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

March 30, 2020

This document includes the corrections, clarifications and policy changes to the 2020 HP standards and guidelines. NCQA has identified the appropriate page number in the printed publication and the standard and head—subhead for each update. Updates have been incorporated into the Interactive Review Tool (IRT). NCQA operational definitions for correction, clarification and policy changes are as follows:

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

An organization undergoing a survey under the 2020 HP standards and guidelines must implement corrections and policy changes within 90 calendar days of the IRT release date, unless otherwise specified. The 90-calendar-day advance notice does not apply to clarifications or FAQs, because they are not changes to existing requirements.

Page	Standard/Element	Head/Subhead	Update	Type of Update	IRT Release Date
5	Overview	Changes to the Policies and Procedures—Section 2	Remove the third subbullet under the third bullet that reads: – An organization that does not score "Met" on three or more must-pass elements could undergo a Resurvey at the Review Oversight Committee's (ROC) discretion.	**CL**	**3/30/2020**
16	Policies and Procedures—Section 1: Eligibility and the Application Process	Evaluation Options—Table 1: Summary of Evaluation Options' eligibility, status duration and HEDIS reporting and scoring	Replace the last sentence in the last column of each row that reads "Refer to HEDIS Reporting in Accreditation" with the following: Refer to *Health Plan Ratings and Accreditation.*	**CO**	**3/30/2020**
20	Policies and Procedures—Section 1: Eligibility and the Application Process	How NCQA Defines an Accreditable Entity—HEDIS/CAHPS reporting unit	Remove the last sentence that reads: Refer to *HEDIS Reporting for Accreditation*, below, for the definition of "reporting unit."	**CO**	**3/30/2020**
34	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Must-Pass Elements and Corrective Action Plan	Add the following bullet immediately above the last bullet in the "Note": • If an organization does not score "Met" in three or more must-pass elements, it receives Provisional Accreditation status and must undergo a Resurvey within 6-9 months to confirm completion of the CAP. ***Note:*** *This is a correction to the 11/25/19 update that inadvertently omitted text about Provisional Accreditation status.*	**CO**	**3/30/2020**

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123	PHM 1, Element A	Scope of review—Documentation	Add the following as the last sentence: The organization may use a single document to describe a strategy that applies across all product lines if the document also describes differences in strategy to support different populations, by product line.	**CL**	**3/30/2020**
142	PHM 3, Element B	Scope of review—Documentation	Revise the text to read: *For First Surveys* and *Renewal Surveys*: NCQA reviews the VBP worksheet to demonstrate that the organization has VBP arrangements in each product line. Worksheets reflect a continuous 12-month period within the look-back period.	**PC**	**3/30/2020**
143	PHM 3, Element B	Explanation	Revise the third paragraph in the explanation to read: The organization demonstrates that it has at least one VBP arrangement by reporting the percentage of total payments made to providers and practitioners associated with each type of VBP arrangement for a continuous 12-month period within the look-back period.	**PC**	**3/30/2020**
143	PHM 3, Element B	Explanation	Revise the explanation under "Calculating VBP reach" to read: The percentage of payments is calculated by: • Numerator: The value-based payments *divided by*, • Denominator: All payments (including fee-for-service). The percentage of payments reflects 12 months of payment within the look-back period and can be based on allowed amounts, actual payments or forecasted payments.	**PC**	**3/30/2020**
153	PHM 5, Element C	Explanation—Assessment and evaluation	Revise the section to read: Assessment and evaluation each require the case manager or other qualified individual to draw and document a conclusion about data or information collected. It is not sufficient to just have raw data or answers to questions. Policies describe the process to both collect information and document a summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan. The organization must draw a conclusion for each factor (unless otherwise stated in the explanation). This may be in separate summaries for each factor or in a combined summary, or in a combination of these.	**CL**	**3/30/2020**

Page	Standard/Element	Head/Subhead	Update	Type of Update	IRT Release Date
			Complex case management policies and procedures state why an assessment might not be appropriate for a factor (e.g., life-planning activities, in pediatric cases). The organization records the specific factor and the reason in the case management system and file.		
153, 159	PHM 5, Elements C, D	Summary of Changes	Revise the first bullet in the summary of changes to read: • Added a second paragraph to the explanation of Factor 2.	**CL**	**3/30/2020**
154, 161	PHM 5, Elements C, D	Explanation—Factor 2: Documentation of clinical history	Add the following text as the last paragraph: Factor 2 does not require assessment or evaluation.	**CL**	**3/30/2020**
160	PHM 5, Element D	Explanation—Assessment and evaluation	Add the following as a second paragraph: The organization must draw a conclusion for each factor (unless otherwise stated in the explanation). This may be in separate summaries for each factor or in a combined summary, or in a combination of these.	**CL**	**3/30/2020**
169	PHM 6, Element A	Explanation—*Experience*	Revise the second paragraph to read: The organization may supplement analysis of member survey or focus group data with member complaint data.	**CL**	**3/30/2020**
202	NET 3, Element A	Explanation—Factor 3: Nonbehavioral requests for and utilization of out-of-network services	Add the following as the last sentence of the first paragraph: The organization reports data per thousand members at the product-line level.	**CL**	**3/30/2020**
229	NET 6, Element B	Look-back period	Revise the look-back period for Renewal Surveys to read: 12 months.	**CL**	**3/30/2020**
231	NET 6, Element C	Scope of review—Documentation	Remove the second paragraph, which reads: For Interim Surveys, NCQA reviews the organization's evaluation of the delegate's network management procedures (factor 1).	**CL**	**3/30/2020**
231	NET 6, Element C	Exceptions	Remove the last paragraph that reads: Factors 2 and 3 are NA for Interim Surveys.	**CL**	**3/30/2020**

Page	Standard/Element	Head/Subhead	Update	Type of Update	IRT Release Date
265, 271, 277, 284	UM 5, Elements A-C, E	Related information	Revise the bullets under *Factor 1: Urgent concurrent requests for commercial and Exchange product lines* to read: • The organization may extend the decision notification time frame if the request to extend urgent concurrent care was made less than 24 hours prior to the expiration of the previously approved period of time or number of treatments. The organization may treat the request as urgent preservice and send a decision notification within 72 hours. • The organization may extend the decision notification time frame if the request to approve additional days for urgent concurrent care is related to care not previously approved by the organization and the organization documents that it made at least one attempt and was unable to obtain the needed clinical information within the initial 24 hours after the request for coverage of additional days. In this case, the organization has up to 72 hours to make the decision.	**CL**	**3/30/2020**
265, 271, 277, 285	UM 5, Elements A-C, E	Related information	Revise the second bullet under the *factors 2, 3* subhead in Elements A, B, E and the *factors 1, 2* subhead in Element C to read: • The organization may extend the time frame by up to 14 calendar days if it needs additional information and notifies the member **or** the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.	**CL**	**3/30/2020**
277, 278	UM 5, Element C	Related information	Revise the subheads under *Extension conditions* to read as follows: Replace the subhead that reads "Factors 2, 3: Urgent concurrent and urgent preservice requests for Medicare and Medicaid product lines" with "Factors 1, 2: Urgent concurrent and urgent preservice requests for Medicare and Medicaid product lines." Replace the subhead that reads "Factor 3: Urgent preservice requests" with "Factor 2: Urgent preservice requests for commercial and Exchange product lines." Replace the subhead that reads "Factors 4, 5: Nonurgent preservice and postservice requests" with "Factors 3, 4: Nonurgent preservice and postservice requests."	**CL**	**3/3/2020**
319	UM 8, Element A	Explanation	Revise the text that follows *Medicare appeals for factors 7–13* to read: The organization's policies and procedures describe its process for sending an upheld denial to MAXIMUS.	**CL**	**3/30/2020**

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320, 325	UM 8, Element A UM 9, Element B	Related information—Verbal notification	Revise the third paragraph regarding Medicaid appeals to read: For Medicaid appeals, verbal notification is appropriate for nonurgent preservice, postservice and expedited appeals. Verbal notification of a decision does not extend the electronic or written notification time frame. Organizations may verbally inform members if there is a delay and must resolve appeals as expeditiously as the member's health requires.	**CL**	**3/30/2020**
324	UM 9, Element B	Explanation—Factors 1-3: Timeliness of appeal process	Revise the third paragraph to read: NCQA measures timeliness of notification from the date when the organization receives the request from the member or the member's authorized representative, even if the organization does not have all the information necessary to make a decision, to the date when the notice was provided to the member or member's authorized representative, as applicable.	**CL**	**3/30/2020**
328	UM 9, Element D	Explanation—Factor 1: The appeal decision	Add the following text as the last paragraph: For appeals resulting from medical necessity review of out-of-network requests, the reason for upheld appeal decision must explicitly address the reason for the request (e.g., if the request is related to accessibility issues, that may be impacted by the clinical urgency of the situation, the appeal decision must address whether or not the requested service can be obtained within the organization's accessibility standards).	**CL**	**3/30/2020**
347	UM 12, Element B	Scope of review—Documentation	Add the following text as the second sentence: If the organization outsources storage of UM information to an external entity, NCQA also reviews the contract between the organization and the external entity.	**CL**	**3/30/2020**
348	UM 12, Element B	Explanation—Factor 6: Securing system data	Revise the last paragraph to read: If the organization contracts with an external entity to outsource storage of UM data, the contract describes how the contracted entity ensures the security of the data.	**CL**	**3/30/2020**

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365	CR 1, Element A	Related information	Add the following text as the second sentence after the "Automated credentialing system" subhead: The organization provides its security and login policies and procedures to confirm the unique identifier and the signature can only be entered by the signatory.	**CL**	**3/30/2020**
413	ME 2, Element A	Look-back period	Revise the text following "For Renewal Surveys:" to read: At least once during the prior year for factor 15; 24 months for all other factors.	**CL**	**3/30/2020**
449	ME 7, Element D	Explanation	Add the following as the first paragraph: This element may not be delegated.	**CL**	**3/30/2020**
472, 476	LTSS 1, Elements B, C	Explanation—Assessment	Revise the section to read: Assessment requires the case manager or other qualified individual to reach and document a conclusion about data or information collected. It is not sufficient to just have raw data or answers to questions. Policies describe the process to both collect information and document a summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan. The organization must reach a conclusion for each factor (unless otherwise stated in the explanation). This may be in separate summaries for each factor or in a combined summary, or in a combination of these. Case management policies and procedures state why an assessment might not be appropriate for a factor (e.g., life-planning activities, in pediatric cases). The organization records the specific factor and the reason in the case management system and file.	**CL**	**3/30/2020**
472, 481	LTSS 1, Elements B, D	Explanation—Factor 2: Documentation of clinical history	Add the following as the last paragraph: Factor 2 does not require assessment or evaluation.	**CL**	**3/30/2020**
480	LTSS 1, Element D	Explanation—Assessment	Add the following as the third paragraph: The organization must reach a conclusion for each factor (unless otherwise stated in the explanation). This may be in separate summaries for each factor or in a combined summary, or in a combination of these.	**CL**	**3/30/2020**

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491	LTSS 1, Element G	Explanation—Assessment	Add the following as a second paragraph: The organization must reach a conclusion for each factor (unless otherwise stated in the explanation). This may be in separate summaries for each factor or in a combined summary, or in a combination of these.	**CL**	**3/30/2020**
493	LTSS 1, Element G	Explanation—Factor 12: Documentation of services received	Revise the text to read: The file or case record documents whether the individual received the services specified in the case management plan.	**PC**	**3/30/2020**
497	LTSS 1, Element I	Explanation—Factors 2, 3: Background checks and additional screening tool	Add the following as the last sentence of the first paragraph: NCQA does not consider it delegation if the organization uses another entity to conduct background checks.	**PC**	**3/30/2020**
2-23	Appendix 2	Automatic Credit for Delegating to an NCQA-Prevalidated Vendor for Health IT Solution	Replace the first paragraph with the following text: Organizations that delegate PHM functions to a NCQA-Prevalidated Vendor for the Health IT solutions that receive the designation "eligible for automatic credit" present the Letter of Eligibility for documentation. The organization is responsible for providing documentation that states the name and the version of the health IT solution the organization is using and the date when it was licensed or implemented by the organization. Documentation may include a contract, agreement, purchase order or other document that states the name and version of the health IT solution and the date when it was licensed or implemented.	**CL**	**3/30/2020**

<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>6-2</td><td>Appendix 6</td><td>Section 2: Accreditation Scoring and Status Requirements</td><td>Remove the third subbullet under the third bullet that reads:
– An organization that does not score “Met” on three or more must-pass elements could undergo a Resurvey at the Review Oversight Committee’s (ROC) discretion.</td><td>CO</td><td>3/30/2020</td></tr>
<tr><td>6-11</td><td>Appendix 6</td><td>Other Modifications and Revisions for 2020 by Standard Category and Element</td><td>Revise the first bullet of the PHM 5, Elements C, D summary of changes to read:
• Added a second paragraph to the explanation of Factor 2.</td><td>CL</td><td>3/30/2020</td></tr>
<tr><td colspan="6">PREVIOUSLY POSTED UPDATES</td></tr>
<tr><td>19</td><td>Policies and Procedures—Section 1: Eligibility and the Application Process</td><td>How NCQA Defines an Accreditable Entity—6. Product/product line</td><td>Replace “Exchange” with “Off-Exchange” in the second paragraph so it reads:
Off-Exchange products must include this membership in the commercial product line.</td><td>CL</td><td>11/25/2019</td></tr>
<tr><td>28</td><td>Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements</td><td>Accreditation Status</td><td>Add a subhead and text immediately above table 4 that reads:
<u>Statuses and Scoring Thresholds by Evaluation Option</u>
The table below shows scoring ranges and statuses by evaluation option.
Modify the first row in the table to read:
Table 4: Scoring ranges for Accreditation statuses
<table>
<tr><th></th><th>Interim</th><th>First and Renewal (Standards Only)</th><th>First and Renewal (With HEDIS/CAHPS)</th></tr>
<tr><td>Accredited with a Star Rating, if applicable</td><td>NA</td><td colspan="2">At least 80% of applicable points in each category of standards (QI, PHM, NET, UM, CR, ME)</td></tr>
</table></td><td>CO</td><td>11/25/2019</td></tr>
</table>

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Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
31	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	How Standards are Scored—Scope of review	Revise the third bullet on the left to read: • PHM 6, Elements A, B.	**CL**	**11/25/2019**
32	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	How Standards Are Scored—Look-back period	Revise the last sentence to read: For example, for most non-file review elements, if the look-back period is 24 months and the survey date is July 10 of the current year, the organization must show evidence that requirements were met at all times, from the survey date back to any date in July two years ago.	**CL**	**11/25/2019**
34	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Must-Pass Elements and Corrective Action Plan	Revise the second paragraph to read: ***Note:*** *The must-pass threshold for all must-pass elements is "Met."* • *If an organization does not score "Met" in any must-pass element:* – *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.* • *If an organization does not score "Met" in three or more UM must-pass timeliness elements (UM 5, Elements A–C and UM 9, Element B), the ROC may issue a Denied Accreditation status.* ***Note:*** *Updated on 3/30/20 to reinstate text about Provisional status.*	**CL**	**11/25/2019**

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<tr><th colspan="6">PREVIOUSLY POSTED UPDATES</th></tr>
<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>38</td><td>Policies and Procedures—Section 3: The Survey Process</td><td>About the Survey Process</td><td>Add a checkmark and asterisk in the “Interim Evaluation Option” column and the “Health Plan Ratings” row and revise the asterisked note so the table reads as follows:
Table 6: Survey component occurrences by Evaluation Option
<table><tr><th>Components of Accreditation Survey</th><th>Interim Evaluation Option</th><th>First Evaluation Option (HEDIS/ CAHPS scored)</th><th>Renewal Evaluation Option (HEDIS/ CAHPS scored)</th></tr><tr><td>Offsite Survey</td><td>✓</td><td>✓</td><td>✓</td></tr><tr><td>Onsite Survey</td><td></td><td>✓</td><td>✓</td></tr><tr><td>Health Plan Ratings</td><td>✓*</td><td>✓</td><td>✓</td></tr></table>*Optional for the first year for the Interim and First Evaluation Options.</td><td>CL</td><td>11/25/2019</td></tr>
<tr><td>44</td><td>Policies and Procedures—Section 4: Reporting Results</td><td>Releasing information</td><td>Revise the first paragraph to read:
NCQA releases Accreditation Survey results to the public, unless an organization going through the Interim Evaluation Option is denied Accreditation based on standards performance.</td><td>CL</td><td>11/25/2019</td></tr>
<tr><td>81</td><td>QI 1, Element A</td><td>Explanation—Factor 5: QI Committee oversight</td><td>Add the following under the first bullet of the factor 5 explanation:
Note: Participating practitioners are external to the organization and part of the organization’s network.</td><td>CL</td><td>11/25/2019</td></tr>
</table>

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87	QI 1, Element D	Explanation—Factor 3: Practitioner participation	Revise the factor 3 explanation to read: The QI Committee facilitates participating practitioner involvement in the QI program activities through attendance and discussion in relevant QI committee or QI subcommittee meetings or on ad hoc task forces. Participating practitioners represent a broad range of specialties, as needed. If participating practitioners are not members of the QI committee, they are involved in a clinical subcommittee or relevant ad hoc task force. ***Note:*** *Participating practitioners are external to the organization and part of the organization's network.*	**CL**	**11/25/2019**
125	PHM 1, Element A	Explanation—Factor 5: Informing members	Remove the last sentence of the second paragraph, which reads: If the organization posts the information on its website, it uses alternative methods to notify members that the information is available online.	**CL**	**11/25/2019**
139	PHM 3, Element A	Explanation—Factor 4: Comparative quality and cost information on selected specialties	Add the following as the first sentence under the explanation for factors 4 and 5: **Factor 4: Comparative quality and cost information on selected specialties** The organization provides comparative quality and, if available, cost information to practitioners or providers to help them make referral decisions. **Factor 5: Comparative pricing information for selected services** The organization provides comparative pricing information to practitioners or providers to help them make referral decisions.	**CL**	**11/25/2019**
139	PHM 3, Element A	Explanation—Factor 4: Comparative quality and cost information on selected specialties	Add the following note after the third paragraph: ***Note:*** *For this factor, "specialties" and "specialty" refers to nonprimary care (i.e., specialties other than pediatrics, internal medicine and general or family medicine).*	**CL**	**11/25/2019**

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164	PHM 5, Element E	Scope of review—Documentation	Revise the second sentence to read: Files are selected from active or closed cases that were identified during the look-back period and remained open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management.	**CL**	**11/25/2019**
168	PHM 6, Element A	Explanation—Factor 1: Quantitative results	Revise the second bullet under the summary of changes to read: • Clarified in the factor 1 explanation what is included in quantitative results.	**CL**	**11/25/2019**
168	PHM 6, Element A	Scope of review—Documentation	Revise the section to read: *For First Surveys:* NCQA reviews the organization's plan for annual comprehensive analysis of its PHM strategy impact or the organization's most recent annual comprehensive analysis of PHM strategy impact. *For Renewal Surveys:* NCQA reviews the organization's most recent annual comprehensive analysis of PHM strategy impact.	**PC**	**11/25/2019**
171	PHM 6, Element B	Scope of review—Product lines	Revise the first sentence to read: *This element applies to Renewal Surveys for all product lines.*	**PC**	**11/25/2019**
171	PHM 6, Element B	Look-back period	Revise the text to read: *For Renewal Surveys:* At least once during the prior year.	**PC**	**11/25/2019**
183	NET 1, Element A	Look-back period	Revise the text for Renewal Surveys to read: *For Renewal Surveys:* 24 months.	**CL**	**11/25/2019**
204	NET 3, Element B	Factor 1	Revise the factor language to read: Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements A, B and C), accessibility (NET 2, Elements A and C) and member experience accessing the network (NET 3, Element A, factors 1 and 3).	**CO**	**11/25/2019**

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<tr><td>205</td><td>NET 3, Element C</td><td>Factor 1</td><td>Revise the factor language to read:
Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements A and D), accessibility (NET 2, Element B) and member experience accessing the network (NET 3, Element A, factors 2 and 4).</td><td>CO</td><td>11/25/2019</td></tr>
<tr><td>241</td><td>UM 1, Element A</td><td>Explanation—File review universe</td><td>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.</td><td>CL</td><td>11/25/2019</td></tr>
<tr><td>250</td><td>UM 3, Element A</td><td>Scoring</td><td>Revise the scoring set up in the IRT Standards and Guidelines to reflect the hardcopy publication so that it reads:<table><tr><th>Met</th><th>Partially Met</th><th>Not Met</th></tr><tr><td>The organization meets 4-5 factors</td><td>The organization meets 3 factors</td><td>The organization meets 0-2 factors</td></tr></table>Note: This issue is specific to the standards and guidelines in the IRT. The language is correct in the printed and electronic publications.</td><td>CO</td><td>11/25/2019</td></tr>
<tr><td>299, 306, 313</td><td>UM 7, Elements C, F, I</td><td>Explanation—Factor 2: Right to representation and appeal time frames</td><td>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.</td><td>CL</td><td>11/25/2019</td></tr>
<tr><td>343</td><td>UM 11, Element E</td><td>Scoring</td><td>Revise the “Not Met” scoring to read:<table><tr><th>Met</th><th>Partially Met</th><th>Not Met</th></tr><tr><td>The organization meets 4-5 factors</td><td>The organization meets 3 factors</td><td>The organization meets 0-2 factors</td></tr></table></td><td>CO</td><td>11/25/2019</td></tr>
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346, 348	UM 12, Elements A and B	Factor 6: Securing System Data	Add the following as the first two sentences: This factor applies to all UM system data. It is not limited to the dates specified in factors 1-5.	**CL**	**11/25/2019**
375	CR 3, Element A	Look-back period	Add the following as the last paragraph: *For all surveys:* For credentialing files where verification of DEA or CDS is before June 1, 2020, and a practitioner who is DEA- or CDS- eligible does not have a DEA or CDS certificate, NCQA accepts either the verification process required in the 2020 standards or the applicable prior year's standards, which state, "If a qualified practitioner does not have a valid DEA or CDS certificate, the organization notes this in the credentialing file and arranges for another practitioner to fill prescriptions."	**PC**	**11/25/2019**
376	CR 3, Element A	DEA- and CDS- eligible practitioners who do not have a certificate	Revise the text to read: The organization verifies that all DEA- and CDS-eligible practitioners who do not have a valid DEA/CDS certificate, and for whom prescribing controlled substance is in the scope of their practice, have in place a designated practitioner to write prescriptions on their behalf. The organization documents the practitioner's lack of DEA/CDS certificate in the credentialing file and obtains the name of a designated alternate prescriber from the practitioner. If the alternate prescriber is a practice rather than an individual, the file may include the practice name. The organization is not required to arrange an alternate prescriber. If the practitioner states in writing that they do not prescribe controlled substances and that in their professional judgment, the patients receiving their care do not require controlled substances, they are therefore not required to have a DEA/CDS certificate, but must describe their process for handling instances when a patient requires a controlled substance. The organization includes the practitioner's statement and process description in the credentialing file.	**CL**	**11/25/2019**

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379	CR 3, Element A	Examples	Replace "None." with the following: **DEA- and CDS-eligible practitioners who do not have a certificate** *Practitioner's statement.* I do not prescribe controlled substances for my patients. If I determine that a patient may require a controlled substance, I refer the patient to their PCP or to another practitioner for evaluation and management.	**CL**	**11/25/2019**
393	CR 7, Element A	Explanation—Factor 2: Confirmation of review and approval by an accrediting body	Revise the third bullet to read: • Copies of credentials (e.g., accreditation report, certificate or decision letter) from the provider.	**CL**	**11/25/2019**
434	ME 5, Element D	Explanation—Exceptions	Remove the first paragraph, which reads: This element is NA for Renewal Surveys for the commercial, Medicare, Medicaid and Exchange product lines.	**CL**	**11/25/2019**
443	ME 7, Element A	Explanation	Revise the second paragraph of the explanation to read: This element applies to all complaints that do not become requests for coverage or requests to overturn a decision.	**CL**	**11/25/2019**
479, 491	LTSS 1, Elements D, G	Scope of review—Documentation	Revise the section to read: NCQA reviews assessments in a random sample of up to 40 case management files. Files are selected from active or closed cases that were identified during the look-back period and remained open for at least 60 calendar days during the look-back period, from the date when the member was identified for case management. The organization must provide the identification date for each case in the file universe	**CL**	**11/25/2019**
479, 491	LTSS 1, Elements D, G	Explanation—HEDIS LTSS measures	Revise the first sentence to read: Organizations may submit performance results on the Comprehensive Assessment and Update (LTSS-CAU) measure instead of completing the file review.	**CL**	**11/25/2019**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
1-1–1-11	Appendix 1		Replace the points under "Partially Met" with "NA" as follows: *For QI* • 1B, 5C, under Interim Survey, First Survey and Renewal Survey • 1C, 3D under First Survey and Renewal Survey *For PHM* • 1B, 2D, 3A under Interim Survey, First Survey and Renewal Survey • 3B under First Survey and Renewal Survey • 4A under First Survey *For NET* • 4A, 5B, 5D, 5G under First Survey and Renewal Survey *For UM* • 12A, 12B under Interim Survey, First Survey and Renewal Survey • 1B, 9F under First Survey and Renewal Survey *For CR* • 1B, 1C, 2A under Interim Survey, First Survey and Renewal Survey • 7D, 7E under First Survey and Renewal Survey *For ME* • 1A, 2B under Interim Survey, First Survey and Renewal Survey • 5D, 7C under First Survey and Renewal Survey *For LTSS* • 2F	**CO**	**11/25/2019**

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<tr><th colspan="6">PREVIOUSLY POSTED UPDATES</th></tr>
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<tr><td>2-13
2-20</td><td>Appendix 2</td><td>Table 2: Automatic credit by Evaluation Option for delegating to an NCQA-Accredited health plan

Table 3: Automatic credit by Evaluation Option for delegating to an NCQA-Accredited MBHO, or a delegate that is NCQA-Accredited in UM, CR or PN or an NCQA-Certified CVO</td><td>Replace “NA” with “Y” for UM 5, Element D as follows:
• Under the Renewal Survey column in Table 2.
<table>
<tr><th></th><th></th><th>Interim</th><th>First</th><th>Renewal</th></tr>
<tr><td>D</td><td>UM Timeliness Report[15]</td><td>NA</td><td>Y</td><td>Y</td></tr>
</table>
• Under Accredited MBHO and Accredited UM-CR-PN columns in Table 3.
<table>
<tr><th rowspan="2"></th><th rowspan="2"></th><th colspan="3">Accredited MBHO</th><th colspan="3">Accredited in UM, CR or PN</th></tr>
<tr><th>Interim</th><th>First</th><th>Renewal</th><th>Interim</th><th>First</th><th>Renewal</th></tr>
<tr><td>D</td><td>UM Timeliness Report[26]</td><td>NA</td><td>Y</td><td>Y</td><td>NA</td><td>Y</td><td>Y</td></tr>
</table></td><td>CO</td><td>11/25/2019</td></tr>
<tr><td>7-10</td><td>Appendix 7</td><td>MEMBER EXPERIENCE—ME 1: Statement of Members’ Rights and Responsibilities</td><td>For row ME 1, Element A: Rights and Responsibilities Statement, delete the check mark (✓) from the Renewal column under Commercial, Medicare and Exchange.</td><td>CL</td><td>11/25/2019</td></tr>
</table>