NCQA Corrections, Clarifications and Policy Changes to the 2025 HPA Standards and Guidelines

March 31, 2025

This document includes the corrections, clarifications and policy changes to the 2025 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 2025 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
8	Overview	How Organizations Are Scored	Add the following note to the end of the subbullet under the first bullet to read: ***Note:*** *Organizations will still be surveyed and scored on all applicable QI standards and elements for 2025. If an organization scores poorly in the QI category (e.g., scores "Not Met"; receives "0" or minimal points across the entire category), the Review Oversight Committee (ROC) makes the final determination of Accreditation status.*	**CL**	**3/31/25**
40	Policies and Procedures—Section 2: Accreditation Scoring and Status Requirements	Responsible Use of Artificial Intelligence	Revise the "Responsible Use of Artificial Intelligence" text to read: NCQA supports the use of technological advancements that improve the quality and equity of health care operations and delivery. Artificial intelligence may be useful in this regard, but there are risks to consider and mitigate. Many AI frameworks have been established to address these risks. NCQA expects organizations that use AI to implement a framework and policies that are fair and equitable to members. Although NCQA does not mandate use of a specific AI framework, the NIST AI Risk Management Framework may be helpful. The Coalition for Health AI is also a useful resource. NCQA may consider use of AI in determining Accreditation/Certification status, even though current NCQA standards do not specifically address AI. For example, with regard to utilization management, NCQA standards require appropriately licensed professionals (not AI) to make medical necessity denial decisions. Other activities that require human decision making, and where AI is used, may be an area for NCQA to consider.	**CL**	**3/31/25**

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97	QI 3, Element A	Scope of review—Documentation	Revise the first and second bullets to read: • *For Interim Surveys:* NCQA reviews the organization's annual plan to collect data on the exchange of information between medical practitioners, between medical and behavioral health practitioners and across settings, or reviews the organization's audited IDSS report or Health Plan Ratings scoresheet, if it reports the required measures as outlined in the "Related information." • *For First Surveys:* NCQA reviews the organization's exchange of information regarding continuity and coordination of care, or reviews the organization's audited IDSS report or Health Plan Ratings scoresheet, if it reports the required measures as outlined in the "Related information."	**PC**	**3/31/25**
98	QI 3, Element A	Explanation	Add the following as a new sub-section at the end of the Explanation section: **Related information** For organizations coming through Interim or First Survey that report HEDIS, CAHPS and/or QRS measures, proof of reporting the required continuity and coordination of care measures may be used to demonstrate exchange of information for this element. If an organization coming through Interim or First Survey demonstrates it reports all required HEDIS, CAHPS and/or QRS measures (listed in Elements B and D) and has a valid reported rate (i.e., a numerical value) for at least 50% of the required measures (i.e., 5 of the 10 required commercial or Medicaid measures, 6 of the 12 for Medicare and 4 of the 8 for Exchange), then Element A is scored "Met." Organizations may demonstrate the reporting of the required measures through the most recent audited IDSS report or the most recent Health Plan Ratings scoresheet for each product line brought forward for Accreditation.	**PC**	**3/31/25**
103	QI 3, Element B	Examples	Revise the last two rows in the Example 2 table to read: Total = 32 Average (32/9) = 3.555	**CO**	**3/31/25**
104	QI 3, Element C	Explanation—Improvement Plans	Revise this section to read: At a minimum, the organization's improvement plan must: • Identify at least one required measure for which the organization received a rating of "1" or "0." • Document all actions the organization plans to take, or has already taken, to improve the measure's rating.	**CL**	**3/31/25**

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			– If the organization identifies more than one measure for improvement, all actions the organization plans to take, or has taken, must be documented for each measure. – If the organization chooses to address more than one measure in the improvement plan, one single action may be used to address all measures, if appropriate (i.e., if it clearly applies to all measures). – Choosing to report a previously unreported measure is not sufficient as the only action. • Specify how the organization will monitor progress, and how frequently. • Identify the parties responsible for performing improvement plan tasks (e.g., staff, department, committee).		
104	QI 3, Element D	Scope of Review—Documentation	Revise this section to read: NCQA will review a documented improvement plan. NCQA also reviews reports as evidence the organization reported the required measures to CMS. Organizations are scored "Met" if the improvement plan contains all components specified in the Explanation and reports indicate all required measures were reported to CMS, as applicable. If a required component is missing from the improvement plan or the organization did not report all required measures to CMS, the organization is scored "Not Met."	**CL**	**3/31/25**
105	QI 3, Element D	Explanation—Improvement Plans	Revise this section to read: At a minimum, the organization's improvement plan must: • Identify at least one required measure for improvement. • Document all actions the organization plans to take, or has already taken, to improve the measure's rating. – If the organization identifies more than one measure for improvement, all actions the organization plans to take, or has taken, must be documented for each measure. – If the organization chooses to address more than one measure in the improvement plan, one single action may be used to address all measures, if appropriate (i.e., if it clearly applies to all measures). – Choosing to report a previously unreported measure is not sufficient as the only action. • Specify how the organization will monitor progress, and how frequently. • Identify the parties responsible for performing improvement plan tasks (e.g., staff, department, committee).	**CL**	**3/31/25**
174	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**

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349	UM 12, Element A	Explanation—Factor 5	Revise the second subbullet of the second bullet of the factor 5 explanation to clarify the language regarding fraud and misconduct to read: • NCQA, when the organization identifies fraud and misconduct. – Self-identification of systemic issues affecting 5% or more of eligible UM files; for example, falsifying of UM request receipt dates or appeal notification dates. Refer to *Section 5: Notifying NCQA of Reportable Events* in the Policies and Procedures for details.	**CL**	**3/31/35**
352	UM 12, Element C	Explanation—Factor 2	Revise the second subbullet of the second bullet under factor 2 to read: • NCQA, when the organization identifies fraud and misconduct, as identified in Element A, factor 4.	**CL**	**3/31/25**
385	CR 1, Element A	Look-Back Period	Revise the look-back period for First and Renewal Surveys to read: *For First Surveys:* 6 months; prior to the survey date for factor 6 and the verification of fellowship component of factor 12. *For Renewal Surveys:* 24 months; prior to the survey date for factor 6 and the verification of fellowship component of factor 12.	**CO**	**3/31/25**
404	CR 3, Element B	Explanation—Factor 2	Revise the second paragraph of the factor 2 explanation to read: The organization obtains Medicare sanction information from any of the following sources: • AMA Physician Master File. • FSMB. • NPDB. • SAM.gov.	**CL**	**3/31/25**
404	CR 3, Element B	Explanation—Factor 3	Add NPDB as an acceptable source for Medicare/Medicaid exclusions: ***Factor 3:* Sources for Medicare/Medicaid exclusions** The organization obtains Medicaid exclusion information from the State Medicaid agency *and* from one of the following additional sources: • List of Excluded Individuals and Entities, maintained by OIG and available over the internet), ***or*** • NPDB.	**CO**	**3/31/25**
			The organization obtains Medicare exclusion information from any of the following sources: • Medicare Exclusion Database. • List of Excluded Individuals and Entities, maintained by OIG and available over the internet). • NPDB.		

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407	CR 3, Element C	Explanation—Factor 6	Replace "ethnicity or language" with "ethnicity and language" in the first paragraph of the factor 6 explanation to read: The organization's application includes fields to enter race, ethnicity and language, and a statement that the organization does not discriminate or base credentialing decisions on an applicant's race, ethnicity and language, and that providing the information is optional.	**CO**	**3/31/25**
411	CR 5, Element A	Summary of Changes	Revise the summary of changes to read: • Added SAM.gov as an acceptable source for verification of Medicare/Medicaid sanctions.	**CO**	**3/31/25**
412	CR 5, Element A	Scope of Review	Revise the scope of review under documentation to read: NCQA reviews the organization's policies and procedures and reports that demonstrate the organization collected and reviewed applicable information. For factors 1-3, if the organization uses a monitoring service, NCQA also reviews the organization's evidence of the subscription with the service.	**CL**	**3/31/25**
412	CR 5, Element A	Explanation—Factor 1	Revise the second paragraph of the factor 1 explanation to read: The organization obtains Medicare sanction information from any of the following sources: • AMA Physician Master File. • FSMB. • NPDB. • SAM.gov.	**CL**	**3/31/25**
412	CR 5, Element A	Explanation—Factor 2	Add NPDB as an acceptable source for Medicare/Medicaid exclusions: ***Factor 2:*** **Sources for Medicare/Medicaid exclusions** The organization obtains Medicaid exclusion information from the State Medicaid agency and from one of the following additional sources: • List of Excluded Individuals and Entities maintained by OIG and available over the internet), ***or*** • NPDB.	**CO**	**3/31/25**
			The organization obtains Medicare exclusion information from any of the following sources: • Medicare Exclusion Database. • List of Excluded Individuals and Entities maintained by OIG and available over the internet). • NPDB.		

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414	CR 5, Element A	Explanation—Factor 5	Revise the factor 5 explanation to clarify the time frame for adverse events. The organization monitors for adverse events: • Before July 1, 2025: At least every 6 months. • On or after July 1, 2025: At least monthly.	**CL**	**3/31/25**
428	CR 8, Element A	Explanation—Factor 5	Revise the second subbullet of the second bullet of the factor 5 explanation to clarify the language regarding fraud and misconduct to read: • NCQA, when the organization identifies fraud and misconduct. – Self-identification of systemic issues affecting 5% or more of eligible credentialing/recredentialing files; for example, falsifying of verification dates. Refer to *Section 5: Notifying NCQA of Reportable Events* in the Policies and Procedures for details.	**CL**	**3/31/25**
429	CR 8, Element B	Explanation—Factor 2	Revise the second subbullet of the second bullet under factor 2 to read: • NCQA, when the organization identifies fraud and misconduct, as identified in Element A, factor 4.	**CL**	**3/31/25**
492	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**
532	LTSS 1, Element H	Look-Back Period	Revise the look-back period for Renewal Surveys to read: *For Renewal Surveys:* 12 months	**CO**	**3/31/25**
551	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 report that it collects and analyzes member complaints.	**CO**	**3/31/25**
1-9	Appendix 1	Element Points for 2025	Change Partially Met scoring for CR 5, Element B, to NA.	**CO**	**3/31/25**
1--12	Appendix 1	LTSS Distinction Points	Change Partially Met scoring for LTSS 1, Element D, to NA.	**CO**	**3/31/25**
PREVIOUSLY POSTED UPDATES					
30	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**

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30	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)	**CL**	**11/18/24**
98	QI 3, Element A	Exceptions	Add an exception for factor 2 that reads: Factor 2 is NA if all purchasers of the organization's services carve out or exclude behavioral healthcare.	**CL**	**11/18/24**
218	NET 5, Element F	Examples	Remove "Quality Check" from the factor 4 examples.	**CL**	**11/18/24**
354	UM 12, Element D	Related information	Replace the second paragraph with the following language: If the organization's system automatically records receipt and decision notification dates, and does not permit changes under any circumstances, the organization may, in lieu of completing a full audit and analysis report, generate, review and submit a complete system log showing there were no changes to dates during the look-back period. The organization may audit using the NCQA 5% or 50 files methodology. The organization audit and analysis report includes the following: • Evidence that the organization's UM system automatically records receipt and decision notification dates, and does not permit changes under any circumstances. • The report date. • The title of the individual(s) who conducted the audit/review. • Auditing/review period. • File universe. • Sampling methodology, if applicable.	**CL**	**11/18/24**

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			• System generated log showing there were no changes to dates. A separate analysis is not required if no dates were changed. If the audit reveals dates were changed, an analysis is required.		
361	UM 12, Element F	Related information	Replace the second paragraph with the following language: If the organization's system automatically records receipt and decision notification dates, and does not permit changes under any circumstances, the organization may, in lieu of completing a full audit and analysis report, generate, review and submit a complete system log showing there were no changes to dates during the look-back period. The organization may audit using the NCQA 5% or 50 files methodology. The organization audit and analysis report includes the following: • Evidence that the organization's UM system automatically records receipt and decision notification dates, and does not permit changes under any circumstances. • The report date. • The title of the individual(s) who conducted the audit/review. • Auditing/review period. • File universe. • Sampling methodology, if applicable. • System generated log showing there were no changes to dates. A separate analysis is not required if no dates were changed. If the audit reveals dates were changed, an analysis is required.	**CL**	**11/18/24**
386	CR 1, Element A	Explanation—Factor 1	Replace "certified nurse midwife" with "physician assistant" in the last bullet to read: • Other medical practitioners who may be within the scope of credentialing (e.g., physician assistant).	**CO**	**11/18/24**
400	CR 3, Element A	Explanation—Factor 5	Replace "120 calendar days" with "180 calendar days" in the explanation to read: *Verification time limit:* 180 calendar days. ***Note:*** *The 180-calendar-day verification time limit applies to files processed by the organization or its delegate(s) on or after July 1, 2025. Files processed before July 1, 2025, are scored against the previous verification time limit requirement of 365 calendar days.*	**CO**	**11/18/24**
403	CR 3, Element B	Explanation	Add the following as the third paragraph of the explanation: The organization verifies sanction and exclusion information (from factors 1-3) for all product lines.	**CL**	**11/18/24**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
404	CR 3, Element B	Explanation—Factor 2	Replace the current factor 2 explanation with the following text: ***Factor 2:*** **Sources for Medicare/Medicaid sanctions** The organization obtains Medicaid sanction information from the State Medicaid agency and from one of the following additional sources: • AMA Physician Master File. • FSMB. • NPDB. • SAM.gov. The organization obtains Medicare sanction information from the following sources: • AMA Physician Master File. • FSMB. • NPDB. • SAM.gov.	**CL**	**11/18/24**
404	CR 3, Element B	Explanation—Factor 3	Replace the current factor 3 explanation with the following text: ***Factor 3:*** **Sources for Medicare/Medicaid exclusions** The organization obtains Medicaid exclusion information from each of the following sources: • The state Medicaid agency. • List of Excluded Individuals and Entities maintained by OIG and available over the internet. The organization obtains Medicare exclusion information from any of the following sources: • Medicare Exclusion Database. • List of Excluded Individuals and Entities maintained by OIG and available over the internet.	**CL**	**11/18/24**
404	CR 3, Element B	Exceptions	Remove the second exception, which reads: Factors 2 and 3 are NA for commercial and Exchange product line.	**CO**	**11/18/24**
412	CR 5, Element A	Explanation	Add the following as the third paragraph under the explanation: The organization verifies sanction and exclusion information (from factors 1-3) for all product lines.	**CL**	**11/18/24**

PREVIOUSLY POSTED UPDATES					
Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**IRT Release Date**
412	CR 5, Element A	Explanation—Factor 1	Replace the current factor 1 explanation with the following text: ***Factor 1:*** **Sources for Medicare/Medicaid sanctions** The organization obtains Medicaid sanction information from the State Medicaid agency and from one of the following additional sources: • AMA Physician Master File. • FSMB. • NPDB. • SAM.gov. The organization obtains Medicare sanction information from the following sources: • AMA Physician Master File. • FSMB. • NPDB. • SAM.gov.	**CL**	**11/18/24**
412	CR 5, Element A	Explanation—Factor 2	Replace the current factor 2 explanation with the following text: ***Factor 2:*** **Sources for Medicare/Medicaid exclusions** The organization obtains Medicaid exclusion information from each of the following sources: • The state Medicaid agency. • List of Excluded Individuals and Entities maintained by OIG and available over the internet. The organization obtains Medicare exclusion information from any of the following sources: • Medicare Exclusion Database. • List of Excluded Individuals and Entities maintained by OIG and available over the internet.	**CL**	**11/18/24**
2-9	Appendix 2	Delegating to NCQA-Accredited/Certified or NCQA-Recognized Organizations	Add the following as the last sentence to the end of the first bullet: The organization is required to include all eligible files in the file universe, but is not required to produce the files as evidence. **SOC:** Revise the last sentence in the second paragraph to clarify that the organization is not required to produce all eligible files as evidence.	**CL**	**11/18/24**