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

March 30, 2020

This document includes the corrections, clarifications and policy changes to the 2019 MBHO standards and guidelines. NCQA has identified the appropriate page number in the printed publication and the standard and head—subhead for each update. Updates have been incorporated into the Interactive Review Tool (IRT). NCQA operational definitions for correction, clarification and policy changes are as follows:

- A ***correction (CO)*** is a change made to rectify an error in the standards and guidelines.
- A ***clarification (CL)*** is additional information that explains an existing requirement.
- A ***policy change (PC)*** is a modification of an existing requirement.

An organization undergoing a survey under the 2019 MBHO 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
201	UM 5, Elements A	Explanation	Revise the language under the factors 2, 3 subhead to read: *Factors 2, 3: Medicare and Medicaid urgent concurrent and urgent preservice* The organization must make a decision and must notify the member **or** the member's authorized representative, as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request. Notification may be orally or in writing. If the decision is a denial, the organization must mail written notification of its decision within 3 calendar days after providing oral notification.	**CL**	**3/30/2020**
202	UM 5, Elements A	Related information	Revise the language under the factors 2, 3 subhead to read: *Factors 2, 3: Urgent concurrent and urgent preservice requests for Medicare and Medicaid* For Medicare and Medicaid, the organization may extend the urgent concurrent and urgent preservice time frame once due to lack of information, for up to 14 calendar days, if the member requests the extension. The organization may extend the time frame by up to 14 calendar days if it needs additional information but must notify the member **or** the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.	**CL**	**3/30/2020**

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	Multiple		Refer to the memo to review requirements that were eliminated for the 2020 Standards Year and will be scored NA for the 2019 Standards Year.	**PC**	**7/29/2019**
15	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Resurvey	Add the following as the last sentence in the first paragraph: The effective date of the accreditation status is the same date specified in the Full Survey decision that precipitated the Resurvey.	**CL**	**7/29/2019**
16	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Introductory Survey—Introductory Follow-Up Survey	Add the following as the last sentence in the second paragraph: The effective date of the accreditation status is the same date specified in the Introductory Initial Survey decision that precipitated the Follow-Up Survey.	**CL**	**7/29/2019**
17	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Add-On Survey	Add the following as the fourth paragraph: The effective date of the accreditation status is the date specified for the currently accredited product/product line.	**CL**	**7/29/2019**
19	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Accreditation Status—Corrective Action	Revise the text to read: In certain circumstances, NCQA may require corrective action by the organization. Corrective action are steps taken to improve performance when an organization does not meet specific NCQA accreditation requirements. Failure to timely comply with requested corrective action may result in a lower score or reduction or loss of accreditation status.	**CL**	**7/29/2019**
25	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Must-Pass Elements and Corrective Action Plan (CAP)	Revise the note to read: ***Note:*** *All must-pass elements apply to Initial and Renewal Evaluation Options.* • *If an organization's score on a must-pass element is lower than 50%, it must submit a Corrective Action Plan (CAP) to NCQA within 30 calendar days.*	**PC**	**7/29/2019**

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			• *The organization receives Provisional Accreditation status and is required to undergo a Resurvey within 6–9 months to confirm completion of the CAP.* • *If an organization fails three or more must-pass elements, the ROC may issue a Denied Accreditation status.* • *If an organization does not meet the must-pass threshold for any must-pass element, a status modifier of "Under Corrective Action" will be displayed after the applicable accreditation status (e.g., Accredited—Under Corrective Action) until NCQA confirms that the organization has completed the CAP.*		
26	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Must-Pass Elements and Corrective Action Plan (CAP)	Update the second paragraph as follows: ***Note:*** *The must-pass threshold for all must-pass elements is 50%.* • *If an organization's score on a must-pass element is lower than 50%:* – *It must submit a Corrective Action Plan (CAP) to NCQA within 30 calendar days.* – *It must undergo a CAP Review on the affected elements to confirm completion of the Corrective Action Plan.* – *A status modifier of "Under Corrective Action" will be displayed after the applicable accreditation status (e.g., Accredited—Under Corrective Action) until NCQA confirms that the organization has completed the CAP.* • *The organization receives Provisional Accreditation status and is required to undergo a Resurvey within 6–9 months to confirm completion of the CAP.* • *If an organization fails three or more must-pass elements, the ROC may issue a Denied Accreditation status.*	**CL**	**11/25/2019**

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34	Policies and Procedures—Section 4: Reporting Results	Reporting Accreditation Status to the Public—Right to release and publish	Revise the last paragraph to read: NCQA publicly reports Denied Accreditation status for one year (unless the organization declines its status under the Introductory Survey option) or until the status is replaced as the result of another survey. An organization that dissolves or ceases to exist is removed from public reporting.	**CL**	**7/29/2019**
34	Policies and Procedures—Section 4: Reporting Results	NCQA MBHO Report Card	Add the following subhead and text as the last section under the subhead: **Under corrective action** NCQA requires the organization to complete corrective actions. Failure to comply timely with requested corrective action may result in a lower score or reduction or loss of accreditation status.	**PC**	**7/29/2019**
36	Policies and Procedures—Section 5: Additional Information	Notifying NCQA of Reportable Events--NCQA Investigation	Revise the first bullet to read: • Request for a review of Corrective Action Plans submitted to state or federal agencies. Revise the fourth bullet to read: • Enact an NCQA Corrective Action Plan until compliance or sustained improvement is achieved.	**CL**	**7/29/2019**
50	QI 1, Element A	Explanation—Factor 3: QI Committee oversight	Add the following under the first bullet of the factor 3 explanation: ***Note:*** *Participating practitioners are external to the organization and part of the organization's network.*	**CL**	**11/25/2019**
55	QI 2, Element A	Explanation—Factor 3: Practitioner participation	Revise the factor 3 explanation to read: The QI Committee facilitates participating practitioner involvement in the QI program activities through attendance and discussion in relevant QI committee or QI subcommittee meetings or on ad hoc task forces. Participating practitioners represent a broad range of specialties, as needed. If participating practitioners are not members of the QI committee, they are involved in a clinical subcommittee or relevant ad hoc task force.	**CL**	**11/25/2019**

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			Note: *Participating practitioners are external to the organization and part of the organization's network.*		
62	QI 4, Element A	Data source	Add "documented process" as a data source.	**CL**	**11/25/2019**
62	QI 4, Element A	Scope of review	Revise the text to read: NCQA reviews the organization's data collection methodology (presented as a documented process or within the report), assessment of unmet member needs, characteristics of the practitioner network and documentation of any adjustments made in the network to meet identified needs at least once within the look-back period.	**CL**	**11/25/2019**
62	QI 4, Element A	Explanation	Revise the text to read: **Explanation** ***Factor 1:*** **Assessing members' needs** *Data collection.* To assess the cultural, ethnic, racial and linguistic needs of its members relative to its network, the organization must first collect data on ethnic, racial and linguistic characteristics of its members. A separate source of data specific to cultural characteristics (e.g., employer demographics, member surveys or focus groups) is not required. *Assessment.* The organization assesses the unmet needs of its members relative to its network. To meet the factor, the organization must address all four needs—cultural, ethnic, racial and linguistic. Cultural preferences and beliefs may be assessed from members (e.g., member surveys or focus groups) or other sources. If using other sources, aspects of culture can be initially inferred from ethnic, racial and linguistic characteristics, but must also be supplemented with information about the cultural needs and preferences (e.g. religion, family traditions, customs) of its population or populations with similar characteristics. The organization may use existing health services research.	**CL**	**11/25/2019**

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			Factor 2: **Practitioner availability** In order to meet member needs, the organization assesses the applicable characteristics (i.e., culture, ethnicity, race, spoken language) of the network practitioners related to the needs identified in factor 1. The organization adjusts the practitioner network to provide the types and number of practitioners necessary to meet the cultural, ethnic, racial and linguistic needs of its members within defined geographical areas. Adjustment of the practitioner network may include requiring existing practitioners to complete cultural competency training, providing practitioners with culturally and linguistically appropriate health education materials, or recruiting practitioners whose cultural and ethnic backgrounds are similar to the underrepresented member population. The organization determines what adjustments are appropriate based on identified needs. The organization receives credit for factor 2 if it demonstrates that, based on its assessment of members' unmet needs and the applicable characteristics of the network, it is not necessary to adjust the practitioner network.		
63	QI 4, Element A	Examples	Revise the text for the first two subheads to read: **Five-step process for meeting the intent of this element** 1. Collect data on ethnic, racial and linguistic needs of members from U.S. Census and enrollment data. 2. Conduct research or review literature on cultural needs and preferences based on the characteristics of the organization's members. 3. Correlate data with members' preferences based on member feedback or complaint data. 4. Assess the cultural, ethnic, racial and linguistic characteristics of network practitioners to evaluate whether network practitioners meet members' needs. 5. Take action to adjust the practitioner network if it does not meet members' cultural, ethnic, racial and linguistic needs.	**CL**	**11/25/2019**

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			Data sources • Data from survey questions or focus groups that identify the health-related preferences or beliefs of specific ethnic groups. • U.S. Census data on the racial/ethnic composition of the population within a service area or region. • Practitioner race, ethnicity and language data collected during the credentialing process. • Published health statistics, health services research, data provided by plan sponsors or government agencies.		
74	QI 6, Element A	Examples- Attitude and Service	Add the following as the third and fourth bullets: • A member complained about the tone and attitude of the customer service representative. • A member complained that a customer service representative provided inaccurate information.	**CL**	**7/29/2019**
81	QI 7, Element A	Explanation—Factor 1: Implementation of screening program	Move the language in the first and second paragraph of the explanation to the explanation under factor 1, so that this section reads: The organization implements screening programs to determine the likelihood that a patient has coexisting substance use and mental health disorders or that presenting signs and symptoms may be influenced by co-occurring issues. Coexisting disorders may include any combination of two or more mental health and substance use disorders identified in the Diagnostic and Statistical Manual of Mental Disorders—V (DSM-V). Patients treated for mental health disorders often misuse substances such as alcohol, nicotine and stimulants. The organization: • Screens members who have a mental health disorder, for the presence of a coexisting substance use disorder. • Screens members who have a substance use disorder, for the presence of a coexisting mental health disorder.	**CL**	**11/25/2019**

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112	QI 9, Element H	Explanation—Factor 10: Evaluation of community resources	Revise the text to read: The file or case record documents the 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 notes reflect that no community resources are needed (e.g., "Member does not need any of the available community resources").	**CL**	**3/25/2019**
144, 172 282 314 367	QI 13, Element A CC 5, Element A CR 8, Element A RR 5, Element A LTSS 4, Element A	Explanation—Factor 1: Mutual agreement	Add the following after the first paragraph of the factor 1 explanation: NCQA considers the effective date specified in the delegation agreement as the mutually agreed-upon effective date. The effective date may be before or after the signature date on the agreement. If the agreement has no effective date, NCQA considers the signature date (meaning the date of last signature) as the mutually agreed upon effective date. NCQA may accept other evidence of the mutually agreed-upon effective date: a letter, meeting minutes or other form of communication between the organization and the delegate that references the parties' agreement on the effective date of delegated activities. NCQA requires submitted evidence for all other delegation factors to consider the same mutually agreed-upon date as the effective date for the delegate's performance of delegated activities.	**CL**	**3/25/2019**
159	CC 2, Element A	Examples—Factor 4: managing coexisting conditions	Add a fifth bullet that reads: • Results of the HEDIS measure Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD).	**CL**	**7/29/2019**

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181	UM 1, Element A	Explanation—The scope of medical necessity review	Add the following as the last paragraph: *Organization employees and their dependents:* The organization may exclude employees and their dependents from the denial and appeal file universe.	**CL**	**11/25/2019**
194	UM 4, Element B	Explanation	Add a new 5th bullet in the explanation that reads: • Doctoral-level Board-Certified Behavioral Analysts: Applied behavioral analysis denials.	**CL**	**3/25/2019**
206	UM 5, Element C	Explanation—Factors 1, 2	Add the following as a second paragraph to the factors 1,2 explanation: Approval decisions must adhere to the timeliness requirements in UM 5 and must be included in factor 1. However, the timeliness of notifications sent for approvals is not required to be included in factor 2.	**CL**	**3/25/2019**
202	UM 5, Elements A	Related information—Extending time frames	Incorporate the sentence regarding the organization choosing to extend the decision time frame, under the "Extending time frames" subhead to the first sentence under the subhead "Factor 1: Urgent concurrent requests for commercial and Marketplace" to read: The organization may extend the decision notification time frame if the request to extend urgent concurrent care was not made prior to 24 hours before the expiration of the prescribed period of time or number of treatments.	**CL**	**7/29/2019**
206	UM 5, Element C	Exceptions	Add the following as the first exception: Factor 2 is NA for notification of approval decisions.	**CL**	**3/25/2019**
216	UM 7, Element C	Explanation—Factor 2: Right to representation and appeal time frames	Revise the second bullet to read: • Provides contact information for the state Office of Health Insurance Consumer Assistance or ombudsman, if applicable. ***Note:*** *This is not required for members covered by the Federal Employee Health Benefits (FEHB) program.*	**CL**	**11/25/2019**

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232	UM 9, Element D	Related information—Medicare appeals	Revise the sentence to read: For Medicare appeal files, factors 1–6 are met if there is evidence that the organization sent the upheld denial to MAXIMUS.	**PC**	**7/29/2019**
242	UM 12, Element A	Explanation—Factor 1: Delegation agreement	Add the following after the first paragraph of the factor 1 explanation: NCQA considers the effective date specified in the delegation agreement as the mutually agreed-upon effective date. The effective date may be before or after the signature date on the agreement. If the agreement has no effective date, NCQA considers the signature date (meaning the date of last signature) as the mutually agreed upon effective date. NCQA may accept other evidence of the mutually agreed-upon effective date: a letter, meeting minutes or other form of communication between the organization and the delegate that references the parties' agreement on the effective date of delegated activities. NCQA requires submitted evidence for all other delegation factors to consider the same mutually agreed-upon date as the effective date for the delegate's performance of delegated activities.	**CL**	**3/25/2019**
268	CR 3, Element C	Explanation—Factor 5: Current malpractice coverage	Revise the Explanation to read: The application states the amount of a practitioner's current malpractice insurance coverage (even if the amount is $0) and the date when coverage expires. If the practitioner's malpractice insurance coverage is current and is provided in the application, it must be current as of the date when the practitioner signed the attestation and include the amount of coverage the practitioner has on the date when the attestation was signed. If the practitioner does not have current malpractice coverage, then it is acceptable to include future coverage with the effective and expiration dates. Documentation of malpractice insurance coverage may also be a face sheet or a federal tort letter as an addendum to the application. In this case, the practitioner is not required to attest to malpractice coverage on the application. The face sheet or federal tort letter must include the	**CL**	**7/29/2019**

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			insurance effective and expiration dates (the future effective date is acceptable).		
3-7	Appendix 3—Delegation and Automatic Credit Guidelines	Delegating to NCQA-Accredited/Certified/ Recognized Organizations—General requirements	Update the second sentence of the fourth bullet as follows: If there are two or more delegates, "70 percent" is cumulative for the same delegated function. If the organization has two or more product lines and manages them the same, 70% is cumulative across all product lines. If the organization manages the product lines differently (e.g., delegating the activity for the commercial product line and not for Medicaid or Medicare product lines), 70% is calculated by product line. ***Note:** 70% is cumulative across product lines in 2019 Standards Year as updated above. NCQA is evaluating this policy for 2020 Standards Year.*	**CL**	**3/25/2019**