# NCQA Clarifications and Regulatory Changes to the 2021 Medicaid Module

***March 29, 2021***

As part of NCQA's Medicaid Deeming or nonduplication efforts, which allow organizations, states and the federal government to avoid duplicate reviews, NCQA made changes and updates to the 2021 MED standards and guidelines to align with the most recent federal regulations, including the Centers for Medicare & Medicaid Services final rule of November 9, 2020, effective July 1, 2021.

This document includes clarifications and regulatory changes to the 2021 MED 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 clarification and regulatory change are as follows:

- A ***clarification (CL)*** is additional information that explains an existing requirement.
- A ***regulatory change (RC)*** is a new requirement or a modification of an existing requirement to align with federal regulations.

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<tr><td>544</td><td>MED 1, Element H</td><td>Element stem</td><td>Revise the element stem to read:<br>The organization provides written notification to affected members of termination of a practitioner or practice group by the later of 30 calendar days prior to the effective date of termination, or within 15 calendar days after receipt or issuance of the termination notice.</td><td>RC</td><td>3/29/2021</td></tr>
<tr><td>545</td><td>MED 1, Element J</td><td>New element</td><td>Add a new Element J.<br>Element J: Physician Incentive Plans<br>The organization provides information about physician incentive plans to members, upon request.
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<tr><th>Scoring</th><th>Met</th><th>Partially Met</th><th>Not Met</th></tr>
<tr><td></td><td>The organization meets the requirement</td><td>No scoring option</td><td>The organization does not meet the requirement</td></tr>
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Data source Documented process, Reports, Materials<br>
Scope of review This element applies to Interim Surveys, First Surveys and Renewal Surveys.<br>NCQA reviews the organization's policies and procedures and reviews evidence that the organization distributes information about its physician incentive plans to members upon request.<br>
Look-back period For All Surveys: 6 months.</td><td>RC</td><td>3/29/2021</td></tr>
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| | | | **Explanation** A **physician incentive plan** is any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan member.<br>When appropriate, the organization provides information about any physician incentive plans in place to members upon request.<br>The organization's report includes the date of the member's request and the date when the organization provided the information to the member.<br>**Distribution of physician incentive plans**<br>Upon request, the organization distributes information about physician incentive plans to members by mail, fax or email, or on its website, if it informs members that the information is available online. The organization mails the information to members who do not have fax, email or internet access.<br>**Exceptions**<br>This element is NA for organizations that do not utilize physician incentive plans.<br>**Examples** None. | | |
| 545 | MED 1, Element K | New element | Add a new Element K.<br>**Element K: Machine-Readable Data**<br>The organization makes the following available on its website in a machine-readable file and format:<br>1. Practitioner and provider directories.<br>2. Formulary drug lists. | **RC** | **3/29/2021** |

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Data source Materials
Scope of review This element applies to Interim Surveys, First Surveys and Renewal Surveys.
NCQA reviews the organization’s website content or screenshots of its website as evidence that information is provided in a machine-readable file and format. NCQA also reviews a statement on the website or in other applicable documentation specifying that the information’s format was in accordance with CMS regulations and guidance. Both must be in place throughout the look-back period.
Look-back period For All Surveys: 6 months.
Explanation The organization provides links to practitioner and provider directories and formulary drug lists in a machine-readable file and format on its website.
The machine-readable file and format (as specified by the Department of Health and Human Services) provide the opportunity for software developers to create resources that aggregate information and create tools to improve transparency.
Factor 1: Practitioner and provider directories
Factor 1 applies to all network providers, practitioners, practitioner groups and facilities that have a network agreement.
Factor 2: Formulary drug lists
The formulary drug list includes the following information:
<ul>
<li>Covered medications (both generic and name brand).</li>
<li>Medication tiers.</li>
</ul>
</td><td>RC</td><td>3/29/2021</td></tr>
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<tr><td></td><td></td><td></td><td>Exceptions<br>None.<br><br>Examples None.</td><td></td><td></td></tr>
<tr><td>545</td><td>MED 1, Element L</td><td>New element</td><td>Add a new Element L.<br>Element L: Excluded Practitioners and Providers<br>The organization does not employ or contract with practitioners and providers excluded from participation in federal health care programs.<br><table><tr><th>Scoring</th><th>Met</th><th>Partially Met</th><th>Not Met</th></tr><tr><td></td><td>The organization meets the requirement</td><td>No scoring option</td><td>The organization does not meet the requirement</td></tr></table>Data source Documented process<br><br>Scope of review This element applies to Interim Surveys, First Surveys and Renewal Surveys.<br>NCQA reviews the organization’s policies and procedures regarding exclusion of practitioners and providers from employment or contract.<br><br>Look-back period For All Surveys: 6 months.<br><br>Explanation The organization’s policies and procedures describe its process for ensuring that it does not employ or contract with practitioners and providers excluded from participation in federal health care programs under either section 1128 or 1128A of the Social Security Act.<br>The organization uses the verification process described in CR 1, Element A, factors 3 and 4 and CR 7, Element A, factor 1, and uses verification data from CR 3, Element B, CR 3, Element C and CR 7, Elements D and E to ensure that the organization does not employ or contract with practitioners and providers that are excluded from federal health care programs.<br>Exceptions<br>None.</td><td>RC</td><td>3/29/2021</td></tr>
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| | | | **Examples** None. | | |
| 558 | MED 5, Element A | Element stem | Add new factors 3–6:<br>3. Ensuring coordination between settings of care.<br>4. Coordinating services members receive from any other organizations.<br>5. Coordinating services members receive in fee-for-service Medicaid.<br>6. Coordinating services members receive from community and social support providers. | **RC** | **3/29/2021** |
| 558 | MED 5, Element A | Scope of review | Revise the first sentence to read:<br>NCQA reviews the organization's policies and procedures for coordinating care for all members for factors 1–6. | **CL** | **3/29/2021** |
| 558 | MED 5, Element A | Look-back period | Revise the look-back period for Renewal Surveys to read:<br>*For Renewal Surveys:* 24 months for factors 1 and 2; 6 months for factors 3-6. | **CL** | **3/29/2021** |
| 558 | MED 5, Element A | Explanation | Revise the subheads in the explanation to read:<br>***Factor 1:* Formally assigned person or entity**<br>***Factor 2:* Contact information**<br>***Factor 3:* Coordination of services between settings of care**<br>***Factors 4–6*** | **CL** | **3/29/2021** |
| 558 | MED 5, Element A | Explanation–Factor 3: Coordination of services and between settings of care | Add the following text:<br>The organization's policies and procedures outline a process for coordinating between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. | **RC** | **3/29/2021** |
| 559 | MED 5, Element A | Examples–Factor 4: Types of organizations | Add the following text as an example for factor 4:<br>Managed care organizations. | **CL** | **3/29/2021** |
| 560 | MED 5, Element C | New element | Add a new Element C.<br>**Element C: Care Plan**<br>The organization's care planning process includes how the care plan is:<br>1. Developed by an individual trained in patient-centered planning. | **RC** | **3/29/2021** |

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2. Approved by the organization in a timely manner.<br>
3. In accordance with any applicable state quality assurance and utilization review standards.
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<tr><td>Data source</td><td>Documented process</td></tr>
<tr><td>Scope of review</td><td>This element applies to Interim Surveys, First Surveys and Renewal Surveys.<br>NCQA reviews the organization’s policies and procedures for developing a care plan.</td></tr>
<tr><td>Look-back period</td><td>For All Surveys: 6 months.</td></tr>
<tr><td>Explanation</td><td>Factors 1–3 apply to all LTSS members. Factors 2 and 3 also apply to members with special health care needs, if the state requires, who have been determined through assessment to need a course of treatment or regular care monitoring.<br>Factor 1: Trained individual<br>The organization’s policies and procedures specify a process for ensuring that the care plan is developed by a person who is trained in:<br>• Person-centered planning.<br>• Using a person-centered process and plan.<br>• Providing care that is driven by the preferences, needs and values of the individual.<br>Person-centered planning process and plan are defined in §441.301(c)(1) and (2).<br>Person-centered planning involves viewing, listening to and supporting individuals to make decisions for maintaining a life that is meaningful to them, based on their strengths, abilities, aspirations and preferences. The resulting care plan reflects the goals and interests of the individual.</td></tr>
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| | | | Individuals should be involved in the care planning process to the extent they prefer.<br>***Factor 2:*** **Approval of the care plan**<br>The organization's policies and procedures specify whether approval of the care plan is required. If approval is required, the organization's process describes how it establishes an approval time frame to ensure timely case management services to members.<br>***Factor 3:*** **Quality assurance and utilization review**<br>No additional explanation.<br>**Exception**<br>Factor 2 is NA if the organization does not require approval of treatment or service plans.<br>**Examples** None. | | |
| 565 | MED 8, Element A | Element stem | Add a new factor 4:<br>4. The extent to which, and how, members may obtain covered benefits from out-of-network providers, including family planning services and supplies. | **RC** | **3/29/2021** |
| 565 | MED 8, Element A | Look-back period | Revise the look-back period for Renewal Surveys to read:<br>*For Renewal Surveys:* 24 months for factors 1-3; 6 months for factor 4. | **CL** | **3/29/2021** |
| 565 | MED 8, Element A | Explanation–Factor 4: How to obtain out-of-network services | Add the following text:<br>The organization provides information to members about the extent to which, and how, they may obtain out-of-network services, including family planning services and supplies. Information includes a statement that the organization may not require a member to obtain a referral before choosing a family planning provider. | **RC** | **3/29/2021** |
| 569 | MED 8, Element E | New element | Add a new Element E.<br>**Element E: Informing Members About Member Handbook Changes**<br>The organization provides written notification to members regarding any significant changes to the member handbook at least 30 days before the intended effective date of the change. | **RC** | **3/29/2021** |

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Data source Documented process, Reports, Materials<br><br>
Scope of review This element applies to Interim Surveys, First Surveys and Renewal Surveys.<br>NCQA reviews the organization’s policies and procedures and evidence that members were notified of any significant changes to the member handbook.<br><br>
Look-back period For All Surveys: 6 months.<br><br>
Explanation The organization gives all members notice of significant changes (as defined by the state) to the member handbook.<br>Distribution of termination notice to members<br>The organization distributes the notification to members by mail, fax or email, or on its website, if it informs members that the information is available online. The organization mails the notification to members who do not have fax, email or internet access.<br>If the organization distributes the notification electronically, it must indicate that the information is available in paper format, upon request.<br>Exception<br>This element is NA if there are no significant changes (as defined by the state) to the member handbook.<br><br>
Examples None.
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<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>570</td><td>MED 9, Element A</td><td>New element</td><td>Add a new Element A.<br>Element A: Advance Notice<br>The organization’s policies and procedures specify that for terminations, suspensions or reductions of previously authorized Medicaid-covered services, the organization gives electronic or written advance notice to practitioners and members at least 10 days before the date of action.<br><table><tr><th>Scoring</th><th>Met</th><th>Partially Met</th><th>Not Met</th></tr><tr><td></td><td>The organization meets the requirement</td><td>No scoring option</td><td>The organization does not meet the requirement</td></tr></table>Data source Documented process, Reports, Materials<br>Scope of review This element applies to Interim Surveys, First Surveys and Renewal Surveys.<br>NCQA reviews the organization's policies and procedures in place throughout the look-back period and reviews evidence that members and practitioners were notified of terminations, suspensions or reductions of previously authorized Medicaid-covered services.<br>Look-back period For All Surveys: 6 months.<br>Explanation Even if there were no terminations, suspensions or reductions of previously authorized Medicaid-covered services, the organization must have policies and procedures for providing advance notice to members and practitioners.<br>Advance notice in cases of probable fraud<br>The organization’s policies and procedures state that the time frame for advance notice may be shortened to 5 days before the date of action if:<br>• The agency has facts indicating that action should be taken because of probable fraud by the member, ***and***<br>• The facts have been verified through secondary sources, if possible.</td><td>RC</td><td>3/29/2021</td></tr>
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| | | | **Exceptions from advance notice**<br>The organization's policies and procedures specify that advance notice may be sent at any point up to the date of action, but no later than the date of action, if any scenario specified in § 428.213 is met.<br>**Distribution of advance notice to members and practitioners**<br>The organization distributes the notification by mail, fax or email, or on its website, if it informs members and practitioners that the information is available online. The organization mails the notification to members and practitioners who do not have fax, email or internet access.<br>**Exceptions**<br>None.<br>**Examples** None. | | |
| 570, 571, 572, 573 | MED 9, Elements B–E | Element stem | Revise the former Elements A–D headings to read:<br>***Element B:* UM Denial Notifications**<br>***Element C:* LTSS Requests for Initial and Continuing Authorization of Services**<br>***Element D:* Coverage of Emergency and Post-Stabilization Services**<br>***Element E:* Affirmative Statement About Incentives** | **CL** | **3/29/2021** |
| 575 | MED 10, Element A | Element stem | Add the following new factors and renumber the other factors accordingly:<br>2. Oral inquiries made by members seeking to appeal a denial must be treated as appeals.<br>7. Ensures that no punitive action is taken against a practitioner or provider that requests an expedited resolution or supports a member's appeal.<br>10. Gives members reasonable assistance in completing forms and taking other procedural steps. | **RC** | **3/29/2021** |
| 575 | MED 10, Element A | Look-back period | Revise the look-back period for Renewal Surveys to read:<br>For Renewal Surveys: 24 months for factors 1, 3-6, 8 and 9; 6 months for factors 2, 7 and 10. | **CL** | **3/29/2021** |
| 576 | MED 10, Element A | Explanation | Revise the following subheads to read:<br>***Factor 2:* Oral inquiries seeking to appeal**<br>***Factor 3:* Information sent by members for consideration in grievances and appeals**<br>***Factor 4:* Notification of grievances and appeals** | **CL** | **3/29/2021** |

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| | | | ***Factor 5:*** **Timely notification**<br>***Factor 6:*** **Oral notification of expedited appeals**<br>***Factor 7:*** **Punitive actions regarding expedited appeals**<br>***Factor 8:*** **Denials of expedited appeals**<br>***Factor 9:*** **Initiating a State Fair Hearing**<br>***Factor 10:*** **Providing assistance** | | |
| 576 | MED 10, Element A | Explanation—Factor 5: Timely notification | Remove the following text from the second paragraph:<br>An oral appeal must be followed by a written appeal. | **RC** | **3/29/2021** |
| 577 | MED 10, Element A | Explanation—Factor 7: Punitive actions regarding expedited appeals | Add the following text:<br>The organization's policies and procedures outline its process for ensuring that practitioners and providers are not penalized for requesting an expedited appeal or supporting a member's appeal. | **RC** | **3/29/2021** |
| 577 | MED 10, Element A | Explanation—Factor 10: Providing assistance | Add the following text:<br>The organization's policies and procedures:<br>• Specify how it helps members with the grievance and appeal process.<br>• Specify how it helps members complete necessary forms.<br>• Describe other assistance provided to members when requested, including access to auxiliary aids and services, interpreter services and toll-free numbers with TTY/TTD and interpreter capability. | **RC** | **3/29/2021** |
| 587 | MED 12, Element C | Element stem | Revise factor 1 to read:<br>1. Informs existing and potential members how to request and access auxiliary aids and services. | **RC** | **3/29/2021** |
| 587 | MED 12, Element C | Element stem | Add a new factor 4:<br>4. Includes a statement that the organization complies with all applicable federal and state laws. | **RC** | **3/29/2021** |
| 587 | MED 12, Element C | Scope of review | Revise the sentence to read: | **RC** | **3/29/2021** |

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| | | | NCQA reviews the organization's policies and procedures and reviews evidence that the organization's member handbook informs members about free access to auxiliary aids and services upon request and that the organization complies with federal and state laws. | | |
| 587 | MED 12, Element C | Look-back period | Revise the look-back period for Renewal Surveys to read:<br>*For Renewal Surveys:* 24 months for factors 1-3; 6 months for factor 4. | **CL** | **3/29/2021** |
| 587 | MED 12, Element C | Explanation | Revise the following subhead to read:<br>***Factors 1-3:* Auxiliary aids and services.** | **CL** | **3/29/2021** |
| 587 | MED 12, Element C | Explanation—Factors 1-3: Auxiliary aids and services | Revise the paragraph to read:<br>The member handbook contains information about auxiliary aids and services (e.g., qualified interpreters, transcription services, assistive listening devices) that are available upon request and free of charge for existing and potential members with disabilities, and instructions for requesting and accessing aids and services. | **RC** | **3/29/2021** |
| 588 | MED 12, Element C | Explanation | Remove the following subhead and text:<br>***Factors 2, 3***<br>No explanation required. | **CL** | **3/29/2021** |
| 588 | MED 12, Element C | Explanation—Factor 4: Compliance with other Federal and State laws | Add the following subhead and text to the Explanation:<br>***Factor 4:* Compliance with other federal and state laws**<br>The organization's member handbook states that the organization complies with all applicable federal and state laws, including:<br>• Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80.<br>• The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91.<br>• The Rehabilitation Act of 1973.<br>• Title IX of the Education Amendments of 1972 (regarding education programs and activities).<br>• Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act. | **RC** | **3/29/2021** |
| 588, 591, 593 | MED 12, Elements D, F and G | Element stem | Remove factor 1, which reads:<br>1. In regular and large print. | **RC** | **3/29/2021** |

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| 588, 591, 593 | MED 12, Elements D, F and G | Look-back period | Revise the look-back period for Renewal Surveys to read:<br>*For Renewal Surveys:* 24 months for factors 2-4; 6 months for factor 1. | **CL** | **3/29/2021** |
| 588, 591, 593 | MED 12, Elements D, F and G | Explanation | Remove the factor 1 subheads and text from the Explanation.<br>*Element D:*<br>***Factor 1:* Availability of the directory in regular and large print**<br>The organization provides written practitioner directories in large print (i.e., in font size no smaller than 18 point).<br>*Element F:*<br>***Factor 1:* Availability of denial notifications in regular and large print**<br>The organization provides written denial notifications in large print (i.e., in font size no smaller than 18 point).<br>*Element G:*<br>***Factor 1:* Availability of the appeal and grievance notifications in regular and large print**<br>The organization provides written notifications in large print (i.e., in font size no smaller than 18 point). | **RC** | **3/29/2021** |
| 588, 591, 593 | MED 12, Elements D, F and G | Element stem | Add a new factor 1.<br>*Element D:*<br>1. With instructions for requesting and accessing auxiliary aids and services.<br>*Elements F and G:*<br>1. Contain instructions for requesting and accessing auxiliary aids and services. | **RC** | **3/29/2021** |
| 588, 591, 593 | MED 12, Elements D, F and G | Explanation | Add the following subhead and text to the Explanation:<br>***Factor 1:* Auxiliary aids and services**<br>The practitioner directory contains information about auxiliary aids and services (e.g., qualified interpreters, transcription services, assistive listening devices) that are available upon request and free of charge for existing and potential members with disabilities, and instructions for requesting and accessing aids and services. | **RC** | **3/29/2021** |
| 589, 590, | MED 12, Elements D-G | Explanation—Factor 4: Availability of the | Add the following as the third paragraph in Element D and the second paragraph in Elements E–G: | **RC** | **3/29/2021** |

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| 592, 593 | | directory with taglines in other languages | Taglines must be printed in a conspicuously visible font size. | | |
| 591, 595 | MED 12, Elements E and I | Exceptions | Add the following text as the first paragraph:<br>Factor 1 is NA for all organizations. | **RC** | **3/29/2021** |
| 601, 602, 604, 605 | MED 14, Elements A-D | Related information | Add the following as the first paragraph:<br>Effective July 1, 2021, CMS amended CFR 438.10(h)(1)(vii), which eliminated a phrase that required organizations to provide information on whether a practitioner completed cultural competency training. Unless this requirement is reinstated, NCQA will not review against this portion of the requirement in factor 3. | **RC** | **3/29/2021** |