For Public Comment
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Overview of Proposed Updates to Health Plan Accreditation 2026

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2026 Health Plan Accreditation: Overview of Proposed Updates

NCQA's Mission: Improve the Quality of Health Care

NCQA is dedicated to improving health care quality.

For 35 years, NCQA has driven improvement throughout the health care system, helping to advance the issue of health care quality to the top of the national agenda. NCQA's programs and services reflect a straightforward formula for improvement: measurement, transparency, accountability.

This approach works, as evidenced by the dramatic improvements in clinical quality demonstrated by NCQA-Accredited health plans. Today, over 180 million Americans are enrolled in an NCQA-Accredited health plan.

The NCQA Advantage

Proposed updates to Health Plan Accreditation aim to align standards with the changing market landscape and stakeholder (states, employers, CMS, consumers) needs and regulatory requirements, and to assist organizations in their pursuit of quality care. The NCQA Accreditation seal is a sign that organizations deliver high-quality care and have strong member protections.

Stakeholders Participating in Public Comment

NCQA shares these updates for public comment to generate thoughtful commentary and constructive suggestions from interested parties. Many comments lead to changes in our standards and policies, and the review process makes our standards stronger for all stakeholders. NCQA asks respondents to consider whether the requirements are feasible as written and are clearly articulated, and to highlight areas that might need clarification.

Background

Over 1,200 health plan lines of business providing coverage to over 180 million individuals across the United States maintain Health Plan Accreditation (HPA): the gold standard of standards and performance-based evaluations. These organizations value the program because it enables a continuous quality improvement process across many functions: measuring and improving key HEDIS metrics (e.g., diabetes, behavioral health), utilization management, credentialing, population health, network adequacy and member experience. The ongoing work also helps meet regulatory requirements, mitigate risk and implement best practices that benefit and protect members.

Change has been the only constant in health care. Payers are working in a dynamic payment, policy and regulatory environment that calls for increased collaboration with providers, alternative payment model adoption to bend the cost curve and improve outcomes, digital transformation, and focus on earning member trust and engagement, to name a few. In alignment with, and to aid the transformation journey in these key areas, NCQA proposes updates to HPA 2026 in the following areas:

- Data exchange and usability (QI).
- Payer-practitioner collaboration (PHM).
- Alternative payment model adoption (PHM).
- Utilization management and prior authorization (UM).
- Behavioral health network adequacy (NET).

The updated programs will be released in July 2025, with an effective survey date on or after July 1, 2026.

A Guide to the Updates

Data Exchange and Usability (QI)

Seamless data exchange and usability (i.e., interoperability) across entities in health care play a crucial role in patient outcomes by improving access to comprehensive data, enabling care coordination, enhancing decision-making and assisting patient empowerment. The *CMS Interoperability and Prior Authorization* final rule (CMS-0057-F) aims to improve data exchange by requiring adoption of industry-developed, consensus-based standards. For example, payers use FHIR® APIs to share patient information with providers and other payers, significantly streamlining the prior authorization process.

While health plans work to meet the CMS final rule requirements, NCQA believes it is important to emphasize how data exchange will enhance quality improvement: It's paramount that teams working on FHIR API implementation are also collaborating with teams overseeing HEDIS® reporting and quality improvement. To enable this collaboration, NCQA proposes a new standard—*QI 4: Data Exchange and Usability Strategy*—which requires organizations to describe how they work across business units to evolve their data strategy for the following use cases:

- Quality measurement and improvement.
- Care coordination.
- Improved data exchange coverage.
- Expanding the universe of data collected and integrated through health information exchanges/networks.
- Provider performance reporting.

While standardized data exchange is in its early stages, it's important to continue to incentivize data sharing, especially in behavioral health, which lags behind clinical data exchange. NCQA proposes the following new element to achieve this goal.

***New* Element: QI 2C: Bidirectional Behavioral Health Data Sharing Arrangements.** Organizations will be required to demonstrate they have one contract arrangement with a behavioral health organization to bidirectionally exchange data required for HEDIS measure performance. The arrangement must address at least one of seven HEDIS behavioral health measures:

1. Follow-Up After Hospitalization for Mental Illness (FUH).
2. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET).
3. Follow-Up Care for Children Prescribed ADHD Medication (Continuation and Maintenance) (ADD-E).
4. Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E).
5. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA).
6. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD).
7. Plan All-Cause Readmissions (PCR).

Payer-Practitioner Collaboration and Alternative Payment Model Adoption

Population Health Management (PHM) standards provide a foundation for managing and improving outcomes for a payer's population, and provide support to enable payer-provider collaboration through data sharing and use of alternative payment models. NCQA's goal is to enable collaboration across key stakeholders (e.g., payers, providers, plan sponsors, vendors) through standards and measures that focus on clearly defined care team responsibilities, data sharing and communication and performance measurement and benchmarks.

High-Level Overview of Updates

- ***Update:*** **PHM 1, Element A: Strategy Description, factor 3.** The organization's strategy incorporates three activities to support practitioners, providers or community-based organizations. The update highlights expectations for payer collaboration and support.

  NCQA also recommends that organizations describe how they inform practitioners and members about available PHM programs (factor 5). Members typically prefer to receive clinical advice from their doctor; this update is intended to help PHM program uptake.

- ***New/Update*****:** Move data sharing from Element B to a separate element with additional expectations. Organizations will be required to share member data with practitioners or providers for the following data elements: case management, utilization (admissions, readmissions, pharmacy, claims) and quality data. The intent is to emphasize data sharing, given its importance to care coordination.

- ***Update:*** Retire expectations regarding evidence-based decision-making aids and comparative pricing information on selected services from PHM 3, Element B: Practitioner or Provider Collaboration and Support. Add a new factor for establishing roles and responsibilities to achieve collaborative care management with provider partners. The intent of this requirement is to prevent care fragmentation and patient abrasion due to lack of collaborative care management.

- ***Update*****:** Reframe PHM 3, Element B to align with industry accepted categories and definitions. Change the title of Element C to "Alternative Payment Models."

- ***New:*** **PHM 3, Element D: Growth in Alternative Payment Models.** Requires organizations to demonstrate an increase in percentage of payments tied to alternative payment models (as listed above). This emphasizes the goal of moving payers and providers from fee-for-service arrangements to alternative payment models.

Behavioral Health Network Adequacy (NET)

A core challenge facing Americans in need of behavioral health services is a lack of access to effective care. Demand is substantial. It is estimated that 20% or 50 million Americans require these services. NCQA recognizes that there are many challenges to addressing access to behavioral health services. Regulators are continuously looking for ways to further define and specify how access should be measured. While the existing NCQA standards provide a good framework for assessing access and availability, recent research findings offer guidance that can be applied in the standards to help identify more targeted opportunities for improvement, which in turn can improve member experience with the health plan's provider network. NCQA proposes the following updates related to behavioral health network adequacy:

High-level overview of updates

- ***Update*** NET 1, Element A: Cultural Needs and Preferences to include collection of age, disabilities and veteran/military status.
- ***Update*** NET 1, Element D: Practitioners Providing Behavioral Healthcare to require organizations to help organizations identify ghost providers and expand access to additional behavioral health provider types.
- ***Update*** NET 2, Element B: Access to Behavioral Healthcare to add a new factor requiring collection and analysis of access to care for emergency crisis.
- ***New:*** NET 2, Element D: Assessment Against Accommodation Standards for Behavioral Health requires organizations to collect and analyze data related to operating hours, scheduling and other practices aligned to member needs. The goal is to identify access gaps and identify opportunities for improvement in *NET 3: Assessment of Network Adequacy.*
- ***Update*** NET 5, Element C: Assessment of Physician Directory Accuracy to increase frequency of assessment from annually to every 6 months. The goal is to enable organizations to identify data discrepancies in a timelier manner (a key area of member dissatisfaction).
- ***Update*** NET 5, Element A: Hospital Directory Data to include behavioral health hospitals to enable members to find needed behavioral healthcare.

Utilization Management and Prior Authorization

NCQA's current UM standards provide a strong foundation for organizations to establish and maintain a UM program that evaluates timeliness of decisions, key aspects of denial letters, appeal processes and appropriate professionals involved in UM decisions, among other areas.

There have been recent significant changes at the federal and state levels regarding prior authorization. As noted above, the Interoperability and Prior Authorization final rule includes regulations requiring use of APIs, reporting of UM rates on health plans' websites and reduced time frames for nonurgent request decisions. Approximately 30 states have enacted, or are considering enacting, legislation related to prior authorization. In the context of these regulatory changes and NCQA's mission to enable appropriate and timely care within the scope of patient benefits, NCQA proposes updates to UM standards. Updates will be aligned across UM Accreditation and MBHO Accreditation to enable automatic credit opportunities and risk mitigation.

High-level overview of updates

- ***New:*** **UM Data Collection and Analysis element.** Requires organizations to annually collect UM data indicators: overall denial rate, denial reasons, overall approval rate, percentage of services that require prior authorization, appeal overturn rate, timeliness of notifications (already required in UM 5, Element D). The intent is for organizations to take a long view of trending rates to aid in identifying opportunities for improvement—**not** to compare rates across organizations or lines of business. The focus is on internal quality improvement, so members and practitioners have a more positive experience with the UM process.
- ***New:*** **UM Committee element.** Requires organizations to annually evaluate the UM program and UM data. The committee will be responsible for identifying actions and following up on whether the organization implemented those actions. The intent is that the committee helps the organization identify areas of friction that might contribute to member and practitioner challenges with the UM process.
- ***New:*** **Implementation of Improvement Actions and Measurement of Effectiveness elements.** Organizations must annually implement follow-up actions and interventions from the UM Committee element to improve the effectiveness of the UM program and address the root causes of UM rates. Organizations must also evaluate the effectiveness of interventions implemented.
- ***New:*** **Non-Accredited Delegate Review element.** Requires organizations to document and report, in the delegation worksheet, findings from the annual audit, corrective actions and completion of corrective actions, as appropriate, for all non-Accredited delegates. The intent is to mitigate risk for organizations through consistent and ongoing tracking.
- ***Update:*** **Timeliness of UM Decisions.** Nonbehavioral, behavioral and pharmacy elements will be updated to require nonurgent preservice request decisions to be completed in 7 calendar days (vs. 14 calendar days, for nonbehavioral and behavioral decisions, and 15 calendar days, for pharmacy decisions). NCQA is aware this update impacts multiple must-pass elements and may consider a glidepath to allow for implementation of the change.
- ***Update:*** **Availability of Criteria.** Requires organizations to make criteria available to practitioners at the point of care (vs. upon request) to enable a more efficient, effective and timely prior authorization process.

Proposed Elements for Retirement

Considering the recent changes and updates to Health Plan Accreditation, NCQA recommends retiring several elements. The elements have become standard practice, and NCQA wants to make room for organizations to focus on more urgent quality improvement initiatives.

For a full list of updates, refer to **Table 1. Summary of Updated Elements.**

Health Plan Accreditation 2026: Proposed Standards Updates

Updates Applicable to Health Plan Accreditation 2026

Table 1. Summary of Updated Elements

Standard/Element		Proposed Update	Rationale and Questions
QI 1: Program Structure and Operations: NO UPDATES			
QI 2: Health Services Contracting			
A	Practitioner Contracts	**NO UPDATES**	
B	Provider Contracts	**NO UPDATES**	
C	Bidirectional Behavioral Health Data Sharing Arrangements	**NEW ELEMENT**	**Questions:** 1. Do you support including this element? 2. Does your organization already share behavioral health data bidirectionally? If not, what are the biggest challenges?
QI 3: Continuity and Coordination of Care: NO UPDATES			
QI 4: Data Exchange and Usability Strategy: NEW			
A	Data Exchange and Usability Strategy	**NEW ELEMENT**	**Questions:** 1. Do you support the inclusion of this new element? 2. Is your organization working on implementing business transformation cases as outlined by NCQA? If not, what is a major barrier that you are experiencing? 3. Does your organization already have governance and staff integration to enable collaboration between the quality and data exchange teams? 4. Does your organization have implementation plans to meet the time frames for CMS' regulated FHIR APIs?

Standard/Element		Proposed Update	Rationale and Questions
QI 4: Delegation of QI: NO UPDATES			
PHM 1: PHM Strategy			
A	Strategy Description	• *Factor 3:* Update to specify that the PHM strategy needs to include three activities that support practitioners, providers or communicated based organizations. • *Factor 5:* Update to require that the organization informs practitioners—in addition to members—about available PHM programs. • Scoring updates.	• *Factor 3:* The intent of this update is to highlight specific expectations for payer collaboration and support. • *Factor 5:* Members typically prefer to receive clinical advice from their doctor and this update is intended to help with PHM program uptake. **Questions:** 1. Factor 3: What additional activities should NCQA consider? What of the proposed activities should not be included? Why? 2. Factor 5: How does your organization currently notify practitioners of available PHM programs?
B	Informing Members	• Scoring updates.	**Question:** Do you support the proposed scoring update for this element?
PHM 2: Population Identification			
A	Data Integration	• *Factor 5:* Organizations must integrate EHR data for 10% of members. • *Factor 7:* Requires organizations to access data from a set of data sources to meet the requirement.	The current expectation integrating data from one practice and/or provider does not enable the desired level of data sharing needed to manage and coordinate care for member populations at scale. **Questions:** 1. Factor 5: Is it feasible for your organization to demonstrate that you are able to integrate EHR data for 10% of members? If not, what would be a more appropriate threshold? 2. Factor 7: Does your organization currently access data from one of the specified sources? Which ones?
B	Population Assessment	**NO UPDATES**	
C	Activities and Resources	**NO UPDATES**	

Standard/Element		Proposed Update	Rationale and Questions
D	Segmentation	**NO UPDATES**	
PHM 3: Delivery System Supports			
A	Data Sharing	**NEW ELEMENT** • Formerly factor 3 in PHM 3, Element A: Practitioner and Provider Support • The element requires organizations to share: – Case management data. – Utilization (admissions, readmissions, pharmacy, claims). – Quality data.	The intent is to emphasize data sharing, given its importance to care coordination. **Questions:** **Do you support the inclusion of this new element?** 1. Factor 1: What are key barriers to sharing case management data as specified? 2. Factor 2: What are key barriers to sharing utilization data as specified? 3. Factor 3: what are key barriers to sharing quality data as specified?
B	Practitioner or Provider Engagement and Support	• Formerly Element A. • Move Factor 1 to a new element A: Data Sharing. • Update Factor 1: Practice Transformation Support to specify activities that meet the requirement. • Retire Factor 2: offering evidence-based or certified decision-making aids. • Update Factor 3 to specify that the information on selected specialties is for the purpose of informing high-value referrals. • New Factor: Establishing clearly defined roles and responsibilities to achieve collaborative care management with provider partners. • Retire Factor 5: Providing comparative pricing information on selected services. • Scoring updates.	**Questions:** 1. Do you support retiring factor 2? 2. Do you support retiring factor 5? 3. Factor 1: Are there other practice transformation support activities that NCQA should consider? What are best practices that have delivered positive results? 4. New factor: Do you support requiring organizations to define roles and responsibilities for collaborative case management? 5. New factor: Does your organization currently define roles and responsibilities to help achieve collaborative care management with provider partners? What are best practices that have shown good results?

Standard/Element		Proposed Update	Rationale and Discussion Questions
C	Alternative Payment Models	• Formerly Element B: Value-Based Payment Arrangements. • Specify data reporting at the factor level. • Replace "shared risk" with "shared savings with downside risk." • Add "payment for reporting not linked to quality." • Add: "overall rate of payment tied to alternative payment models."	The expectations related to this element are not changing significantly and align with industry-accepted reporting categories. **Question:** 1. Do you support the proposed updates to this element?
D	Alternative Payment Models Growth	**NEW ELEMENT** • Requiring organizations to demonstrate an increase in total percentage of payments tied to alternative payment models.	The intent of this element is to emphasize the goal of moving payers and providers from fee-for-service arrangements to alternative payment models. **Question:** 1. Do you support the inclusion of this new requirement?
PHM 4: Wellness and Prevention			
A	Frequency of Health Appraisal Competition	**NO UPDATES**	
B	Topics of Self-Management Tools	• Scoring updates.	**Question:** 1. Do you support the proposed scoring update?
PHM 5: Complex Case Management: NO UPDATES			
PHM 6: Population Health Management Impact			
A	Measuring Effectiveness	**NO UPDATES**	
B	Improvement and Action	• *Factor 1:* Increase the number of opportunities identified from one to two. • *Factor 2:* Increase the number of opportunities acted on from one to two.	These expectations have been in place for several years; organizations should be expected to take one more than one opportunity. **Questions:** 1. For factor 1, do you support the proposed updates to this factor? 2. For factor 2, do you support the proposed updates to this factor?
PHM 7: Delegation of PHM: NO UPDATES			

Standard/Element		Proposed Update	Rationale and Discussion Questions
NET 1: Availability of Practitioners			
A	Cultural Needs and Preferences	Add additional characteristics for data collection and assessment, including veteran/military status, age (child/adolescent/older adult) and disabilities.	**Questions:** 1. For factor 1, do you support requiring the collection of additional characteristics such as age, urban/rural geography, disability, and veteran/military status? Are there additional characteristics we should consider? 2. For factor 1, should NCQA require organizations to meet four needs? If not, why?
B	Availability and Accessibility in Primary Care	• No updates	
C	Availability and Accessibility in Specialty Care	• No updates	
D	Availability and Accessibility in Behavioral Healthcare	• Add to factor 1 minimum practitioner types for organizations to include in their analysis: psychiatrists, clinical psychologists, social workers, licensed professional counselors, psychiatric nurse practitioners, peer support specialists, and inpatient, residential and ambulatory provider organizations. • Factor 2: Increasing the requirement to require three ways of expressing the number of behavioral healthcare practitioners. • Factor 3: Increasing the requirement to two out of four ways of expressing standards for geographic distribution.	• *Factor 1:* Provide clarity for organizations and surveyors regarding the practitioner/provider types required for analysis. • *Factor 2:* We are creating an additional way of evaluating organizations network availability and accessibility for those seeking services, • *Factor 3:* Provide additional flexibility for organizations for monitoring geographic access. **Questions:** 1. Do you support the proposed updates? 2. Should NCQA require organizations to define all types of behavioral health practitioners and providers, not just high-volume practitioners and providers? Why or why not? 3. Do you support a new data collection template to capture ghost networks, in addition to ratios? 4. For factor 3, should NCQA require organizations to meet two of the four requirements listed? If not, why?

Standard/Element		Proposed Update	Rationale and Discussion Questions
NET 2: Accessibility of Services			
A	Access to Primary Care	**NO UPDATES**	
B	Access to Behavioral Healthcare	**NEW FACTOR** • Added a new factor 1 to require organizations to annually collect and analyze access to care for an emergency crisis. • Added language to the Scope of Review and Explanation for factor 2 to clarify that there are additional options beyond the emergency room (e.g., 988 Suicide and Crisis Lifeline, behavioral health urgent care, psychiatric ED, or mobile crisis response teams).	• *Factor 1:* This is currently a gap in monitoring access. • *Factor 2:* Provide additional flexibility for organizations to ensure access to care for non-life-threatening emergencies. **Questions:** 1. Do you support the proposed updates? 2. For factors 1-5, do you support the proposed new requirement describing the use of alternatives to the emergency department, when possible?
C	Access to Specialty Care	**NO UPDATES**	
D	Assessment Against Accommodation Standards for Behavioral Health	**NEW ELEMENT**	Monitoring access to appointments during standard working hours, evenings, and weekends has not previously been addressed. **Questions:** 1. Do you support adding this new requirement? 2. Do you support the inclusion of this new element?
NET 3: Assessment of Network Adequacy			
A	Assessment of Member Experience Accessing the Network	**NO UPDATES**	
B	Opportunities to Improve Access to Nonbehavioral Healthcare Services	**NO UPDATES**	
C	Opportunities to Improve Access to Behavioral Healthcare Services	Added a reference to the new element NET 2, Element D, to require organizations to include and prioritize opportunities from analysis of accommodation standards.	Include new requirements for accommodation standards in the prioritization of improvement opportunities. **Question:** 1. Do you support the proposed updates?
NET 4: Continued Access to Care: NO UPDATES			

Standard/Element		Proposed Update	Rationale and Discussion Questions
NET 5: Physician and Hospital Directories			
A	Physician Directory Data	• Incorporate search functions in the stem (formerly Element E). • Scoring updates. • *Factor 3:* Clarification that applies to behavioral health practitioners.	Increase scoring rigor: Most organizations (99%) met this requirement in 2023. **Questions:** 1. Do you support the proposed updates? 2. Should NCQA require organizations to list practitioners' areas of expertise? Why or why not? 3. Should NCQA require organizations to include telehealth and in-person appointments in the directory?
B	Physician Directory Updates	**NO UPDATES**	
C	Assessment of Physician Directory Accuracy	Increase the frequency to every 6 months from annually.	It is important to perform this assessment more frequently than annually. **Question:** 1. Do you support the proposed updates?
D	Identifying and Acting on Opportunities	**NO UPDATES**	
E	Searchable Physician Web-Based Directory	Incorporate into Element A: Physician Directory Data	It is standard practice for organizations to have searchable directories. NCQA will no longer score the directory data and the search function separately.
F	Hospital Directory Data	• Incorporate search functions (formerly Element H). • Update scoring. • Expand the scope to include behavioral health hospitals.	• Increase scoring rigor: Most organizations (96%) met this requirement in 2023. • Behavioral health hospitals should be assessed by health plans, not just acute care hospitals. **Question:** 1. Do you support the proposed updates?
G	Hospital Directory Updates	**NO UPDATES**	

Standard/Element		Proposed Update	Rationale and Discussion Questions
H	Searchable Hospital Web-Based Directory	Incorporate into Element F: Hospital Directory Data.	It is standard practice for organizations to have searchable directories. NCQA will no longer score the directory data and the search function separately.
I	Usability Testing	Scoring updates.	Increase scoring rigor: Most organizations (96%) met this requirement in 2023. **Question:** 1. Do you support the proposed scoring updates?
J	Availability of Directories	**RETIRE ELEMENT** Retire element for Medicare, commercial and Exchange lines of business.	Maintain the requirement for Medicaid because it aligns with regulations in the Medicaid Managed Care Rule. **Question:** 1. Do you support retiring this element from Medicare, commercial and Exchange lines of business?
NET 6: Delegation of NET: NO UPDATES			
UM 1: Program Structure			
A	Program Description	• Formerly "Written Program Description." • Factor and explanation updates. • **NEW FACTORS 5, 6**	*Factor 5:* Bring accountability of UM functions under the UM Committee. *Factor 6:* Note a process for evaluating how organizations determine requests that require prior authorization. **Questions:** 1. Do you support the inclusion of new factor 5? 2. Do you support the inclusion of new factor 6?
B	UM Data Collection	**NEW ELEMENT**	• New element requiring organizations to annually calculate UM indicators separately for Medicare, Medicaid, Exchange, and commercial. • UM indicators include: • Overall approval rate. • Percent of services that require prior authorization, with an approval rate of 90% or more. • Overall denial rate. • Denial rates by reason.

			• Overall appeal rate. • Appeals overturn rate. • Timeliness of notification rates. **Questions:** 1. Do you support the inclusion of this new element? 2. Do you support the requirement to be reported on an annual basis? 3. Do you support requiring the element to be reviewed and scored by Medicare, Medicaid, Exchange, and Commercial? Should NCQA require other dimensions for stratification? 4. For factor 2, should NCQA require organizations to report the prior authorization data at the procedural level, the individual code level within a procedure, or across all codes subject to prior authorization? 5. For factor 2, do you support the 90% approval rate? If not, should NCQA consider a different threshold? 6. For factor 4, do you support the proposed categories of reasons for denials? If not, should NCQA consider including other denial reasons? 7. Do you support moving UM 5, Element D: Timeliness Report to factor 7? 8. 7. For factor 7, do you support expanding the scope to all UM denial decisions not limited to medical necessity determinations?
C	Analysis of UM Data Collection	**NEW ELEMENT**	Organizations must perform a quantitative and qualitative analysis and identify trends in the UM indicators from Element B for continuous quality improvement. **Question:** 1. Do you support the inclusion of this new element?

Standard/Element		Proposed Update	Rationale and Discussion Questions
D	UM Committee	**NEW ELEMENT**	The UM Committee evaluates the organization's UM program and identifies actions based on the results of the analysis from Element C. **Question:** 1. Do you support the inclusion of this new element?
E	Implementation of Improvement Actions	**NEW ELEMENT**	Organizations annually implement interventions based on the recommendations from the UM Committee. **Question:** 1. Do you support the inclusion of this new element?
F	Measurement of Effectiveness	**NEW ELEMENT**	Organizations evaluate the effectiveness of interventions implemented in Element E. **Question:** 1. Do you support the inclusion of this new element?
B	Annual Evaluation	Incorporate into new Elements UM 1, Elements D-F.	**Question:** Do you support repurposing UM 1, Element B: Annual Evaluation to UM 1, Elements D-F?
UM 2: Clinical Criteria for UM Decisions			
A	UM Criteria	**NO UPDATES**	
B	Availability of Criteria	Updates to factors 1 and 2.	Merged factors 1 and 2 and revised the element to require criteria to be available at the point of care, which will reduce burden and facilitate access to care for patients. **Questions:** 1. Do you support consolidation of factors 1 and 2? 2. Do you support the requirement that UM criteria are made available at the point of care? What are the biggest barriers to meeting this requirement?
C	Consistency in Applying Criteria	**NO UPDATES**	

Standard/Element		Proposed Update	Rationale and Discussion Questions
UM 3: Communication Services			
A	Access to Staff	**NEW FACTOR 6**	Factor 6 requires patient navigation assistance with denials, appeals and other UM questions. **Question:** 1. Do you support inclusion of a new factor 6?
UM 4: Appropriate Professionals: NO UPDATES			
UM 5: Timeliness of UM Decisions			
A	Notification of Nonbehavioral Healthcare Decisions	Updates to factors 3 and 4.	*Factor 3 and 4 Updates:* Revise factor 3 and 4 to remove the product line reference and update the notification time frame for nonurgent preservice requests from 14 calendar days to 7 calendar days across all product lines, to align with the CMS Interoperability Rule. **Questions:** 1. For factor 3, do you support the proposed update to the notification timeframe across all product lines? 2. What is a feasible glidepath for implementation of the time frame update?
B	Notification of Behavioral Healthcare Decisions	Updates to factors 3 and 4.	*Factor 3 and 4 Updates:* Revise factor 3 and 4 to remove the product line reference and update the notification time frame for nonurgent preservice requests from 14 calendar days to 7 calendar days across all product lines, to align with the CMS Interoperability Rule. **Questions:** 1. For factor 3, do you support the proposed update to the notification timeframe across all product lines? 2. What is a feasible glidepath for implementation of the time frame update?

	Standard/Element	Proposed Update	Rationale and Discussion Questions
C	Notification of Pharmacy Decisions	Update to factor 5.	*Factor 5 Update:* Revise the notification time frame for nonurgent preservice requests from 15 calendar days to 7 calendar days for commercial and Exchange. **Questions:** 1. For factor 5, do you support the proposed update to the notification timeframe? 2. What is a feasible glidepath for implementation of the time frame update?
D	UM Timeliness Report	Incorporate into new Element B: UM Data Collection.	Move this element to new element (UM 1, Element B: UM Data Collection, factor 7) to consolidate all UM data indicators in one place, allowing for a thorough and collective review. **Question:** 1. Do you support repurposing UM 5, Element D: Timeliness Report to NEW UM 1, Element B: UM Data Collection, factor 7?
E	Interim: Policies and Procedures	**Update to element title.**	This element will now be titled UM 5, Element D: Interim Policies and Procedures.
UM 6: Clinical Information: NO UPDATES			
UM 7: Denial Notices: NO UPDATES			
UM 8: Policies for Appeals: NO UPDATES			
UM 9: Appropriate Handling of Appeals			
A	Preservice and Postservice Appeals	**NO UPDATES**	
B	Timeliness of the Appeal Process	**NO UPDATES**	
C	Appeal Reviewers	**NO UPDATES**	

Standard/Element		Proposed Update	Rationale and Discussion Questions
D	Notification of Appeal Decision/Rights	**NEW FACTOR 7**	Factor 7 requires organizations to provide notice that members do not bear IRO costs. This factor was previously in UM 9, Element E. **Questions:** 1. Do you support moving UM 9, Element E, factor 3 to UM 9, Element D? 2. Do you support inclusion of new factor 7 in this element? (formerly in retired 2025 element UM 9F: Appeals Overturned by IRO)
E	Final Internal and External Appeal Files	**RETIRE ELEMENT**	Element does not increase program value due to how it is assessed (organizations select files for review). **Question:** 1. Do you support retirement of all factors in UM 9E other than factor 3 (proposed for movement to UM 9D: Notification of Appeal Decisions/Rights)
F	Appeals Overturned by the IRO	**RETIRE ELEMENT**	Element does not increase program value due to how it is assessed (organizations select files for review). **Question:** 1. Do you support retirement of UM 9, Element F: Appeals Overturned by the IRO?
UM 10: Evaluation of New Technology: NO UPDATES			
UM 11: Procedures for Pharmaceutical Management:			
A	Pharmaceutical Management Procedures	**NO UPDATES**	
B	Pharmaceutical Restrictions/Preferences	Update to element stem.	Revise element stem to “annually and within 30 calendar days after updates.” **Question:** 1. Do you support the proposed update to a frequency of 30 calendar days for updates?
C	Pharmaceutical Patient Safety Issues	**NO UPDATES**	

Standard/Element		Proposed Update	Rationale and Discussion Questions
D	Reviewing and Updating Procedures	**NO UPDATES**	
E	Considering Exceptions	**NO UPDATES**	
UM 12: UM Information Integrity: NO UPDATES			
UM 13: Delegation of UM			
A	Delegation Agreement	**NO UPDATES**	
B	Predelegation Evaluation	**NO UPDATES**	
C	Review of the UM Program	**NO UPDATES**	
D	Opportunities for Improvement	**NO UPDATES**	
E	Non-Accredited Delegate Review	**NEW ELEMENT**	Formalizes organization review of non-NCQA-Accredited/ Certified delegates. Requires organizations to demonstrate they audited non-Accredited/Certified delegates and identified and implemented necessary corrective actions. **Question:** 1. Do you support the inclusion of this new element?
CR 1: Credentialing Policies: NO UPDATES			
ME 1: Statement of Members' Rights and Responsibilities: NO UPDATES			
ME 2: Subscriber Information			
A	Subscriber Information	**RETIRE ELEMENT** • Retire element for Medicare, commercial and Exchange lines of business for Renewal Surveys. • Scoring updates.	Most organizations (99%) meet this requirement, although it is important for new organizations coming through for survey to have a process in place. Maintain the requirement for Medicaid to enable alignment with regulations in the Medicaid Managed Care Rule. **Question:** 1. Do you support retiring this element?

Standard/Element		Proposed Update	Rationale and Discussion Questions
B	Distribution of Subscriber Information	**RETIRE ELEMENT** Retire element for Medicare, commercial and Exchange lines of business for Renewal Surveys.	Most organizations (99%) meet this requirement, although it is important for new organizations coming through for survey to have a process in place. Maintain the requirement for Medicaid to enable alignment with regulations in the Medicaid Managed Care Rule. **Question:** 1. Do you support retiring this element?
C	Interpreter Services	**RETIRE ELEMENT** Retire element for Medicare, commercial and Exchange lines of business.	Most organizations (99%) meet this requirement, and it is covered under ME 2, Element A, factor 5. Maintain the requirement for Medicaid to enable alignment with regulations in the Medicaid Managed Care Rule. **Question:** 1. Do you support retiring this element?
ME 3: Marketing Information			
A	Materials and Presentations	**RETIRE ELEMENT** Retire element for Medicare, commercial and Exchange lines of business for First and Renewal Surveys.	Most organizations (98%) meet this requirement and have solid processes in place. Maintain the requirement for Medicaid to enable alignment with the Medicaid Managed Care Toolkit. **Question:** 1. Do you support retiring this element?
B	Communicating With Prospective Members	**RETIRE ELEMENT** Retire element for Medicare, commercial and Exchange lines of business for First and Renewal Surveys.	Most organizations (97%) meet this requirement and have solid processes in place. Maintain the Interim Surveys and for the Medicaid product line. **Question:** 1. Do you support retiring this element?
C	Assessing Member Understanding	**RETIRE ELEMENT** Retire element for Medicare, commercial and Exchange.	Retiring this element will reduce burden for organizations. Maintain the requirement for Medicaid to enable alignment with the Medicaid Managed Care toolkit. **Question:** 1. Do you support retiring this element?

Standard/Element		Proposed Update	Rationale and Discussion Questions
ME 4: Functionality of Claims Processing: NO UPDATES			
ME 5: Pharmacy Benefit Information			
A	Pharmacy Benefit Information: Website	**NO UPDATES**	
B	Pharmacy Benefit Information: Telephone	**NO UPDATES**	
C	QI Process on Accuracy of Information	**RETIRE ELEMENT** Retire element for all product lines.	100% of organizations meet this requirement. **Question:** 1. Do you support retiring this element?
D	Pharmacy Benefit Updates	**NO UPDATES**	
ME 6: Personalized Information on Health Plan Services: NO UPDATES			
ME 7: Member Experience: NO UPDATES			
ME 8: Delegation of ME: NO UPDATES			

Public Comment Instructions

Public Comment Questions

Public comment is integral to the development of all NCQA standards and measures. NCQA considers all suggestions. NCQA encourages reviewers to provide insights on global issues related to the proposed updates including:

1. Will proposed updates assist your organization in meeting its objectives? If so, how? If not, why not?
2. Are there key expectations not addressed in the proposed requirements?

Documents

Draft standards and explanations for updates can be found in: Health Plan Accreditation_Proposed Standards Updates

How to Submit Comments

Respond to topic and element-specific questions for each product on NCQA's public comment website. NCQA does not accept comments by mail, email or fax.

1. Go to http://my.ncqa.org and enter your email address and password.
2. Once logged in, scroll down and click **Public Comments**.
3. Click **Add Comment** to open the comment box.
4. Select one or more of the following from the drop-down box:
   - **Updates to Health Plan Accreditation 2026**
5. Click to select the **Topic** and **Element** (question) on which you would like to comment.
6. Click to select your support option (**Support, Do not support, Support with modifications**).
   a. If you choose **Do not support**, include your rationale in the text box.
   b. If you choose **Support with modifications**, enter the suggested modification in the text box.
7. Enter your comments in the **Comments** box.
   Note: *There is a 2,500-character limit for each comment. We suggest you develop your comments in Word to check your character limit; use the "cut and paste" function to copy your comment into the Comments box.*
8. Use the **Submit** button to submit more than one comment. Use the **Close** button to finish leaving comments; you can view all submitted comments in the **Public Comments** module.

All comments must be entered by 11:59 ET on Tuesday, March 25

Next Steps

The final Standards and Guidelines for HPA 2026 will be released in 2025, following approval by the NCQA Standards Committee and the Board of Directors.

Requirements for all programs will take effect for surveys starting July 1, 2026.