurement cycle.	**CL**	**11/20/2017**
105	QI 7, Element D	Scope of review	Add the following as the second paragraph: *This element applies if delegation was implemented in the look-back period.*	**CL**	**7/30/2018**
105	QI 7, Element D	Explanation—Predelegation evaluation	Revise the language in this section to read: The organization evaluated the delegate's capacity to meet NCQA requirements within 12 months prior to implementing delegation. NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date. If the time between the predelegation evaluation and implementation of delegation exceeds the 12 months, the organization conducts another predelegation evaluation. If the organization amends the delegation agreement to include additional QI activities within the look-back period, it performs a predelegation evaluation for the additional activities.	**CL**	**7/30/2018**

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107	QI 7, Element E	Exceptions	Replace the second paragraph with the following: Factor 2 is NA.* Replace the third paragraph with the following: Factors 3 and 4 are NA for Interim Surveys. **Note: Factor 2 will be scored NA given that this requirement is no longer applicable in the QI standards; complex case management was moved to the PHM category.*	**CL**	**11/20/2017**
112	PHM 1, Element A	Explanation—Factors 1, 2: Four areas of focus	Replace the second sentence in the second paragraph with the following: A program is a collection of services and activities to manage member health. Services are singular activities or interventions in which individuals can participate to help reach a specified health goal.	**CL**	**3/26/2018**
114	PHM 1, Element B	Explanation	Revise the first paragraph to read: This element applies to PHM programs or services in the PHM strategy that require interactive contact with members, including those offered directly by the organization.	**CL**	**3/26/2018**
117	PHM 2, Element A	Explanation—Factor 1: Claims or encounter data	Revise the second sentence to read: Behavioral claim data are not required if all purchasers of the organization's services carve out behavioral healthcare services.	**CL**	**12/3/2018**
117	PHM 2, Element A	Explanation—Factor 7: Advanced data sources	Add an Exceptions section under the Factor 7 section in the explanation that reads: **Exceptions** None.	**CL**	**12/3/2018**
117	PHM 2, Element A	Explanation—Factor 7: Advanced data sources	Add the following as the last section before the Examples: **Related information** The data sources that meet factors 1-6 may not be used to meet factor 7.	**CL**	**12/3/2018**

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<tr><td>122</td><td>PHM 2, Element D</td><td>Examples—Health Plan A: Medicare</td><td>Revise the table to correctly reflect accurate calculations so that it reads:
Health Plan A: Medicare
<table>
<tr><th>Subset of Population</th><th>Targeted Intervention for Which Members Are Eligible</th><th>Number of Members</th><th>Percentage of Membership</th></tr>
<tr><td>Multiple chronic conditions</td><td>Complex case management: Over 65</td><td>2,000</td><td>5%</td></tr>
<tr><td>Over 65, needs assistance with 2 or more ADLs</td><td>Long-term services and supports</td><td>2,800</td><td>7%</td></tr>
<tr><td>COPD: High risk</td><td>Complex case management: Over 65</td><td>1,600</td><td>4%</td></tr>
<tr><td>Osteoporosis: High-risk women</td><td>Targeted member newsletter</td><td>8,800</td><td>22%</td></tr>
<tr><td><u>BMI over 30</u></td><td><u>Weight management program</u></td><td><u>4,800</u></td><td><u>12%</u></td></tr>
<tr><td>No risk factors</td><td>Routine member newsletters</td><td><u>12,000</u></td><td><u>30%</u></td></tr>
<tr><td>No associated data</td><td>None</td><td><u>8,000</u></td><td><u>20%</u></td></tr>
</table></td><td>CL</td><td>7/30/2018</td></tr>
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123	PHM 3, Element A	Element A: Practitioner or Provider Support	Revise the factor 2 language to read: 2. Offering evidenced-based or certified decision-making aids.	**CL**	**3/26/2018**
124	PHM 3, Element A	Explanation—Factor 2: Certified shared-decision making aids	Revise the subhead to read: ***Factor 2:* Evidence-based or certified decision-making aids** Revise the last paragraph of the explanation to read: SDM aids are certified by a third party entity that evaluates quality, or are created using evidence-based criteria. If certified, the organization provides information about how, when, what conditions and to whom certified SDM aids are offered. If created using evidence-based criteria, criteria must be cited. At least one certified or evidence-based SDM aid must be offered to meet the intent.	**CL**	**3/26/2018**
129	PHM 4	Intent	Revise the intent statement to read: The organization helps adult members identify and manage health risks through evidence-based tools that maintain member privacy and explain how the organization uses collected information.	**CL**	**3/26/2018**
129, 132, 133, 139	PHM 4, Elements A–C, H	Scope of review	Add the following text as the last sentence of the third paragraph: If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.	**CL**	**11/20/2017**
130, 132, 134, 136, 137, 138,	PHM 4, Elements A-G	Related information—Use of vendors for HA services	Revise the last sentence to read: NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.	**CL**	**3/26/2018**
133	PHM 4, Element C	Look-back period	Revise the look-back period for Renewal Surveys to read: *For Renewal Surveys:* 24 months; 6 months for factor 14.	**CO**	**11/20/2017**
140, 141, 142, 143	PHM 4, Elements H-K	Related information—Use of vendors for self-management tool services	Revise the last sentence to read: NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's self-management tools against the requirements. Refer to *Vendor Relationships* in Appendix 5.	**CL**	**3/26/2018**

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141, 142	PHM 4, Elements I, J	Exception	Revise the sentence to read: Factors marked "No" in Element H are scored NA in this element.	**CO**	**11/20/2017**
148	PHM 5, Element C	Look-back period	Revise the look-back period for Renewal Surveys to read: For *Renewal Surveys*: 24 months; 6 months for factors 3, 5 and 11 and for the "current medications, including schedules and dosages" aspect of factor 1 and all of factor 2.	**PC**	**12/3/2018**
148	PHM 5, Element C	Look-back period	Revise the look-back period for Renewal surveys to read: Renewal Surveys: 24 months; 6 months for factors 3, 5 and 11.	**CL**	**3/26/2018**
148	PHM 5, Element C	Explanation— Factor 1: Initial assessment of members' health status	Add a fourth bullet to the factor 1 explanation to read: • Current medications, including schedules and dosages.	**PC**	**12/3/2018**
148	PHM 5, Element C	Explanation— Factor 2: Documentation of clinical history	Revise the language to read: Complex case management policies and procedures specify the process for documenting clinical history, including: • Past hospitalization and major procedures, including surgery. • Significant past illnesses and treatment history. • Past medications.	**PC**	**12/3/2018**
148	PHM 5, Element C	Explanation—Factor 2: Documentation of clinical history	Revise the paragraph to read: Complex case management policies and procedures specify the process for documenting clinical history (e.g., disease onset; acute phases; inpatient stays; treatment history; current and past medications, including schedules and dosages). ***Note: Updated the issue in ISS only. The language is correct in the printed publication.***	**CL**	**3/26/2018**
148	PHM 5, Element C	Look-back period	Revise the look-back period for Renewal Surveys to read: *For Renewal Surveys:* 24 months; 6 months for factor 5.	**CO**	**11/20/2017**

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148	PHM 5, Element C	Explanation—Factor 3: Initial assessment of activities of daily living	Revise the sentence to read: Complex case management policies and procedures specify the process for assessing functional status relative to at least the six basic ADLs: bathing, dressing, going to the toilet, transferring, feeding and continence.	**CL**	**11/20/2017**
149	PHM 5, Element C	Explanation—Factor 6: Initial assessment of life-planning activities	Revise the second paragraph to read: If life planning activities are determined to be appropriate, the case manager documents what activities the member has taken and what documents are in place. If determined not to be appropriate, the case manager documents the reason in the case management record or file.	**PC**	**7/30/2018**
150	PHM 5, Element C	Explanation—Factor 11: Evaluation of community resources	Add "nutritional support" as the fifth bullet.	**CL**	**11/20/2017**
152	PHM 5, Element C	Examples—Factor 14: Assessment of barriers	Revise the subhead title for number 14 to read: **Factor 13: Assessment of barriers**	**CL**	**7/30/2018**
153	PHM 5, Element D	Look-back period	Revise the look-back period for Renewal Surveys to read: *For Renewal Surveys:* 12 months; 6 months for factor 5.	**CO**	**11/20/2017**
153, 157	PHM 5, Element D, E	Scope of review	Revise the second sentence of the second paragraph to read: Files are selected from active or closed cases that were opened during the look-back period and remained open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management.	**CL**	**7/30/2018**
154	PHM 5, Element D	Explanation—Timeliness of assessment	Revise the second sentence to read: NCQA scores each factor "No" for files of initial assessments completed more than 60 calendar days from member identification, unless the delay was due to circumstances beyond the organization's control:	**CL**	**11/20/2017**
154	PHM 5, Element D	Explanation—Timeliness of assessment	Revise the first paragraph to read: The organization begins the initial assessment within 30 calendar days of identifying a member for complex case management and completes it within 60 calendar days of identification. If the initial assessment was started after	**CL**	**7/30/2018**

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			the first 30 calendar days of member identification, NCQA scores only factor 1 "No"; the remaining factors are not marked down for starting after the first 30 calendar days of identification. Additionally, NCQA scores any factor for which the initial assessment is completed more than 60 calendar days from member identification "No", unless the delay was due to circumstances beyond the organization's control:		
154	PHM 5, Element D	Explanation—Timeliness of assessment	Add the following as the fourth paragraph: Members are considered eligible upon identification unless they subsequently opt out or additional information reveals them to be ineligible.	**CL**	**11/20/2017**
155	PHM 5, Element D	Explanation— Factor 2: Documentation of clinical history	Replace the third bullet with: • Past medications.	**CL**	**12/3/2018**
155	PHM 5, Element D	Explanation—Factor 3: Initial assessment of activities of daily living	Replace the section to read: The file or case record documents the results of the ADL assessment. For ADLs with which the member needs assistance, the type of assistance and reason for need of assistance is recorded. The case manager does not need to describe ADLs the member does not need assistance with. If the member does not need assistance with any ADLs, the case file or case notes reflect that no assistance is needed (e.g., "Member is fully independent with ADLs").	**CL**	**3/26/2018**
155	PHM 5, Element D	Explanation—Factor 3: Initial assessment of activities of daily living	Revise the explanation to read: The file or case record documents the results of the ADL assessment, including activities with which the member needs assistance. If the member does not need assistance, the file or case record notes reflect it.	**CL**	**11/20/2017**
155	PHM 5, Element D	Explanation—Factor 6: Evaluation of cultural and linguistic needs	Delete the third bullet, which reads: • Health literacy.	**CL**	**3/26/2018**

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156	PHM 5, Element D	Explanation—Factor 10: Evaluation of community resources	Replace the section to read: The file or case record documents a case manager's evaluation of the member's eligibility for community resources and the availability of those resources and documents which the member may need. For the community resources the member needs, the availability and member's eligibility is also recorded in the file. The case manager does not need to address community resources the member does not need. If no community resources are needed by the member, the case file or case notes reflect that no community resources are needed (e.g., "Member does not need any of the available community resources").	**CL**	**3/26/2018**
156	PHM 5, Element D	Explanation—Factor 11: Initial assessment of life planning activities	Revise the second and third paragraphs to read: If life planning activities are determined to be appropriate, the case manager documents what activities the member has taken and what documents are in place. If determined not to be appropriate, the case manager documents the reason in the case management record or file.	**PC**	**7/30/2018**
160	PHM 5, Element F	Scope of review	Revise the scope of review for Renewal Surveys to read: During the most recent year, the organization obtains and analyzes member feedback about: • Information about the overall program. • The program staff. • Usefulness of the information disseminated. • Members' ability to adhere to recommendations. • Percentage of members indicating that the program helped them achieve health goals. During the previous year, the organization obtains and analyzes member feedback about: • Information about the overall program. • The program staff. • Usefulness of the information disseminated. • Members' ability to adhere to recommendations.	**CO**	**11/20/2017**

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160	PHM 5, Element F	Look-back period	Revise the look-back period for Renewal Surveys to read: *For Renewal Surveys*: 24 months; at least once during the prior year for the percentage of members component of factor 1.	**CL**	**11/20/2017**
164	PHM 6, Element A	Explanation--Experience	Remove "complex case management" from the second sentence in the first paragraph to read: Feedback is specific to the programs being evaluated and covers, at a minimum: Revise the text in the third paragraph to read: The organization analyzes feedback from at least two types of programs. The organization may use its complex case management member experience results and member experience results from one other program or service (e.g., disease management program or wellness program).	**CL**	**11/20/2017**
167, 169, 170, 174	PHM 7, Elements A-C, F	Look-back period	Revise the look-back period for Renewal Surveys to read: *For Renewal Surveys:* 6 months for delegated PHM 1, Elements A, B; PHM 2, Elements A-D; PHM 3, Element A; PHM 4, Element C, factor 14; PHM 5, Element C, factors 3, 5 and 11, Element D, factor 5; PHM 5, Element F, factor 1 (percentage of members component of the factor); 24 months for all other PHM activities.	**CL**	**3/26/2018**
167, 169, 170, 174	PHM 7, Elements A–C, F	Look-back period	Revise the look-back period for Renewal Surveys to read: *For Renewal Surveys:* 6 months for delegated PHM 1, Elements A, B; PHM 2, Elements A-D; PHM 3, Element A; PHM 4, Element C, factor 14; PHM 5, Elements C, D, factor 5; PHM 5, Element F, factor 1 (percentage of members component of the factor); 24 months for all other PHM activities.	**CL**	**11/20/2017**
171	PHM 7, Element D	Scope of review	Add the following as the second paragraph: *This element applies if delegation was implemented in the look-back period.*	**CL**	**7/30/2018**
171	PHM 7, Element D	Look-back period	Revise the look-back period for Renewal Surveys to read: *For Renewal Surveys:* 6 months for delegated PHM 1, Elements A, B; PHM 2, Elements A-D; PHM 3, Element A; PHM 4, Element C, factor 14; PHM 5, Element C, factors 3, 5 and 11, Element D, factor 5; PHM 5, Element F,	**CL**	**3/26/2018**

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			factor 1 (percentage of members component of the factor); 12 months for all other PHM activities.		
171	PHM 7, Element D	Look-back period	Revise the look-back period for Renewal Surveys to read: *For Renewal Surveys:* 6 months for delegated PHM 1, Elements A, B; PHM 2, Elements A-D; PHM 3, Element A; PHM 4, Element C, factor 14; PHM 5, Elements C, D, factor 5; PHM 5, Element F, factor 1 (percentage of members component of the factor); 12 months for all other PHM activities.	**CL**	**11/20/2017**
171-172	PHM 7, Element D	Explanation—Predelegation evaluation	Revise the language in this section to read: The organization evaluated the delegate's capacity to meet NCQA requirements within 12 months prior to implementing delegation. NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date. If the time between the predelegation evaluation and implementation of delegation exceeds the 12 months, the organization conducts another predelegation evaluation. If the organization amends the delegation agreement to include additional PHM activities within the look-back period, it performs a predelegation evaluation for the additional activities.	**CL**	**7/30/2018**
173	PHM 7, Element E	Look-back period	Revise the look-back period for Renewal Surveys to read: *For Renewal Surveys:* Once during the prior year for delegated PHM 1, Elements A, B; PHM 2, Elements A-D; PHM 3, Element A; PHM 4, Element C, factor 14; PHM 5, Element C, factors 3, 5 and 11, Element D, factor 5; PHM 5, Element F, factor 1 (percentage of members component of the factor); 24 months for all other PHM activities.	**CL**	**3/26/2018**
173	PHM 7, Element E	Look-back period	Revise the look-back period for Interim and First Surveys to read: *For Interim Surveys and First Surveys:* Once during the prior year. Revise the look-back period for Renewal Surveys to read: *For Renewal Surveys:* Once during the prior year for delegated PHM 1, Elements A, B; PHM 2, Elements A-D; PHM 3, Element A; PHM 4, Element	**CL**	**11/20/2017**

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			C, factor 14; PHM 5, Elements C, D, factor 5; PHM 5, Element F, factor 1 (percentage of members component of the factor); 24 months for all other PHM activities.		
173	PHM 7, Element E	Explanation	Revise the second paragraph to read: NCQA scores factors 2 and 3 "yes" if all delegates are NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.	**CL**	**3/26/2018**
173	PHM 7, Element E	Exceptions	Remove the following exception: Factor 1 is NA for NCQA-Accredited/Certified WHP organizations.	**CL**	**3/26/2018**
~~173~~	~~PHM 7, Element E~~	~~Explanation~~	~~Add "or WHP organizations" to the second paragraph of the Explanation so it reads:~~ ~~NCQA scores factor 2 and 3 "yes" if all delegates are NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs or WHP organizations, unless the element is NA.~~ ***Updated the issue on March 26, 2018, to reflect that if an organization contracts with a WHP vendor to meet PHM requirements, NCQA does not consider the relationship to be delegation and delegation oversight is not required.***	~~**CL**~~	~~**11/20/2017**~~
~~173~~	~~PHM 7, Element E~~	~~Exceptions~~	~~Add an exception for WHP organizations that reads:~~ ~~Factor 1 is NA for NCQA-Accredited/Certified WHP organizations.~~ ***Updated the issue on March 26, 2018.***	~~**CL**~~	~~**11/20/2017**~~
181	NET 1, Element C	Explanation—Factor 1: High-volume and high-impact specialists	Add the following as the last sentence in the first paragraph: Even if the organization only identifies the minimum specialties as high-volume and high-impact, the organization must state this in its policies and procedures.	**CL**	**11/20/2017**

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187	NET 2, Element A	Explanation	Rearrange the explanation text to read: This is a **structural requirement**. The organization must present its own documentation. **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 practitioner or member population or from a statistically valid sample. If the organizations collects data using surveys or practitioner self-reported information, 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. If the organization's analysis reveals issues at the organizational level, the organization conducts a practitioner-level analysis across all primary care practitioners and practices or from a statistically valid sample of them. **Factors 1–3: Access to appointments and after-hour care** Factors 1-3 apply to access to primary care services. Standards may be quantified in a specific number of hours or days or the number or percent of complaints concerning access to each type denoted in the factors. Data to measure whether the standards are being met must reflect the standard. For example, if hours or days is the standard, then the measure of performance must be hours or days. **Exceptions** None.	**CL**	**7/30/2018**
188	NET 2, Element B	Explanation	Rearrange the explanation text to read: This is a **structural requirement**. The organization must present its own documentation.	**CL**	**7/30/2018**

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			Factors 1 and 2 are **critical factors**; both factors must be met for the organization to score higher than 20% on this element. The organization meets factor 1 if it directs members with non-life-threatening emergencies are directed to the ER. **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 practitioner or member population or from a statistically valid sample. If the organization collects data using surveys or practitioner self-reported information, it supplements the data with an analysis of complaints regarding behavioral healthcare access. **Quantitative and qualitative analyses** 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. If analysis reveals issues at the organizational level, the organization conducts a practitioner-level analysis across all behavioral healthcare practitioners and practices or from a statistically valid sample of them. **Factors 1-4: Access to behavioral healthcare and appointments** The organization's report includes separate analyses of appointment availability for behavioral healthcare practitioners who prescribe medications (e.g., psychiatrists) and for behavioral healthcare practitioners who do not prescribe (e.g., psychologists) for each factor. **Factor 3: Initial routine care** Initial routine care appointments do not include follow-up care for an existing problem.		

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			Factor 4: Follow-up routine care appointments 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. **Exceptions** This element is NA if all purchasers of the organization's services carve out or exclude behavioral healthcare.		
190	NET 2, Element C	Explanation	Rearrange the explanation text to read: **Data collection methods** The organization determines its data collection methodology and performance goals. The organization collects data using member surveys or direct assessment of appointment wait times from practices through self-report or secret-shopper assessments. If the organization collects data using surveys or self-reported practitioner information, it supplements the data with an analysis of complaints about access. **Quantitative and qualitative analyses** The organization annually conducts quantitative analysis against its accessibility standards and a qualitative analysis of the performance results. If analysis reveals issues at the organizational level, the organization conducts a practitioner-level analysis across all affected high-volume and high-impact practitioners and practices or from a statistically valid sample of them. **Factor 1: High-volume specialists** The organization analyzes data to determine if access to appointments with high-volume specialists identified in NET 1, Element C is sufficient for members. **Factor 2: High-impact specialists** The organization analyzes data to determine if access to appointments with high-impact specialists identified in NET 1, Element C is sufficient for members.	**CL**	**7/30/2018**

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			Exceptions None.		
193	NET 3, Element B	Factor 1	Add "out-of-network services data" to factor 1 and revise the factor to read: 1. 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) and out-of-network services data (NET 3, Element A, factor 3).	**CO**	**11/20/2017**
193	NET 3, Element B	Scope of review	Add the following as the last two paragraphs: *For Renewal Surveys,* during the most recent year of the look-back period, the organization prioritizes opportunities for all aspects in factor 1. *For Renewal Surveys,* during the previous year of the look-back period, the organization prioritizes opportunities for availability, accessibility, CAHPS survey results and member complaints and appeals.	**CL**	**11/20/2017**
194	NET 3, Element B	Look-back period	Revise the look-back period for Renewal Surveys to read: For *Renewal Surveys*: 24 months; at least once in the prior year for the out-of-network services data component of factor 1.	**CL**	**11/20/2017**
194	NET 3, Element B	Explanation—Factors 1-3	Revise the first sentence of the paragraph to read: The organization summarizes opportunities identified from analyses of nonbehavioral healthcare data from NET 3, Element A, factors 1 and 3 to show a comprehensive overview of network access issues.	**CL**	**11/20/2017**
194	NET 3, Element C	Factor 1	Add "out-of-network services data" to factor 1 and revise the factor to read: 1. Prioritizes improvement opportunities identified from analyses of availability (NET 1), accessibility (NET 2), complaints and appeals or member experience (NET 3, Element A, factor 2) and out-of-network services data (NET 3, Element A, 3).	**CO**	**11/20/2017**
194	NET 3, Element C	Scope of review	Add the following as the last two paragraphs: *For Renewal Surveys, during the most recent year of the look-back period,* the organization prioritizes opportunities for all aspects in factor 1.	**CL**	**11/20/2017**

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			For Renewal Surveys, during the previous year of the look-back period, the organization prioritizes opportunities for availability, accessibility, complaints and appeals and member experience.		
194	NET 3, Element C	Look-back period	Revise the look-back period for Renewal Surveys to read: For *Renewal Surveys*: 24 months; at least once in the prior year for out-of-network services data.	**CL**	**11/20/2017**
195	NET 3, Element C	Explanation—Factors 1-3	Revise the first sentence of the paragraph to read: The organization summarizes opportunities identified from analyses of behavioral healthcare data from NET 3, Element A, factors 2 and 3 to show a comprehensive overview of network access issues.	**CL**	**11/20/2017**
200	NET 4, Element C	Element stem	Revise the element stem to read: To assess member experience with its services, the organization annually evaluates member complaints, appeals and requests for out-of-network services by:	**CO**	**7/30/2018**
200	NET 4, Element C	Scope of review	Add the following as the last two paragraphs for Renewal Surveys: *During the most recent year of the look-back period* for factor 2, the organization presents a report that includes both requests for and utilization of out-of-network services per thousand members. *During the previous year of the look-back period* for factor 2, the organization presents a report that includes data on requests for out-of-network services.	**CL**	**11/20/2017**
211	NET 6, Element C	Explanation—Factor 4	Add the following as a new section in the Explanation: **Exception** Factor 4 is NA for an integrated HMO model (i.e., all practitioners and office staff are employees of the organization).	**CL**	**3/26/2018**
220	NET 6, Element K	Related information—Use of vendors for usability testing services	Revise the last sentence to read: NCQA does not consider the relationship to be delegation, and delegation oversight is not required under NET 7. NCQA evaluates the vendor's	**CL**	**3/26/2018**

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			documentation against the requirements. Refer to *Vendor Relationships* in Appendix 5.		
222, 224, 225, 229	NET 7, Element A-C, F	Look-back period	Revise the look-back period for Renewal Surveys to read: *For Renewal Surveys:* 6 months for delegated NET 3, Element A, factor 3; Elements B, C, factor 1 (out-of-network services component of the factor); 24 months for all other NET activities.	**CL**	**11/20/2017**
226	NET 7, Element D	Look-back period	Revise the look-back period for Renewal Surveys to read: *For Renewal Surveys:* 6 months for delegated NET 3, Element A, factor 3; Elements B, C, factor 1 (out-of-network services component of the factor); 12 months for all other NET activities.	**CL**	**11/20/2017**
226	NET 7, Element D	Scope of Review	Add the following as the second paragraph: *This element applies if delegation was implemented in the look-back period.*	**CL**	**7/30/2018**
226	NET 7, Element D	Explanation—Predelegation evaluation	Revise the language in the *Predelegation evaluation* section to read: The organization evaluated the delegate's capacity to meet NCQA requirements within 12 months prior to implementing delegation. NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date. If the time between the predelegation evaluation and implementation of delegation exceeds the 12 months, the organization conducts another predelegation evaluation. If the organization amends the delegation agreement to include additional NET activities within the look-back period, it performs a predelegation evaluation for the additional activities.	**CL**	**7/30/2018**
228	NET 7, Element E	Scope of Review	Replace the fifth paragraph with the following: For *First Surveys*, NCQA reviews the organization's most recent annual review, audit, performance evaluation and semiannual evaluation. For *Renewal Surveys*, NCQA reviews the organization's most recent and previous year's annual reviews, audits, performance evaluations and four semiannual evaluations.	**CL**	**11/20/2017**

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228	NET 7, Element E	Look-back period	Revise the look-back period for Renewal Surveys to read: *For Renewal Surveys:* Once during the prior year for delegated NET 3, Element A, factor 3; Elements B, C, factor 1 (out-of-network services component of the factor); 24 months for all other NET activities.	**CL**	**11/20/2017**
250	UM 4, Element B	Explanation	Add the following as the second bullet: • Nurse practitioners*: Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials. Add the following note under the second paragraph: *In states where the organization has determined that practice acts or regulations allow nurse practitioners to practice as independent practitioners, nurse practitioners may review requests that are within the scope of their license.	**CL**	**3/26/2018**
259, 262, 264, 267, 277	UM 5, Elements A-D, H	Scope of Review	Add the following as the first paragraph: Because the requirement for timeliness of UM **decisions/notifications** for the Medicare and Medicaid product lines is being revised for the 2019 standards year for factor 1, NCQA will apply the change to factor 1 for surveys beginning on or after July 1, 2018. For Medicare and Medicaid urgent concurrent requests, the organization **makes decisions/sends notifications** within 72 hours of receipt of the request.	**PC**	**7/30/2018**
259, 264	UM 5, Elements A, C	Explanation—Factors 1-4: Timeliness of decision making	Remove "postservice decisions" from the second paragraph so that it reads: *For Medicaid and Medicare only:* Nonurgent preservice decisions must be made within 14 calendar days.	**CL**	**3/26/2018**
259, 270	UM 5, Element A, E	Explanation—Classification of UM requests	Add the following as the first bullet under "Urgent request": • Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgement, ***or*** ***Note: The type of update was reclassified from "CL" to "PC" on 8/27/18.**	**PC**	**7/30/2018**

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259, 265, 277	UM 5, Element A, C, H	Explanation—Factors 1-4: Timeliness of decision making	**In Elements A and C, revise the fourth paragraph to read:** An organization may have procedures for ongoing review of urgent concurrent care it approved initially. For ongoing reviews, the notification period begins on the day of the review. The organization documents the date of the ongoing review, the decision and the notification in the UM denial file. **In Element H, revise the third paragraph to read:** An organization may have procedures for ongoing review of urgent concurrent care it approved initially. For ongoing reviews, the notification period begins on the day of the review. the organization documents the date of the ongoing review, the decision and the notification in the UM denial file.	**CL**	**3/26/2018**
262, 267	UM 5, Elements B, D	Explanation—Factors 1-4: Timeliness of notification	Remove "postservice decisions" from the first paragraph so that it reads: *For Medicaid and Medicare only:* For nonurgent preservice decisions, the organization gives electronic or written notification of the decision to practitioners and members within 14 calendar days of the request.	**CL**	**3/26/2018**
262, 267, 273	UM 5, Elements B, D, F	Explanation	Revise the second paragraph to read: This element applies to all **nonbehavioral healthcare/behavioral healthcare/pharmaceutical** denial determinations resulting from medical necessity review.	**PC**	**7/30/2018**
263, 268, 274	UM 5, Elements B, D, F	Related information—Oral notification	Revise the first paragraph to read: If the organization provides initial oral notification of a denial decision within 24 hours of an urgent concurrent request or within 72 hours of an urgent preservice request, it has an additional 3 calendar days following oral notification to provide written or electronic notification. The organization records the time and date of the notification and the staff member who spoke with the practitioner or member. Oral notification must involve communication with a live person; the organization may not leave a voicemail.	**CL**	**11/20/2017**

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263, 268, 275	UM 5, Elements B, D, F	Related information—Failure to follow filing procedures	Revise the second bullet to include "postservice decisions" so it reads: • *For nonurgent preservice and postservice decisions,* the organization notifies the practitioner or member within 5 calendar days of receiving the request for services.	**CL**	**3/26/2018**
263, 268, 275	UM 5, Elements B, D, F	Related information	Add the following as the last paragraphs: *Use of practitioner web portals.* The organization may provide electronic denial notifications to practitioners through a web portal if: • The organization informs practitioners of the notification mechanism and their responsibility to check the portal regularly, ***and*** • The organization documents the date and time when the information was posted in the portal, ***and*** • The information posted in the portal meets the requirements in UM 4-UM 7. The organization must have an alternative notification method for practitioners who do not have access to the web portal.	**CL**	**11/20/2017**
270	UM 5, Element E	Explanation—Factors 1-7: Timeliness of pharmaceutical decision making	Revise the second paragraph to read: An organization may have procedures for ongoing review of urgent concurrent care it approved initially. For ongoing reviews, the notification period begins on the day of the review. The organization documents the date of the ongoing review, the decision and the notification in the UM denial file.	**CL**	**3/26/2018**
280, 282, 283	UM 6, Elements A-C	Explanation—Relevant clinical information	Add the following text as the second paragraph: The relevance of clinical information is considered in terms of the criteria used by the organization to make its decision (i.e., the clinical information must be related to the criteria the organization said were not met in its denial notice). Organizations must gather clinical information when determining medical necessity. If enough clinical information relevant to the criteria is not provided with the request, the organization must document in the denial file its attempts to gather the clinical information needed to make a decision.	**CL**	**3/26/2018**

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Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
286, 292, 298	UM 7, Elements B, E, H	Explanation—Factor 1: Reason for denial	Replace the first paragraph with the following text: The denial notification states the reason for the denial in terms specific to the member's condition or request and in language that is easy to understand, so the member and practitioner know why the organization denied the request and have enough information to file an appeal. The notification includes a complete explanation of the grounds for the denial, in language that a layperson would understand, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand. An organization is not required to spell out abbreviations/acronyms if they are clearly explained in lay language. To illustrate, for the acronym DNA, spelling out would be "a DNA (deoxyribonucleic acid)" whereas explaining would be "a DNA test is a test that looks at your genetic information." Denial notifications sent only to practitioners may include technical or clinical terms.	**CL**	**12/3/2018**
287, 292, 298	UM 7, Elements B, E, H	Explanation—Factor 1: Reason for denial	Add the following as the last sentence in the first paragraph: Denial notifications sent only to practitioners may include technical or clinical terms.	**CL**	**3/26/2018**
289, 296, 301	UM 7, Elements C, F, I	Related information	Revise the last paragraph to read: *Medicare denials and Fully Integrated Dual Eligible (FIDE) denials*. CMS requires organizations to issue an Integrated Denial Notice (IDN) for non-inpatient medical service denials for Medicare and FIDE members. The IDN meets factors 1–3 for these members.	**PC**	**12/3/2018**
289, 296, 301	UM 7, Elements C, F, I	Related information—Notification exception	Add the following to the beginning of this section: NCQA does not require the organization to notify a member about an urgent preservice decision. The organization may notify only the attending or treating practitioner, because NCQA considers the attending or treating practitioner to be acting as the member's representative.	**CL**	**3/26/2018**

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Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
304-305	UM 8, Element A	Explanation—Factors 7-9: Appeal decisions	Replace the first paragraph with the following text: Appeal policies and procedures specify that appeal decisions and notification are timely. The appeal decision notification states the reason for upholding the denial in terms specific to the member's condition or request and in language that is easy to understand, so the member and practitioner understand why the organization upheld the appeal decision and have enough information to file the next level of appeal. An appropriately written notification includes a complete explanation of the grounds for the upheld appeal decision, in language that a layperson would understand, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand. The organization is not required to spell out abbreviations/acronyms if they are clearly explained in lay language. To illustrate, for the acronym DNA, spelling out would be "a DNA (deoxyribonucleic acid)" whereas explaining would be "a DNA test is a test that looks at your genetic information." Upheld appeal notifications sent only to practitioners may include technical or clinical terms.	**CL**	**12/3/2018**
305	UM 8, Element A	Explanation—Factors 7-9: Appeal decisions	Add the following as the last sentence in the first paragraph: Appeal notifications sent only to practitioners may include technical or clinical terms.	**CL**	**3/26/2018**
305	UM 8, Element A	Explanation—Factors 7-9: Appeal decisions	Remove the word "Medicare" and revise the last paragraph to read: For **Medicaid only**, decisions for postservice appeals and notifications to members must be within 30 calendar days of receipt of the request.	**CO**	**11/20/2017**
305	UM 8, Element A	Explanation—Factor 13: Titles and qualifications	Revise the first sentence of the first paragraph to read: Appeal policies and procedures require the appeal notice to identify each reviewer who participated in the appeal, including:	**CL**	**11/20/2017**

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Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
305	UM 8, Element A	Explanation—Factor 13: Titles and qualifications	Revise the bulleted language for benefit and medical necessity appeals to read: • *For a benefit appeal:* The reviewers' title (name of reviewers' position or job within the organization). • *For a medical necessity appeal:* The reviewers' title (name of reviewers' position or job within the organization), qualifications (clinical credentials, such as MD, DO, PhD) and specialty (e.g., pediatrician, general surgeon, neurologist, clinical psychologist).	**CL**	**7/30/2018**
306	UM 8, Element A	Related information—Extending the time frame to obtain additional information	Add "or" to the end of the first bullet so that it reads: The member agrees to extend the appeal time frame, ***or***	**CL**	**12/3/2018**
307	UM 8, Element B	Look-back period	Revise the look-back period to read: *For Renewal Surveys:* 24 months.	**CL**	**11/20/2017**
309, 310, 312, 313	UM 9, Elements A-D	Scope of review	Add the word "upheld" in the second sentence of the scope of review so that it reads: NCQA reviews a random sample of up to 40 upheld appeal files for evidence… • That the appeal file contains all three factors **(Element A)**. • Of timeliness of decision making **(Element B)**. • Of involvement of nonsubordinate and same-or-similar specialist reviewers **(Element C)**. • That appeal letters meet all 6 factors **(Element D)**.	**CL**	**11/20/2017**
310	UM 9, Element B	Explanation—Factors 1-3: Timeliness of appeal process	Remove the word "Medicare" and revise the last paragraph to read: For **Medicaid only**, decisions for postservice appeals and notifications to members must be within 30 calendar days of receipt of the request.	**CO**	**11/20/2017**
313	UM 9, Element D	Explanation—Factor 1: The appeal decision	Replace the language with the following text: The appeal decision notification states the reason for upholding the denial in terms specific to the member's condition or request and in language that is easy to understand, so the member and practitioner understand why the	**CL**	**12/3/2018**

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			organization upheld the appeal decision and have enough information to file the next level of appeal. An appropriately written notification includes a complete explanation of the grounds for the upheld appeal decision, in language that a layperson would understand, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand. The organization is not required to spell out abbreviations/acronyms if they are clearly explained in lay language. To illustrate, for the acronym DNA, spelling out would be "a DNA (deoxyribonucleic acid)" whereas explaining would be "a DNA test is a test that looks at your genetic information." Upheld appeal notifications sent only to practitioners may include technical or clinical terms.		
314	UM 9, Element D	Explanation—Factor 1: The appeal decision	Add the following as the last sentence in the second paragraph: Appeal notifications sent only to practitioners may include technical or clinical terms.	**CL**	**3/26/2018**
314	UM 9, Element D	Explanation—Factor 5: Titles and qualifications	Revise the bulleted language for benefit and medical necessity appeals to read: • *For a benefit appeal:* The reviewers' title (name of reviewers' position or job within the organization). • *For a medical necessity appeal:* The reviewers' title (name of reviewers' position or job within the organization), qualifications (clinical credentials, such as MD, DO, PhD) and specialty (e.g., pediatrician, general surgeon, neurologist, clinical psychologist).	**CL**	**7/30/2018**
314	UM 9, Element D	Explanation—Factor 6: Additional appeal rights	Add the following as the second sentence in the second paragraph: The statement that members are not required to bear costs of the IRO, including filing fees, does not apply to appeals by members in self-funded accounts or to members covered by Medicare, Medicaid or the FEHB Program.	**CL**	**3/26/2018**

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Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
314	UM 9, Element D	Exceptions	Revise the first sentence to read: Factors 3, 4 and 5 are NA for Medicaid Part D appeals.	**CL**	**3/26/2018**
336	UM 13, Element D	Scope of Review	Add the following as the second paragraph: *This element applies if delegation was implemented in the look-back period.*	**CL**	**7/30/2018**
336	UM 13, Element D	Explanation—Predelegation evaluation	Revise the language in this section to read: The organization evaluated the delegate's capacity to meet NCQA requirements within 12 months prior to implementing delegation. NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date. If the time between the predelegation evaluation and implementation of delegation exceeds the 12 months, the organization conducts another predelegation evaluation. If the organization amends the delegation agreement to include additional UM activities within the look-back period, it performs a predelegation evaluation for the additional activities.	**CL**	**7/30/2018**
354	CR 3, Element A	Explanation—Factor 3: Education and training—*Completion of residency training*	Remove the subbullet under "FCVS for closed residency programs" and make the following text a separate paragraph: NCQA only recognizes residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) (in the United States) or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada.	**CL**	**11/20/2017**
357	CR 3, Element B	Explanation—Factor 1: Scope of review for sanctions or limitations on licensure	Add as the first sentence in the first paragraph: The organization verifies state sanctions, restrictions on licensure or limitations on scope of practice in all states where the practitioner provides care to members.	**CL**	**11/20/2017**
377	CR 8, Element C	Look-back period	Revise the first sentence to read: *For Interim Surveys* and *First Surveys*: At least once during the prior year.	**CL**	**12/3/2018**

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377	CR 8, Element C	Scope of Review	Add the following as the second paragraph: *This element applies if delegation was implemented in the look-back period.*	**CL**	**7/30/2018**
378	CR 8, Element C	Explanation—Predelegation evaluation	Revise the language in this section to read: The organization evaluated the delegate's capacity to meet NCQA requirements within 12 months prior to implementing delegation. NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date. If the time between the predelegation evaluation and implementation of delegation exceeds the 12 months, the organization conducts another predelegation evaluation. If the organization amends the delegation agreement to include additional CR activities within the look-back period, it performs a predelegation evaluation for the additional activities.	**CL**	**7/30/2018**
380	CR 8, Element D	Exceptions	Add the following as the third exception: Factors 2-4 are NA for Interim Surveys.	**CL**	**12/3/2018**
404	RR 5, Element D	Scope of Review	Add the following as the second paragraph: *This element applies if delegation was implemented in the look-back period.*	**CL**	**7/30/2018**
404	RR 5, Element D	Explanation—Predelegation evaluation	Revise the language in this section to read: The organization evaluated the delegate's capacity to meet NCQA requirements within 12 months period prior to implementing delegation. NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date. If the time between the predelegation evaluation and implementation of delegation exceeds the 12 months, the organization conducts another predelegation evaluation.	**CL**	**7/30/2018**

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			If the organization amends the delegation agreement to include additional RR activities within the look-back period, it performs a predelegation evaluation for the additional activities.		
411	MEM 1	Standard and Intent Statement	Revise the standard and intent statement to read: **Standard statement:** The organization provides members with timely and accurate information about their claims. **Intent statement:** The organization allows members to access and track claims through the claims process on its website and by telephone.	**CO**	**11/20/2017**
412	MEM 1, Element A	Related information—Use of vendors for claims processing services	Revise the last sentence to read: NCQA does not consider the relationship to be delegation, and delegation oversight is not required under MEM 5. NCQA evaluates the vendor's system against the requirements. Refer to *Vendor Relationships* in Appendix 5.	**CL**	**3/26/2018**
430	MEM 4, Element A	Related information—Use of vendors for technology services	Revise the last sentence to read: NCQA does not consider the relationship to be delegation, and delegation oversight is not required under MEM 5. NCQA evaluates the vendor's documentation against the requirements. Refer to *Vendor Relationships* in Appendix 5.	**CL**	**3/26/2018**
430	MEM 4, Element A	Related information	Add the following text as paragraph 4 under *Related information:* *Partners in Quality.* The organization can receive automatic credit for factors 2, 4, 5 and 6 if the organization is an NCQA-designated Partner in Quality. The organization must provide documentation of its status.	**CL**	**11/20/2017**
435	MEM 5, Element D	Scope of Review	Add the following as the second paragraph: *This element applies if delegation was implemented in the look-back period.*	**CL**	**7/30/2018**
435	MEM 5, Element D	Explanation—NCQA-Accredited/Certified delegates	Revise the first sentence under the subhead to read: NCQA scores this element 100% if all delegates are NCQA Accredited under health plan standards, or are NCQA Certified in HIP, and if the	**CL**	**3/26/2018**

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			delegated activities were included within the scope of the delegate's survey, unless the element is NA.		
436	MEM 5, Element D	Explanation—Predelegation evaluation	Revise the language in this section to read: The organization evaluated the delegate's capacity to meet NCQA requirements within 12 months prior to implementing delegation. NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date. If the time between the predelegation evaluation and implementation of delegation exceeds the 12 months, the organization conducts another predelegation evaluation. If the organization amends the delegation agreement to include additional MEM activities within the look-back period, it performs a predelegation evaluation for the additional activities.	**CL**	**7/30/2018**
437	MEM 5, Element E	Explanation—NCQA-Accredited/Certified delegates	Revise the first sentence under the subhead to read: NCQA scores factor 2 "Yes" if all delegates are NCQA-Accredited health plan organizations, or are NCQA-Certified HIP organizations, and if delegated activities were included within the scope of the delegate's survey, unless the element is NA.	**CL**	**3/26/2018**
438	MEM 5, Element F	Explanation—NCQA-Accredited/Certified delegates	Revise the first sentence under the subhead to read: NCQA scores this element 100% if all delegates are NCQA-Accredited health plan organizations or NCQA-Certified HIP organizations, and if delegated activities were included within the scope of the delegate's survey, unless the element is NA.	**CL**	**3/26/2018**
478	LTSS 1, Element E	Explanation—Factor 1: Prioritized goals	Replace "Element B" with "Element F" under the Factor 1 subhead.	**CO**	**7/30/2018**
478	LTSS 1, Element E	Explanation—Factor 1: Prioritized goals	Add as the last two sentences to the paragraph under the factor 1 explanation: Designating goals as long-term or short-term is not sufficient to meet the requirement. The organization must rank or prioritize goals.	**CL**	**7/30/2018**

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478	LTSS 1, Element E	Explanation—Factor 3: Life-planning activities	Revise the first and second sentences of the second paragraph to read: If life planning activities are determined to be appropriate, the case manager documents what activities the member has taken and what documents are in place. If determined not to be appropriate, the case manager documents the reason in the case management record or file.	**PC**	**7/30/2018**
480	LTSS 1, Element F	Explanation—Factor 1: Individualized case management plan	Add as the last two sentences to the paragraph under the factor 1 explanation: Designating goals as long-term or short-term is not sufficient to meet the requirement. The organization must rank or prioritize goals.	**CL**	**7/30/2018**
500	LTSS 2, Element G	Explanation--Exceptions	Revise the first sentence to read: Factors 2 and 3 are NA:	**CL**	**7/30/2018**
504	LTSS 3, Element A	Examples—Factor 4: Track the status of transitions	Revise the subhead to read: ***Factor 6:*** **Track the status of transitions**	**CO**	**3/26/2018**
510	LTSS 4, Element C	Scope of Review	Add the following as the second paragraph: This element applies if delegation was implemented in the look-back period.	**CL**	**7/30/2018**
510	LTSS 4, Element C	Explanation—Predelegation evaluation	Revise the language in the *Predelegation evaluation* section to read: The organization evaluated the delegate's capacity to meet NCQA requirements within 12 months prior to implementing delegation. NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date. If the time between the predelegation evaluation and implementation of delegation exceeds the 12 months, the organization conducts another predelegation evaluation. If the organization amends the delegation agreement to include additional LTSS activities within the look-back period, it performs a predelegation evaluation for the additional activities.	**CL**	**7/30/2018**

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Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
512	LTSS 4, Element D	Exceptions	Remove the following language: Factor 2 is NA if: • The organization does not delegate case management activities. • Delegation arrangements have been in effect for less than 12 months.	**CL**	**3/26/2018**
597	MED 15, Element C	Scope of Review	Add the following as the second paragraph: *This element applies if delegation was implemented in the look-back period.*	**CL**	**7/30/2018**
598	MED 15, Element C	Explanation—Predelegation evaluation	Revise the language in this section to read: The organization evaluated the delegate's capacity to meet NCQA requirements within 12 months prior to implementing delegation. NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date. If the time between the predelegation evaluation and implementation of delegation exceeds the 12 months, the organization conducts another predelegation evaluation. If the organization amends the delegation agreement to include additional MED activities within the look-back period, it performs a predelegation evaluation for the additional activities.	**CL**	**7/30/2018**
55 (MED Module)	MED 11, Element A	Explanation—Factor 1: Continued coverage pending the outcome	Revise the language under the subhead to read: If a member requests continued coverage, the organization informs the member that benefits scheduled for reduction or termination will continue if the member files an appeal or requests a State Fair Hearing.	**CL**	**12/3/2018**
63-64 (MED Module)	MED 12, Element E	Explanation	Revise the following Explanation factor titles to read: **Factor 1: Availability of the member handbook in regular and large print** **Factor 2: Availability of the member handbook in alternative formats** **Factor 3: Availability of the member handbook in other languages** **Factor 4: Availability of the member handbook with taglines in other languages**	**CL**	**12/3/2018**

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

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Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
1-12	Appendix 1	Standard and Element Points for 2018	Revise the CR 8 title to read: **CR 8: DELEGATION OF CR**	**CL**	**11/20/2017**
1-14	Appendix 1	Standard and Element Points for 2018	Click here for *Appendix 1: Standard and Element Points For 2018* that includes updates to the points for First Surveys for QI 4, PHM 4, PHM 7, CR 8, RR 5 and MEM 5.	**CO**	**3/26/2018**
1-14	Appendix 1	Standard and Element Points for 2018	Click here for *Appendix 1: Standard and Element Points For 2018* that includes the points for the ***New*** *Medicaid Module.*	**PC**	**3/26/2018**
2-3	Appendix 2	HEDIS Measures Required for 2018 HP Accreditation—Commercial	Add total count of HEDIS measures and CAHPS at the end for each section as follows: *Commercial HEDIS Measures = 29* *(CDC counts as 2)* *Commercial CAHPS = 10* *(Rating of the Health Plan counts as 2)*	**CL**	**3/26/2018**
2-4	Appendix 2	HEDIS Measures Required for 2018 HP Accreditation—Medicare	Add total count of HEDIS measures and CAHPS as follows: *Medicare HEDIS Measures = 21* *(CDC counts as 2)* *Medicare CAHPS = 8* *(Rating of the Health Plan counts as 2)*	**CL**	**3/26/2018**
2-5	Appendix 2	HEDIS Measures Required for 2018 HP Accreditation—Medicaid	Add total count of HEDIS measures and CAHPS as follows: *Medicaid HEDIS Measures = 30* *(CDC counts as 2)* *Medicaid CAHPS =9* *(Rating of the Health Plan counts as 2)*	**CL**	**3/26/2018**
2-5	Appendix 2	HEDIS and CAHPS Points for HEDIS Reporting Year 2018	Add the following footnote for the *Frequency of Prenatal Care (≥81 percent of expected visits only)* measure: The *Frequency of Prenatal Care (≥81 percent of expected visits only) (FPC)* measure was retired from the HEDIS measurement set in October 2017. For Accreditation 2018, this measure will be scored NA.	**PC**	**11/20/2017**

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3-3, 3-7	Appendix 3	Points by Reporting Category for 2018—Access and Services	Add the following footnote for the *Emergency Department Utilization* measure: For Accreditation 2018, the Emergency Utilization Measure will be scored NA.	**CL**	**3/26/2018**
3-8	Appendix 3	Points by Reporting Category for 2018—Staying Healthy	Add the following footnote for the *Frequency of Prenatal Care (≥81 percent of expected visits only)* measure: The *Frequency of Prenatal Care (≥81 percent of expected visits only)* (FPC) measure was retired from the HEDIS measurement set in October 2017. For Accreditation 2018, this measure will be scored NA.	**PC**	**11/20/2017**
5-3	Appendix 5	Activities That May Not Be Delegated	Add the following as activities that cannot be delegated: MED 1: Medicaid Benefits and Services, Elements A-G, I. MED 2: Practice Guidelines, Element C. MED 3: Practitioner Office Site Quality, Element A. MED 4: Privacy and Confidentiality. MED 7: Quality Assessment and Performance Improvement. MED 8: Informing Members of Services. MED 9: UM Decisions About Payment Services. MED 10: Grievances and Appeals. MED 11: Continued Coverage. MED 12: Information Services for Members, Elements A-C, E. MED 13: Member Communications, Elements A, C. MED 14: Practitioner and Provider Directories. MED 15: MED Delegation Oversight.	**PC**	**3/26/2018**
5-5	Appendix 5	How NCQA Evaluates Delegation—Delegation oversight	Add the following subhead and text immediately after the "Scoring delegation oversight" subsection: ***Subdelegation*** When a delegate subdelegates to a third entity, either the delegate or the organization oversees the subdelegate's work. The delegation agreement between the organization and the delegate specifies the entity responsible	**CL**	**11/20/2017**

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			for overseeing subdelegates. If the delegate oversees the subdelegate, it must report to the organization regarding the subdelegate's performance. NCQA confirms that oversight of the subdelegate is performed according to its standards. The organization is responsible for oversight of all activities performed by the delegate and subdelegate on its behalf.		
5-7	Appendix 5	Delegating to NCQA-Accredited/Certified or NCQA-Recognized Organizations—General Requirements	Add the following as the last sentence of the fourth bullet: If there are two or more delegates, "70 percent" is cumulative.	**CL**	**12/3/2018**
5-9, 5-15	Appendix 5	Product line match	Add the following as the last paragraph: ***Note: Product line match exception.*** *If an organization's accredited delegate has a single practitioner network with centralized credentialing for all product/product lines, but is not accredited for the delegated product line, the organization is eligible for automatic credit.*	**CL**	**11/20/2017**
5-9	Appendix 5	Table 2: Automatic credit by Evaluation Option for delegating to an NCQA-Accredited/Certified WHP organization	Move footnote 34, under PHM 4, Element C that reads "For PHM 4, Element C, factor 14, automatic credit is available if the delegate is accredited under 2018 standards and beyond" from table 4 to table 2.	**CL**	**12/3/2018**
5-9	Appendix 5	Table 2: Automatic credit by Evaluation Option for delegating to an NCQA-Accredited health plan	Add the following text to Table 2 as QI 4, Element F: F | Behavioral Healthcare Opportunities for Improvement | NA | NA | Y	**CL**	**3/26/2018**

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PREVIOUSLY POSTED UPDATES

<table>
<tr><th>Page</th><th>Standard/Element</th><th>Head/Subhead</th><th>Update</th><th>Type of Update</th><th>IRT Release Date</th></tr>
<tr><td>5-14</td><td>Appendix 5</td><td>Table 2: Automatic credit by Evaluation Option for delegating to an NCQA-Accredited health plan</td><td>Revise the reference for MED 2: Practice Guidelines and MED 4: Practitioner Office Site Quality to read:
<table><tr><td colspan="5">MED 2: Practice Guidelines</td></tr><tr><td>B</td><td>Distribution of Practice Guidelines</td><td>Y</td><td>Y</td><td>Y</td></tr><tr><td colspan="5">MED 3: Practitioner Office Site Quality</td></tr></table></td><td>CL</td><td>3/26/2018</td></tr>
<tr><td>5-16</td><td>Appendix 5</td><td>Table 3: Automatic credit by Evaluation Option for delegating to an NCQA-Accredited MBHO, NCQA-Accredited UM, CR or PN or NCQA-Certified CVO</td><td>Replace the text under PHM 2 with the following:
<table><tr><td>B</td><td>Population Assessment
Factor 5: Individuals with serious and persistent mental illness.</td></tr></table></td><td>CL</td><td>11/20/2017</td></tr>
<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-Accredited UM, CR or PN or NCQA-Certified CVO</td><td>Replace the text under NET 3, Element A with the following:
<table><tr><td colspan="5">NET 3: Assessment of Network Adequacy</td></tr><tr><td>A</td><td>Assessment of Member Experience Accessing the Network[23]
Factor 2: Analyzes data from member experience, complaints and appeals about network adequacy from BH services from QI 4, E
Factor 3: Compiles and analyzes requests for and utilization of out-of-network services
Factor 4: Uses analyses from factors 1-3 to determine if there are gaps in the network specific to particular geographic areas or types of practitioners or providers</td><td>NA</td><td>Y</td><td>Y</td></tr></table></td><td>CL</td><td>11/20/2017</td></tr>
</table>

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<tr><td>5-17</td><td>Appendix 5</td><td>Footnote 23</td><td>Revise footnote 23 to read:
For NET 3, Element A, factors 3 and 4, automatic credit is available for the behavioral healthcare component only if the delegate is an NCQA-Accredited MBHO.</td><td>CL</td><td>11/20/2017</td></tr>
<tr><td>5-18</td><td>Appendix 5</td><td>Table 3: Automatic credit by Evaluation Option for delegating to an NCQA-Accredited MBHO, NCQA-Accredited-UM, CR or PN or NCQA-Certified CVO</td><td>Add the following row under UM 2, Element B:<table><tr><td>C</td><td>Consistency in Applying Criteria</td><td>NA</td><td>Y25</td><td>Y25</td><td>NA</td><td>Y</td><td>Y</td></tr></table>Note: Updated the issue in ISS only. The language is correct in the printed publication.</td><td>CL</td><td>3/26/2018</td></tr>
<tr><td>5-19</td><td>Appendix 5—Delegation and Automatic Credit Guidelines</td><td>Table 3: Automatic credit by Evaluation Option for delegating to an NCQA-Accredited MBHO, NCQA-Accredited UM, CR or PN or NCQA-Certified CVO</td><td>Revise the row for UM 4, Element F under “Accredited UM, CR, PN” column from “NA” to “Y” for Interim Surveys to read:<table><tr><th></th><th></th><th colspan="3">Accredited UM, CR, PN</th></tr><tr><td>F</td><td>Use of Board-Certified Consultants</td><td>Y</td><td>Y</td><td>Y</td></tr></table></td><td>CO</td><td>7/30/2018</td></tr>
<tr><td>5-19</td><td>Appendix 5—Delegation and Automatic Credit Guidelines</td><td>Table 3: Automatic credit by Evaluation Option for delegating to an NCQA-Accredited MBHO, NCQA-Accredited-UM, CR or PN or NCQA-Certified CVO</td><td>Add UM 4, Element G under the UM, CR, or PN column as follows:<table><tr><th></th><th></th><th colspan="3">Accredited UM, CR or PN</th></tr><tr><th></th><th></th><th>Interim Survey</th><th>First Survey</th><th>Renewal Survey</th></tr><tr><td>G</td><td>Affirmative Statement About Incentives</td><td>Y</td><td>Y</td><td>Y</td></tr></table></td><td>CL</td><td>3/25/2019</td></tr>
</table>

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Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
~~5-22~~	~~Appendix 5~~	~~Table 4: Automatic credit by Evaluation Option for delegating to an NCQA-Accredited/Certified WHP organization~~	~~Add the following footnote for PHM 4, Element C:~~ ~~For PHM 4, Element C, factor 14, automatic credit is available if the delegate is accredited under 2018 standards and beyond.~~ ***Updated the issue on December 3, 2018 to place the footnote under Table 2.***	~~**CL**~~	~~**3/26/2018**~~
7-2	Appendix 7	Definitions	Revise the definitions for "reorganization" and "reorganization date" as follows: **reorganization** The process of reorganizing or altering the corporate structure of an organization, including the creation of a new organization or the dissolution of the organization as an entity. The filing for petition for bankruptcy or the initiation of receivership, liquidation or state insurance supervision should be reported to NCQA as Reportable Events under NCQA Accreditation program policy and not under the MAC Policy. **reorganization date** The effective date of the new entity, dissolution or corporate restructuring plan.	**CL**	**11/20/2017**
7-3	Appendix 7	Written Notice—Timing of written notice	Revise the first paragraph to read: An NCQA-Accredited organization involved in a merger, acquisition, consolidation or reorganization must submit written notice of such action to NCQA within 30 calendar days following the merger, acquisition, consolidation or reorganization date, or earlier, if possible.	**CL**	**11/20/2017**
7-3	Appendix 7	Written Notice—Timing of written notice	Update the NCQA address to read: National Committee for Quality Assurance 1100 13th Street NW, Third Floor Washington, DC 20005	**CL**	**11/20/2017**

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<tr><td>7-7</td><td>Appendix 7</td><td>2018 HP Standards for MAC Survey</td><td>Remove the following information that reads:<table><tr><td colspan="2">MEDICAID BENEFITS AND SERVICES</td></tr><tr><td colspan="2">MED 3: Emergency Services</td></tr><tr><td>A</td><td>Coverage of Emergency Services</td></tr><tr><td colspan="2">MED 4: Practitioner Office Site Quality</td></tr><tr><td>A</td><td>Performance Standards and Thresholds</td></tr><tr><td>B</td><td>Site Visits and Ongoing Monitoring</td></tr></table></td><td>CL</td><td>3/26/2018</td></tr>
<tr><td>7-7</td><td>Appendix 7</td><td>2018 LTSS Distinction Standards for MAC Survey</td><td>Add the following under the table:
2018 Medicaid Standards for MAC Survey<table><tr><td colspan="2">2018 Standards/Elements</td></tr><tr><td colspan="2">MED 3: Practitioner Office Site Quality</td></tr><tr><td>A</td><td>Performance Standards and Thresholds</td></tr><tr><td>B</td><td>Site Visits and Ongoing Monitoring</td></tr><tr><td colspan="2">MED 9: UM Decisions About Payment and Services</td></tr><tr><td>C</td><td>Coverage of Emergency and Post-Stabilization Services</td></tr></table></td><td>CL</td><td>3/26/2018</td></tr>
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