NCQA Corrections, Clarifications and Policy Changes to the 2024 HPA Standards and Guidelines

March 31, 2025

This document includes the corrections, clarifications and policy changes to the 2024 Health Plan Accreditation standards and guidelines. NCQA has identified the appropriate page number in the publication the standard/element head and 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.
- A ***regulatory change (RC)*** is a new requirement or a modification of an existing requirement to align with federal regulations.

An organization undergoing a survey under the 2024 Health Plan Accreditation 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; nor does it apply to regulatory changes, because they align with federal regulations.

Page	Standard/ Element	Head/Subhead	Update	Type of Update	IRT Release Date
186	PHM 7, Element C	Explanation—Factor 2	Replace the link for the "8/30 methodology" with "https://www.ncqa.org/wp-content/uploads/2018/07/20180110_830_Procedure.pdf."	**CL**	**3/31/25**
479	ME 7, Element B	Scope of Review	Revise the paragraph under *Product lines* to read: This element applies to Interim Surveys, First Surveys and Renewal Surveys for the commercial, Exchange and Medicaid product lines.	**CO**	**3/31/25**
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6	Overview	Notable Changes and Clarifications to the Standards and Guidelines	Remove the following notable change for LTSS 2, Element B that reads: Revised the look-back period to "prior to the survey date" for All Surveys.	**CL**	**3/25/24**
14	Policies and Procedures—Section 1: Eligibility and the Application Process	Table 1: Summary of Evaluation Options' eligibility, status duration and HEDIS reporting and scoring	For the "Interim" and "First" Evaluation Option rows in Table 1, revise the first sentence in the first paragraph of the "HEDIS/CAHPS Measures Reporting and Scoring" column to read: Required reporting by the HEDIS submission date deadline and Health Plan Rating scoring in the next calendar year following the effective date of Accreditation status.	**CL**	**11/18/24**
25	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Follow-Up Survey *(applies to First Evaluation Option)*	Replace "effective date" with "expiration date" in the last sentence of the third paragraph to read: The expiration date of the Accreditation status is the date specified in the Full Survey decision that precipitated the Follow-Up Survey.	**CL**	**3/25/24**

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Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
25	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Resurvey *(applies to First and Renewal Evaluation Options)*	Replace "effective date" with "expiration date" in the last sentence of the third paragraph to read: The expiration date of the Accreditation status is the date specified in the Full Survey decision that precipitated the Resurvey.	**CL**	**3/25/24**
27	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Add-On Survey *(applies to First and Renewal Evaluation Options)*	Replace "effective date" with "expiration date" in the first sentence in the fifth paragraph to read: The expiration date of the Accreditation status for the new product line through an Add-On Survey aligns with the current Accreditation earned during the most recent Full Survey.	**CL**	**3/25/24**
32	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Table 3: Scoring ranges for Accreditation statuses	Revise the **Provisional with a Health Plan Rating, if applicable**, row to read: Greater than or equal to 55% but below 80% of applicable points in any category of standards (QI, PHM, NET, UM, CR, ME) ***or*** Not receiving a score of Met in 3 or more must-pass elements	**CL**	**11/18/24**
32	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Table 3: Scoring ranges for Accreditation statuses	Revise the fourth row in Table 3 to read: **Denied with a Health Plan Rating, if applicable** Scores below 80% of applicable points in any category of standards (QI*, PHM, NET, UM, CR, ME) Scores below 55% of applicable points in any category of standards (QI*, PHM, NET, UM, CR, ME)	**CO**	**11/18/24**
41	Policies and Procedures—Section 3: The Survey Process	Survey process results	Revise the second paragraph to read: The organization may only use results from the readiness evaluation for internal business purposes (to examine, review and otherwise analyze its business operations), and may not use, disclose, represent or otherwise communicate these results to any third party for any other purpose. The ROC reviews the preliminary results with all relevant information to determine Accreditation. NCQA does not allow the release of preliminary results to third parties as representative of the survey results or findings which are presented in the final report. The organization may not use reports or numeric results to represent that it is NCQA Accredited without a final NCQA Accreditation decision, as described above.	**CL**	**7/29/24**

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43	Policies and Procedures—Section 3: The Survey Process	Offsite review	Revise the section to read: The organization must submit a complete survey tool (including self-assessed scores and supporting evidence) to NCQA on the scheduled survey start date (submission date). The survey team conducts an initial review of all information and evidence submitted, and documents findings and questions in the survey tool. During a survey conference call with the survey team, the organization has the opportunity to address surveyor questions and initial findings. The organization may also submit additional supporting evidence, if needed to resolve outstanding issues. Any additional supporting evidence must be submitted by the due date for submitting responses to the survey team's outstanding questions and initial findings. The organization may not introduce new evidence after this point in the survey process. The organization should not attach documents to the survey tool that contain protected health information (PHI) or other personal identifiable information (PII), as defined by the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations. If original documentation contains PHI or PII, the organization must de-identify the information prior to submission. Refer to "de-identify" in Appendix 4: Glossary. All documentation provided to NCQA during the survey process must be in English, or with English translation. The organization has one opportunity during the survey process to address surveyor questions and initial findings and to submit additional supporting evidence if needed. All applicable evidence must be provided during the survey; new supporting evidence may not be introduced after the survey has concluded.	**CL**	**7/29/24**
47	Policies and Procedures—Section 3: The Survey Process	Documents dated after submission	Revise the section to read: The organization may only submit information that existed at the time of the original survey submission; it may not introduce information that did not exist at the time of the original survey submission. Evidence submitted in response to the survey team's initial questions and findings must have existed at survey submission. The organization may not alter or update evidence to address an issue, but may bookmark or highlight this information.	**CL**	**7/29/24**

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47	Policies and Procedures—Section 3: The Survey Process	Onsite review	Revise the section to read: The onsite review date is usually scheduled for 7 weeks after submission of the survey tool. The onsite review is primarily a file review, but might also require review of additional information, staff interviews or system queries. The onsite survey can be conducted either in person or virtually, depending on the organization's preferences and ability to present files electronically. The onsite review must be conducted in English, and all records or files that are part of the review must be provided in English, or with English translation.	**CL**	**7/29/24**
49	Policies and Procedures—Section 3: The Survey Process	Comments about errors or omissions	Revise the section to read: NCQA gives the organization access to preliminary survey results in the IRT for review and comment. The organization has 10 calendar days to submit comments regarding factual errors or omissions before the survey report is sent to the Review Oversight Committee (ROC) for the final status decision. The organization comment process is not an opportunity to introduce new supporting evidence that was not included in the survey submission or provided in response to initial survey team issues. NCQA only considers comments and supporting evidence that are related to factual errors or omissions in the preliminary report and based on information and evidence presented during the survey.	**CL**	**7/29/24**
51	Policies and Procedures—Section 3: The Survey Process	Materials not accepted during Reconsideration	Revise the section to read: To protect the integrity of the Accreditation process, NCQA does not accept materials during Reconsideration that did not exist at the time of the original completed survey tool submission. The organization may not submit—and the Reconsideration Committee does not consider—documentation that represents actions taken by the organization after it submitted the survey tool. The organization may not introduce new or additional supporting evidence that was not available during the survey (i.e., with original submission of evidence, or in response to the survey team's questions and initial findings).	**CL**	**7/29/24**

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90	QI 1, Element D	Scoring	**E-PUBLICATION VERSION ONLY EDIT** Revise the scoring table to read as follows: **Met** The organization meets 4-5 factors **Partially Met** The organization meets 3 factors **Not Met** The organization meets 0-2 factors	**CO**	**3/25/24**
138	PHM 2, Element B	Explanation	Replace "at least annually" with "annually" in the first paragraph of the Explanation.	**CL**	**3/25/24**
296	UM 5, Element E	Related information—Extension conditions	Revise the first bullet under "Extension conditions" 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, or any time after, the expiration of the previously approved period or number of treatments. The organization may treat the request to extend urgent concurrent care as urgent preservice and send a decision notification within 72 hours.	**CL**	**3/25/24**
389	CR 1, Element A	Explanation – Factor 1	Revise the example in the last bullet under Medical practitioners to read: • Other medical practitioners who may be within the scope of credentialing (e.g., physician assistant).	**CO**	**11/18/24**
435	CR 8, Element C	Explanation—NCQA-Accredited/Certified delegates	Revise the third paragraph under NCQA-Accredited/Certified delegates to read: Automatic credit for factors 5 and 6 is available if all delegates are NCQA Accredited under 2022 (or later) standards for Health Plan Accreditation, MBHO Accreditation, UM-CR-PN Accreditation or for NCQA Certified CVOs under the 2024 (or later) standards.	**CL**	**3/25/24**
541	LTSS 2, Element A	Look-back period	Revise the look-back period for Renewal Surveys to read: *For Renewal Surveys:* At least once during the prior year.	**CO**	**3/25/24**
541	LTSS 2, Element A	Scope of Review	Revise the scope of review to read: *For Renewal Surveys:* NCQA reviews the organization's most recent annual data collection and evaluation reports that it collects and analyzes member complaints.	**CO**	**11/18/24**
676	MA 7, Element E	Factor 1	Revise factor 1 to read: 1. Practice guidelines and utilization management guidelines are based on current evidence in widely used treatment guidelines or clinical literature.	**CL**	**3/25/24**

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677	MA 7, Element E	Explanation—Factor 1	Revise the factor 1 Explanation to read: ***Factor 1:* Guidelines based on clinical evidence** The organization's QI Committee or other designated clinical committee approves clinical practice guidelines. The organization adopts guidelines from recognized sources. It uses one of the following in adopting its clinical practice guidelines: • Current evidence in widely used treatment guidelines, ***or*** • Clinical literature.	**CL**	**3/25/24**
697	MA 20, Element A	Explanation—Factor 8	Revise the factor 8 Explanation to read: ***Factor 8:* Serving a diverse membership** The program description outlines the organization's approach to address the cultural and linguistic needs of its membership. The description must also include how the organization incorporates activities that reduce disparities in health and health care. These activities must be broadly accessible irrespective of race, ethnicity, national origin, religion, sex, or gender. These activities may be based upon health status and health needs, geography, or factors not listed in the previous sentence only as appropriate to address the relevant disparities in health and health care. The QI program description includes other objectives the organization deems appropriate.	**CL**	**3/25/24**
734	SNP 2, Element A	Explanation	Revise the second paragraph in the Explanation to read: The organization conducts an initial and annual health risk assessment using a comprehensive health risk assessment tool and ensures results from the initial assessment and annual reassessment conducted for each member enrolled in the plan are addressed in the member's individualized care plan as required under 422.101(f)(1)(i) and 422.101(f)(1)(ii). Beginning January 1, 2024, the comprehensive risk assessment tool must include one or more questions on each of the following domains: • Housing stability. • Food security. • Access to transportation.	**CL**	**3/25/24**

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1-11	Appendix 1—Element Points	LTSS Distinction Points	Revise the scoring to read: Met = 1 Partially Met = NA Not Met = 0	**CO**	**11/18/24**
3-8	Appendix 3—MAC Policy	Table 2: 2024 LTSS Distinction Standards for MAC Survey	Update the LTSS table to read: ***Table 2: 2024 LTSS Distinction Standards for MAC Survey*** **2024 Standards/Elements** **LONG-TERM SERVICES AND SUPPORTS** **LTSS 1: Core Features** A Program Description B Service Authorization C Notification of Service Authorization D Demographic Data Collection E Privacy Protections for Data F Assessment of Health, Functioning and Communication Needs G Resource Assessment H Comprehensive Assessment Implementation I Person-Centered Assessments J Person-Centered Care Planning Process K Implementing the Care Planning Process **LTSS 3: Care Transitions** A Process for Transitions of Care	**CL**	**7/29/24**