NCQA Corrections, Clarifications and Policy Changes to the 2013 PHQ Standards and Guidelines

July 25, 2022

This document includes the corrections, clarifications and policy changes to the 2013 PHQ 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 Survey System (ISS). NCQA operational definitions for correction, clarification and policy changes are as follows:

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

An organization undergoing a survey under the 2013 PHQ standards and guidelines must implement corrections and policy changes within 90 calendar days of the ISS release date, unless otherwise specified. The 90-calendar-day advance notice does not apply to clarifications or FAQs, because they are not changes to existing requirements.

Page	Standard/Element	Head/Subhead	Update	Type of Update	ISS Release Date
37	Policies and Procedures—Section 4: Additional Information	Notifying NCQA of Reportable Events	Add the following as a new second and third paragraph: Reporting obligations are effective upon issuance of the notice of sanctions, issuance of a fine or request for corrective action. The notification requirement is not paused as a result of any appeal or negotiations with the applicable regulatory authority. All Reportable Events must be submitted through My NCQA (https://my.ncqa.org).	**CL**	**7/25/22**
37	Policies and Procedures—Section 4: Additional Information	Notifying NCQA of Reportable Events—Annual Attestation of Compliance With Reportable Events	Revise the information in this section to read: On an annual basis, the organization must also complete an attestation signed by an officer or other authorized signatory of the organization affirming that it has notified NCQA of all Reportable Events specified within NCQA policies and procedures. Failure to comply with Reportable Events submission or annual attestation requirements may result in suspension or revocation of Certification status. Annually, NCQA will send an e-mail reminder to the designated accreditation contact to complete the annual attestation on My NCQA (https://my.ncqa.org). The attestation must be completed within 30 days of the email notification.	**CL**	**7/25/22**

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37	Policies and Procedures—Section 4: Additional Information		Add the following new section head and text between "Notifying NCQA of Reportable Events" and "Discretionary Survey." **Interrater Reliability** NCQA strives for consistency in the Accreditation/Certification process and across all surveys. NCQA defines "interrater reliability" (IRR) as the extent to which two or more independent surveyors produce similar results when assessing whether the same requirement is met—the level of confidence that similarly trained individuals would be likely to produce similar scores on the same standards for the same product when the same evidence is evaluated. To support consistency, NCQA will continue to clarify standards and educate surveyors. Organizations preparing for survey should also review all applicable standards, including changes between standards years and related NCQA corrections, clarifications, and policy changes, as well as FAQs, focusing on the standards' intent, scored elements and factors, explanations, and type of evidence (data sources) required to demonstrate that a requirement is met. **Reporting IRR Issues to NCQA** Report suspected IRR issues to NCQA during the following survey stages: • When the organization responds to initial issues (following the conference call with the surveyor and ASC). • During the organization review and comment stage (during the post-survey review process). • During a Reconsideration (after the survey is completed). Issues may be reported in the survey tool (IRT) or by submitting a case to My NCQA (https://my.ncqa.org). To protect the integrity of the Accreditation process, NCQA does not accept materials in an IRR report that did not exist at the time of the original completed survey tool submission. As a reminder, file review results may not be disputed or appealed once the onsite survey is complete, whether completed in-person or virtually. If you suspect an IRR issue related to a file review element, the issue should be reported during the onsite survey.	**CL**	**7/25/22**

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			NCQA performs an expedited review of reported IRR concerns on non-file review elements to ensure timely and accurate Accreditation/ Certification decisions. Based on review of a potential issue, NCQA may: 1. *If NCQA's scoring was inconsistent for non-file review elements,* issue a one-time exception for scoring of the standard, and require a Corrective Action Plan (CAP). NCQA reserves the right to determine if scoring was inconsistent. 2. *If no inconsistency is found,* maintain the standard score. NCQA analyzes IRR information to identify opportunities to clarify requirements or enhance surveyor education.		
42	Policies and Procedures—Section 4: Additional Information	Suspending Certification	Add the following as a new fifth bullet under "Grounds for immediate suspension" subhead: • Failure to comply with Reportable Events submission or annual attestation completion requirements.	**CL**	**7/25/22**
42	Policies and Procedures—Section 4: Additional Information	Revoking Certification	Revise the second bullet under "Grounds for revocation" to read: • The organization violates other published NCQA policies, including failure to submit Reportable Events or completion of annual attestation.	**CL**	**7/25/22**
43	PQ 1, Element A	Explanation—Selecting standardized measures	Add the following note after the second subbullet under the second bullet. ***Note:*** *Due to the dissolution of AMA-PCPI, organizations may only receive credit for AMA-PCPI measures for surveys incorporating results from measurement year 2021 or earlier.*	**CL**	**7/25/22**
2-3	Appendix 2—Glossary		Add the following as a new definition: **interrater reliability:** The extent to which two or more independent surveyors produce similar results when assessing whether the same requirement is met—the level of confidence that similarly trained individuals would be likely to produce similar scores on the same standards for the same product when the same evidence is evaluated.	**CL**	**7/25/22**

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	PHQ MAC Policy for Physician and Hospital Quality		Click **here** to access Appendix 7: PHQ Merger, Acquisition and Consolidation Policy for Physician and Hospital Quality Certification.	**PC**	**7/30/18**
NA	Policies and Procedures	Acknowledgments	Update the NCQA address on the page preceding the **Acknowledgments** page to read: 1100 13th Street NW, Third Floor Washington, DC 20005 Update the Policy Clarification Support link to read: http://my.ncqa.org	**CL**	**11/20/17**
5	Overview	NCQA offers the following evaluation programs:	Remove the following evaluation programs: • Special Needs Plans (SNP). • Medicare Advantage (MA) Deeming.	**CL**	**7/27/15**
9	Policies and Procedures—Section 1: Eligibility and the Application Process	Eligibility for Certification—Eligibility criteria	Add the following as the second sentence in the second bullet: The organization must have taken action at least 90 calendar days prior to the survey date in order to allow sufficient time for the organization to receive any complaints from consumers.	**CL**	**3/26/18**
12	Policies and Procedures—Section 1: Eligibility and the Application Process	Organization Obligations	Add the following as sub-bullets under the third bullet: – An organization that ceases to do business or no longer operates the physician measurement or hospital transparency program before the end of its NCQA Certification cycle will be removed from the NCQA Physician and Hospital Quality Report Card. – An organization that continues to operate the program and elects to withdraw from certification and not continue to meet NCQA requirements before the end of its NCQA Certification cycle, will be reported as "Revoked" on the NCQA Physician and Hospital Quality Report Card.	**CL**	**7/30/18**
12	Policies and Procedures—Section 1	Organization Obligations	Add the following note as a separate paragraph under the last bullet: ***Note:*** *If NCQA conducts a Discretionary Survey, it reviews the organization against the standards in effect at the time of the Discretionary Survey.*	**CL**	**11/20/17**

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12	Policies and Procedures—Section 1: Eligibility and the Application Process	Organization Obligations	Add the following as the second paragraph under *Note:* *The organization must obtain appropriate permission and/or licensure for use of NCQA measures. Participation in the PHQ program does not grant permission to use NCQA or any other third-party organization's measures, nor the right to provide those measures to any third party. Contact NCQA at my.ncqa.org to obtain the appropriate license for use of NCQA measures.*	**PC**	**3/30/20**
~~12~~	~~Policies and Procedures—Section 1~~	~~Applying for an NCQA Survey—Application request~~	~~Update the NCQA address to read:~~ ~~National Committee for Quality Assurance~~ ~~1100 13th Street NW, Third Floor~~ ~~Washington, DC 20005~~ ***Updated on March 26, 2018.***	~~**CL**~~	~~**11/20/17**~~
~~12~~	~~Policies and Procedures—Section 1~~	~~Applying for an NCQA Survey—Survey application~~	~~Revise the first sentence of the second paragraph to read:~~ ~~NCQA does not begin to process an application or schedule survey dates until the organization has satisfied all requirements for the application and has submitted the application and supporting attachments, the coverage area report, a signed current Agreement for Physician and Hospital Quality Certification Survey, Business Associate Agreement and the application fee.~~ ***Updated on March 26, 2018.***	~~**CL**~~	~~**11/20/17**~~
13	Policies and Procedures—Section 1: Eligibility and the Application Process	Applying for an NCQA Survey—Application request	Revise the section to read: NCQA has implemented a new web-based application process. Organizations with current NCQA Certification can apply for a Renewal Survey at http://my.ncqa.org. Log in, click **My Apps** and then click **Go To Site** for the certification application tool. Review and edit the prepopulated application information and submit the application directly to NCQA. Contact the application and scheduling account representative (ASAR) with questions or go to http://www.ncqa.org/programs/accreditation/online-application-process for information on NCQA's new application process. Organizations without current certification or that are applying for Physician and Hospital Quality certification for the first time can contact Customer Support at **888-275-7585** or submit a question in the **My Questions** section at http://my.ncqa.org to begin the prequalification and application process.	**CL**	**3/26/18**

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13	Policies and Procedures—Section 1: Eligibility and the Application Process	Applying for an NCQA Survey—Survey application	Revise the section to read: Organizations identify the programs for which they seek certification. The completed application for certification contains relevant information about an organization (e.g., its structure, products that will be surveyed). This information helps NCQA structure a survey around the operational characteristics of the organization.	**CL**	**3/26/18**
~~13~~	~~Policies and Procedures—Section 1: Eligibility and the Application Process~~	~~Applying for an NCQA Survey~~	~~Add the following subhead and text~~ ~~**Processing criteria**~~ ~~NCQA only processes a complete application, which comprises:~~ ~~• The web-based application for an NCQA Physician and Hospital Quality Certification Survey.~~ ~~• A current, signed Agreement for Physician and Hospital Quality Certification Survey ("the Agreement").~~ ~~***Note:** Unless state or other applicable law requires modifications, all organizations are required to sign the Agreement. Requests to change the standard Agreement due to legal conflicts must be approved by NCQA, and must be submitted with evidence of the legal conflict at least 12 months before the requested survey date.*~~ ~~• A current, signed Business Associate Agreement.~~ ~~• The application fee.~~ ~~***Updated on March 30, 2020.***~~	~~**CL**~~	~~**3/26/18**~~
13	Policies and Procedures—Section 1: Eligibility and the Application Process	Applying for an NCQA Survey—Processing criteria	Replace the text with the following: NCQA only processes a complete application, which includes: • The application for NCQA Physician and Hospital Quality Certification Survey. • A signed Agreement for NCQA Physician and Hospital Quality Certification Survey ("the Agreement"). • A signed Business Associate Agreement. • The application fee.	**CL**	**3/30/20**

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			Note: *The signed legal agreements establish the terms and conditions that all organizations must accept to participate in the survey, and that will apply for the length of the Certification. NCQA does not accept edits to the Agreements unless state or other applicable law requires modifications.* An organization that has a legal conflict with a term or provision may submit to NCQA for review and consideration of a waiver or revision. Requests must be submitted with evidence of the legal conflict at least 12 months before the requested survey date and must be approved by NCQA. Signed Agreements will remain in effect for resurveys and any subsequent renewals. An organization may be required to resign the legal agreements if there is lapse in its Certification status.		
13	Policies and Procedures—Section 1: Eligibility and the Application Process	Applying for an NCQA Survey	Add the following subhead **Application timeline** Organizations submit the complete application a *minimum of nine months* before the requested survey date. If an organization submits complete materials less than nine months before it wants to be surveyed, NCQA may not be able to accommodate the requested survey date.	**CL**	**3/26/18**
~~18~~	~~Policies and Procedures—Section 2: The Certification Process~~	~~Adjusting Certification Status—Must-pass elements~~	~~Add the following as the last paragraph:~~ ~~If an organization does not meet the must-pass threshold for any must-pass element, a status modifier of "Under Corrective Action" will be displayed after the applicable status (e.g., Certified—Under Corrective Action) until NCQA confirms that the organization has completed a corrective action plan.~~ ~~***Updated on November 25, 2019.***~~	~~**PC**~~	~~**7/29/19**~~
18	Policies and Procedures—Section 2	Adjusting Certification Status—Must-Pass Elements	Revise the first bullet to read: • PQ 1, Elements A, C, D	**CO**	**3/25/13**
18	Policies and Procedures—Section 2: The Certification Process	Adjusting Certification Status—Denial of certification	Remove the second paragraph, which reads: NCQA does not publish the names of organizations denied certification.	**CL**	**11/25/19**

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18	Policies and Procedures—Section 2: The Certification Process	Adjusting Certification Status—Must-pass elements	Remove the third paragraph, which reads: If an organization does not meet the must-pass threshold for any must-pass element, a status modifier of "Under Corrective Action" will be displayed after the applicable status (e.g., Certified—Under Corrective Action) until NCQA confirms that the organization has completed a corrective action plan.	**CO**	**11/25/19**
18	Policies and Procedures—Section 2: The Certification Process	Adjusting Certification Status	Add the following subhead and text under the **ROC determination** subhead and text: **Corrective Action** In certain circumstances, NCQA may require corrective action by the organization. Corrective action are steps taken to improve performance when an organization does not meet specific NCQA certification requirements. Failure to comply timely with requested corrective action may result in a lower score or reduction or loss of certification status.	**PC**	**7/29/19**
18	Policies and Procedures—Section 2: The Certification Process	Corrective action	Replace the text with the following: In certain circumstances, NCQA may require corrective action and submission of a corrective action plan (CAP) by the organization. Corrective actions are steps taken to improve performance when an organization does not meet specific NCQA Certification requirements. Failure to timely comply with requested corrective action may result in a lower score or reduction or loss of Certification status. A CAP is considered complete when NCQA notifies the organization that all identified deficiencies are resolved and corrective actions have been implemented. If the CAP is not completed within the agreed-on time frame, the organization must notify NCQA of the reason. The ROC determines completion of the CAP. If the CAP is considered incomplete, the ROC may extend the CAP, reduce the organization's status or issue a Denied Certification status as specified below.		

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<tr><td></td><td></td><td></td><td><table><tr><th>If the Organization…</th><th>The ROC May…</th></tr><tr><td>Formulates a satisfactory CAP but fails to adequately implement it within the time frame specified in the CAP.</td><td>Extend the CAP or reduce the organization's status from Certified to Denied.</td></tr><tr><td>Does not complete the CAP after an extension, or
Is unwilling or unable to formulate a satisfactory CAP within the required time frame, or
Makes no attempt to complete an agreed-on CAP.</td><td>Issue a Denied Certification status.</td></tr></table></td><td>CL</td><td>11/23/20</td></tr>
<tr><td>21</td><td>Policies and Procedures—Section 2</td><td>Add-On Survey</td><td>Add the following immediately after the Add-On Survey subhead and text:
Expedited Survey
Although an organization with Denied Certification status may not reapply for accreditation/certification until one year from the date of the Denied status, there are certain circumstances under which an organization may apply for a new Certification Survey in less than a year. These surveys are called Expedited Surveys.
An Expedited Survey is a full-scope survey. The look-back period for an Expedited Survey is six months. The organization is reviewed against the standards and guidelines in effect at the time of the Expedited Survey. The organization must provide documentation for all requirements; documentation may have been submitted previously or may be new.
The organization may bring forward new programs that were not included in the original submission.
To qualify for an Expedited Survey, the organization must first submit a written request listing the steps it has taken to address the substantive issues that led to Denied Certification status.</td><td>PC</td><td>7/29/13</td></tr>
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			Upon receiving an organization's request, NCQA may, at its sole discretion, grant a request for an Expedited Survey in less than one year, in the following circumstances: • The organization demonstrates to NCQA's satisfaction that it can resolve the issues identified in the original survey in less than one year and that the correction of the issues would raise the organization's certification status in a new survey. • There are licensure or regulatory consequences associated with Denied Certification status.		
23	Policies and Procedures—Section 2: The Certification Process	Reporting Certification Status to the Public—Right to release and publish	Revise the third paragraph to read: NCQA publicly reports Denied status for one year or until the status is replaced as the result of another survey. An organization that dissolves or ceases to exist is removed from public reporting.	**PC**	**7/29/19**
23	Policies and Procedures—Section 2: The Certification Process	Reporting Certification Status to the Public—Right to release and publish	Add the following as the fourth paragraph: NCQA publicly reports expired status and that the organization was previously Certified and has chosen not to undergo a survey to renew its status or the organization has chosen to withdraw its status before expiration of its Certification cycle.	**PC**	**11/25/19**
23	Policies and Procedures—Section 2: The Certification Process	Reporting Certification Status to the Public—Right to release and publish	Add the following as the fourth paragraph: NCQA will also report when an organization is required to complete corrective actions. Failure to comply timely with requested corrective action may result in a lower score or reduction or loss of certification status.	**PC**	**7/29/19**
27	Policies and Procedures—Section 3	Attach documents	Replace the fifth paragraph with the following: **The organization should not attach documents to the Survey Tool that contain protected health information (PHI), as defined by the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations. If original documentation contains PHI, the organization must de-identify that information prior to submission.** For more information, refer to the definition of "PHI" and "de-identify" in the Glossary.	**CL**	**7/29/13**

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29	Policies and Procedures—Section 3	Overriding the scoring guidelines	Remove the subhead and text that read: **Overriding the scoring guidelines** If the survey team finds that circumstances may exist to warrant recommending a score different from that indicated by the guidelines, the team documents the reasons for its recommendation. Surveyors can recommend overriding the guidelines if they find that the guidelines do not cover the organization's situation. The ROC makes the final decision on all scores.	**PC**	**11/16/15**
30	Policies and Procedures—Section 3: The Survey Process	Scoring and Certification Status—Findings that do not address NCQA standards	Revise the fourth paragraph to read: NCQA reserves the right to notify applicable regulatory agencies if aspects of the organization's operations pose a potential imminent threat to the health and safety of consumers and/or NCQA has a reason to believe that information submitted to NCQA has been falsified or the organization is required to implement corrective. Before NCQA notifies applicable regulatory agencies, it gives the organization 24 hours to correct the condition to rebut the findings prior to notifying a regulatory agency.	**PC**	**7/29/19**
33	Policies and Procedures—Section 4: Additional Information	Reconsideration—Reconsideration procedure	Add the following as the last sentence of the second paragraph: The request may be mailed to NCQA Office of Program Integrity, 1100 13th Street NW, 3rd Floor, Washington DC 20005 or submitted via email to Reconsiderations@ncqa.org.	**CL**	**7/30/18**
34	Policies and Procedures—Section 4: Additional Information	Reconsideration—Documentation that supports Reconsideration	Delete the last sentence of the note, which reads: The organization must provide NCQA with 12 copies of such materials.	**CL**	**7/30/18**
35	Policies and Procedures—Section 4	Complaint Review Process	Add the following before the **Discretionary Survey** subhead: **Complaint Review Process** NCQA accepts written complaints from patients, members or practitioners regarding accredited or certified organizations. Upon receipt of such a complaint, NCQA will: 1. Review the complaint to determine that the organization referenced is NCQA Accredited or NCQA Certified. 2. Determine if the complaint is germane to the organization's NCQA Accreditation or NCQA Certification.	**PC**	**7/28/14**

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			3. Obtain an authorization for disclosure of PHI to NCQA to investigate if the complaint involves a quality of care issue or other matters involving PHI. 4. Forward the complaint to the organization with a request that the organization review and respond directly to the individual filing the complaint within 30 calendar days, and copy NCQA on the response. 5. Review the organization's response to determine whether the complaint was handled in accordance with NCQA requirements and that all issues raised in the complaint have been addressed. Failure to comply with NCQA's complaint review process is grounds for suspension or revocation of accreditation or certification status.		
35	Policies and Procedures—Section 4	Reporting Hotline for Fraud and Misconduct—How to Report	Replace the "English-speaking USA and Canada" toll free telephone number with **844-440-0077.**	**CO**	**11/20/17**
35	Policies and Procedures—Section 5	Additional Information	Add after the Complaint Review Process section: **Reporting Hotline for Fraud and Misconduct** NCQA does not tolerate submission of fraudulent, misleading or improper information by organizations as part of their survey process or for any NCQA program. NCQA has created a confidential and anonymous Reporting Hotline to provide a secure method for reporting perceived fraud or misconduct, including submission of falsified documents or fraudulent information to NCQA that could affect NCQA-related operations (including, but not limited to, the survey process, the HEDIS measures and determination of NCQA status and level). **How to Report** • **Toll-Free Telephone:** – English-speaking USA and Canada: **855-840-0070** (not available from Mexico). – Spanish-speaking North America: **800-216-1288** (from Mexico, user must dial 001-800-216-1288). • **Web Site:** https://www.lighthouse-services.com/ncqa • **E-Mail:** reports@lighthouse-services.com (must include NCQA's name with the report). • **Fax:** 215-689-3885 (must include NCQA's name with the report).	**PC**	**7/27/15**

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36	Policies and Procedures—Section 4	Reporting Hotline for Fraud and Misconduct	Add a new section, "Notifying NCQA of Reportable Events", after the subhead. See the attached **Policies and Procedures** to review the section, which includes the definition of Reportable Events, the process for notifying NCQA of Reportable Events and a description of the investigative process that NCQA may initiate following a Reportable Event.	**PC**	**11/20/17**
36	Policies and Procedures—Section 4: Additional Information	Notifying NCQA of Reportable Events	Revise the third subbullet under the first bullet to read: – Request for corrective action where the substance of such corrective action relates to the organization's handling of important patient safety matters.	**CL**	**7/29/19**
36	Policies and Procedures—Section 4: Additional Information	Notifying NCQA of Reportable Events—Annual Attestation of Compliance With Reportable Events	Revise the second sentence in the second paragraph to read: Submit Reportable Events via email to ReportableEvents@ncqa.org and annual attestations electronically to Attestations@ncqa.org, by fax to 202-955-3599 or by mail to the address below:	**CL**	**7/30/18**
37	Policies and Procedures—Section 4	Discretionary Survey	Revise the Discretionary Survey section to read: NCQA may survey an organization while a certification status is in effect. This survey is called a **Discretionary Survey** and its purpose is to validate the appropriateness of the organization's ongoing certification. **Structure** NCQA determines the scope and content of Discretionary Surveys, which may consist of one or more of the following: • An offsite document review. • An onsite survey. • A teleconference. **Target** Discretionary Surveys address issues regarding the organization's continued performance against NCQA's standards and other considerations that may pose an imminent threat to members. <u>During a discretionary review, an accredited organization will be reviewed under the NCQA standards in effect at the time of the discretionary review.</u>	**PC**	**11/21/16**

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			The Discretionary Survey may include file review (encompassing a sample of consumer complaint files or physician requests for changes, as appropriate) and interviews with organization staff. Any relevant look-back period for file review standards will be determined at the time of the Discretionary Survey and may or may not reflect the full look-back period identified in the standards. **Time frame** The Discretionary Survey is generally conducted within 60 calendar days of notification by NCQA of its intent to conduct a Discretionary Survey. Discretionary Survey costs are borne by the organization and correspond to the complexity and scope of the Discretionary Survey and NCQA pricing policies in effect at the time of the Discretionary Survey. **Change in status** When NCQA notifies the organization in writing of its intent to conduct a Discretionary Survey, the organization's existing certification status is listed with the notation "Under Review by NCQA." NCQA may suspend the organization's accreditation status pending completion of a Discretionary Survey. Upon completion of the Discretionary Survey and after the ROC's Decision, the organization's status may change. The organization has the right to Reconsideration if its certification status changes because of the Discretionary Survey.		
37	Policies and Procedures—Section 4	Discretionary Survey—Time frame	Revise the first sentence to read: The Discretionary Survey is generally conducted within 60 calendar days of notification by NCQA of its intent to conduct a Discretionary Survey, but may include an unannounced survey.	**PC**	**11/20/17**
37	Policies and Procedures—Section 4	Program Change Review	Revise the first sentence to read: As described in *Organization Obligations,* organizations are required to report any significant changes to the functions or activities reviewed by NCQA, including, but not limited to, changes to the methodology used, the addition of other cost or quality measures or the expansion of a program to additional geographic areas.	**CL**	**3/25/13**

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40	Policies and Procedures—Section 4	Suspending Certification	Revise the text to read: Grounds for recommending suspension of certification status pending a Discretionary Survey include, but are not limited to: • The organization has been placed in receivership or under rehabilitation and the outcome is undetermined. • A component of the organization's system has been placed in receiver-ship or under rehabilitation. • Facts or allegations suggesting an imminent threat to the health and safety of members or patients. • Allegations of fraud or other improprieties in the information submitted to NCQA to support accreditation. • State, federal or other duly authorized regulatory or judicial action restricts or limits the organization's operations. Because suspension of certification status is temporary and is designed to allow NCQA to investigate and gather information for decision making, Reconsideration is not available when status has been suspended.	**PC**	**7/28/14**
40	Policies and Procedures—Section 4: Additional Information	Mergers and Acquisitions	Revise the email address in the second paragraph to read: SIG@ncqa.org	**CO**	**3/28/22**
40	Policies and Procedures—Section 4	Mergers and Acquisitions	Replace the language with the following: An NCQA-Certified organization involved in a merger, acquisition, consolidation or other form of corporate reorganization, including filing for dissolution, must submit written notice of such action to NCQA within 30 calendar days following the date of the merger, acquisition, consolidation or reorganization, or earlier, if possible. An NCQA-Certified organization must also notify NCQA in writing within 30 calendar days of any change in operational structure or the organization's status that affects the scope of review under NCQA's standards for Physician and Hospital Quality Certification, such as material changes in the provider delivery system, legal structure, ownership or governing body of the organization. Notices can be submitted electronically to NCQA-Accreditation@ncqa.org; by fax to 202-955-3599 or by mail to the address below:	**PC**	**11/20/17**

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			National Committee for Quality Assurance 1100 13th Street NW, Third Floor Washington DC 20005 Attention: AVP Accreditation		
41	Policies and Procedures—Section 4	Privacy, Security and Confidentiality Requirements	Add the following prior to the **Revisions to Policies and Procedures** subhead: **Privacy, Security and Confidentiality Requirements** Nothing contained in the NCQA standards is intended to conflict with the organization's responsibility to comply with HIPAA and other federal and state laws. The organization must access, use and share health information in accordance with HIPAA and other federal and state laws and only disclose the minimum amount of PHI necessary to accomplish the purposes of the NCQA Accreditation Program.	**PC**	**7/28/14**
41	PQ 1, Element A	Explanation - Documentation	Revise the Note under "Documentation" to read: ***Note:*** *The organization is not required to provide a copy of measure specifications for any measure for which NCQA is the measure steward (e.g., NCQA HEDIS Volume 2 Technical Specifications) if it adjusts the measure according to the Rules for Allowable Adjustments. If the organization makes adjustments to the measure outside the Rules for Allowable Adjustments, it must provide a copy of the measure specifications that specifies the adjustments that were made.*	**CL**	**11/22/21**
42	PQ 1, Element A	Explanation—Following standardized measure specifications	Add the following after the third paragraph of this section: HEDIS measures may only be adjusted according to NCQA's Rules for Allowable Adjustments of HEDIS (the "Rules"). Effective with surveys starting on or after January 1, 2021, HEDIS measures must be un-adjusted or follow the Rules to be considered standardized measures.	**CL**	**3/30/20**
43	PQ 1, Element A	Explanation—Selecting standardized measures	Add the following as the last sub-bullet: – Measures required for the Physician Quality Reporting System (PQRS).	**CL**	**3/27/17**

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43	PQ 1, Element A	Explanation—Following standardized measure specifications	Add as the last sentence: **Changes in endorsement status** If a measure receives or loses endorsement during an organization's survey period, the organization may use the measure if it was endorsed for at least half the measurement period. ***Note:*** *Added the subhead "Changes in endorsement status" on 3/30/20.*	**CL**	**7/27/15**
44	PQ 1, Element A	Explanation	Add the following text as a new section under the "Following standardized measure specifications" section: **Use of Performance-Based Designation Programs** There are a variety of nationally recognized performance-based designation programs for physician measurement. Organizations may incorporate physician participation in these programs as a quality measure in their own physician measurement programs. The organization's program methodology must specify how it makes use of the programs, including the time frame during which a physician is recognized by or otherwise participates in the program. That period is considered the "measurement year" for the purposes of this requirement. For example, "For ABC Health Plan's 2021 Star Network, credit is given if a physician is NCQA PCMH-Recognized any time from January 1–December 31, 2019." In this case, the measurement year (MY) is 2019. Because the number of standardized quality measures in each program is known, organizations do not need to provide documentation of measurement specifications. Organizations must complete the measure workbook and indicate how they use the designation to take action. The composition of the performance-based designation programs changes periodically; NCQA will update Appendix 4 as needed and will include effective and expiration dates of performance-based designation programs based on the measurement year for which they may be used. If an organization uses a program for more than one measurement year, and the number of measures changed during the interval, the organization receives credit for the program one time for the version that has the greater number of standardized measures. Organizations enter only that single program in the worksheet.	**CL**	**11/23/20**

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44	PQ 1, Element A	Explanation—Specialty board measurement initiatives	Add the following as the first sentence: Board certification does not count as a standardized measure.	**CL**	**7/29/13**
50	PQ 1, Element D	Element title	Revise the title to read: **Taking action**	**CL**	**7/27/15**
52	PQ 1, Element D	Explanation—Taking action on cost, resource use or utilization measure	Replace the third and fourth bullets with the following: • Identify for NCQA the total number of physicians by specialty subject to the measurement program and of those the number that do not have quality performance included 1) where there are applicable quality measures but insufficient data (e.g. observations) to calculate measure results and 2) where there is an absence of applicable quality measures for the specialty, including Maintenance of Certification or other accepted performance designation programs. The including of physicians in these two groups should be mutually exclusive by definition. • Prominently indicate for any individual physician that quality performance is not known wherever cost performance is acted on alone. This requires that, for example, public report cards on the internet specifically denote each physician who has insufficient information to report on quality in the same place where cost performance is displayed. A generic note on a public report card is not sufficient.	**CL**	**7/29/13**
58	PQ 2, Element B	Explanation	Add the following subhead and text immediately above **Examples** subhead: **Exceptions** The following are exceptions to the 45-day-notice requirement: • If an organization recalculates results (e.g., as part of annual remeasurement for a public report) without changing its methodology or measures, it does not need to provide the information required for factor 1 again, as long as it supplies instructions for obtaining the information and makes the information available upon request. • If the action is a pay-for-performance activity that is not publicly reported (e.g., an action that is only between the organization and the physician). In this instance, the organization may provide the results and methodology concurrent with an additional or bonus payment. The organization must still provide a process for the physician to request corrections or changes.	**CO**	**7/29/13**

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~~60~~	~~PQ 2, Element C~~	~~Look-back period~~	~~Revise the text to read:~~ ~~*For Initial Surveys:* NCQA reviews a sample of files for complaints received by the organization within 6 months prior to the survey date.~~ ~~*For Renewal Surveys:* NCQA reviews a sample of files for complaints received by the organization within 24 months prior to the survey date.~~ ~~***Note:** The revised look-back periods are effective beginning January 1, 2016.~~	~~**PC**~~	~~**7/27/15**~~
60	PQ 2, Element C	Look-back period	Revise the look-back period to read: *For Initial Surveys and Renewal Surveys:* NCQA reviews a random sample of files of physician requests for corrections or changes (open or closed requests) that are related to the most recent version or cycle of actions included in the scope of review and received by the organization before the start of the survey.	**CO**	**11/22/21**
61	PQ 2, Element C	Explanation—Review and investigation of the request	Remove the third sentence, which reads, "The time frame must be no fewer than 21 days."	**CO**	**3/25/13**
63	PQ 3, Element A	Explanation—Documentation	Revise the explanation to read: For factor 4, the organization uses language that addresses the material intent of the factor. If the organization is required by a third party to post specific language, it may use that language. If the language does not address the material intent of the factor fully, the organization supplements the disclosure, unless prohibited by a regulatory requirement or other legal requirement.	**CL**	**3/25/13**
63	PQ 3, Element A	Explanation—Documentation	Revise the explanation to read: NCQA reviews the organization's documented processes and materials demonstrating to whom, and how, the organization communicates the information. The organization publicly reports information on the percentage of total payments based on performance. Information on physician payment is placed in proximity to the information the organization publishes on physician performance. If no payment is based on performance, the organization discloses this publicly, even if the program under review by NCQA is not a pay-for-performance program.	**CL**	**3/25/13**

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63	PQ 3, Element A	Explanation—Exception	Add the following as the second paragraph: Factors 3-5 are NA if the organization does not display physician performance information for its pay-for-performance program.	**CL**	**7/29/13**
63	PQ 3, Element A	Examples	Revise the examples to include a subhead that reads: **Publicly reporting information on the percentage of total payments based on performance** • NYSAG Settlement Agreements read, "... [the organization] shall disclose to consumers: ... (2) that physician performance ratings are only a guide to choosing a physician, that consumers should confer with their existing physicians before making a decision, and that such ratings have a risk of error and should not be the sole basis for selecting a doctor"	**CL**	**3/25/13**
64	PQ 3, Element B	Explanation	Add the following subhead and text immediately after the last paragraph: **Exception** This element is NA if the organization does not display physician performance information for its pay-for-performance program.	**CL**	**7/29/13**
67	PQ 3, Element D	Look-back period	Replace the first paragraph with the following: *For Initial Surveys:* NCQA reviews a sample of files for complaints received by the organization within 6 months prior to the survey date. *For Renewal Surveys:* NCQA reviews a sample of files for complaints received by the organization within 24 months prior to the survey date. ***Note:*** This update is effective for surveys beginning on or after January 1, 2016.	**PC**	**4/13/15**
67	PQ 3, Element D	Look-back period	Revise the first paragraph to read: *For Initial Surveys:* NCQA reviews a sample of files for complaints received by the organization within 6 months prior to the survey date. *For Renewal Surveys:* NCQA reviews a sample of files for complaints received by the organization within 24 months prior to the survey date, or beginning after the completion of the prior survey, if the 24 months would extend into the prior survey. ***Note:*** *The revised look-back period are effective beginning January 1, 2016.*	**PC**	**7/27/15**

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67	PQ 3, Element D	Explanation—Exceptions	Add the following as the third bullet: • If the organization does not display physician performance information for its pay-for-performance program.	**CL**	**7/29/13**
68	PQ 4, Element A	Explanation	Add the following before **Soliciting physician input on measure selection:** **Soliciting consumer input on measure selection** The organization solicits input from consumers or consumer representatives about the development of measures or measurement activities that the organization may be able to use in its physician measurement program. The solicitation addresses at a minimum measures to include in the program and how information about physicians should be reported to help understand what is useful and understandable to consumers. The organization may solicit input from several individual consumers or consumer groups. The organization may communicate with consumers or consumer groups through face-to-face meetings, conference calls or through surveys or direct mail. A **consumer** is defined as a non-health care professional who has or would utilize health care services. A **consumer group** is defined as an organization that advocates for people who are actual or potential users of healthcare services.	**CL**	**11/17/14**
69	PQ 4, Element A	Examples	Add the following before the **Soliciting feedback** subhead: **Consumer groups** • American Association of Retired People • Consumers Union • National Partnership for Women & Families • Child Welfare League of America	**CL**	**11/17/14**
70	PQ 4, Element B	Explanation—Exceptions	Delete the first paragraph, which reads: This element is NA for Interim Surveys.	**CL**	**3/25/19**
70	PQ 4, Element B	Explanation—Exception	Add the following as the first paragraph: Factor 1 and the customer portion of factor 4 are NA if the organization does not display physician performance information for its pay-for-performance program.	**CL**	**7/29/13**
71	PQ 4, Element B	Explanation—Feedback Timeframe	Revise the first sentence to read: The organization seeks feedback at least every measurement cycle.	**CL**	**3/25/13**

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72	PQ 4, Element C	Explanation—Assessing Impact	Revise the paragraph to read: At least once per measurement cycle, the organization identifies the purpose of its physician measurement program and the program's desired results (e.g., patient volume shifts to higher-performing physicians; improved physician performance). The organization creates and executes an evaluation strategy to determine if its program is having the desired results and, if it is not, explores opportunities for improvement. If the organization has a two-year measurement cycle, it may meet factors 1 and 2 by identifying areas for improvement and implementing changes in those areas every two years.	**CL**	**3/25/13**
79	HQ 1, Element B	Explanation	Add an **Exception** subhead immediately above **Examples** and move NA text below to the new subhead. Requirements regarding prospective consumers are NA for organizations that do not enroll consumers.	**CL**	**7/29/13**
80	HQ 1, Element C	Data source	Replace "documented process" with "materials."	**CL**	**7/29/13**
81	HQ 1, Element C	Explanation	Revise the NA text to address factor 3 and move it to a new subhead immediately above **Examples:** Factor 3 is NA for organizations that do not enroll consumers.	**CL**	**7/29/13**
87	HQ 1, Element F	Explanation	Add an **Exception** subhead immediately above the last paragraph so the text reads: **Exception** This element is NA if the organization does not make payments to hospitals (e.g., an information provider).	**CL**	**7/29/13**
1-1	Appendix 1	Standard and Element Points for 2013	Revise the points table to include a column for Interim Survey points. **2013 Standard/ Element** | **Standard Description** | **Interim Survey Points** | **2013 Points**	**CL**	**3/25/13**
1-1	Appendix 1	Standard and Element Points for 2013	Revise the head for the Hospital Quality standard to read: **Hospital Quality (HQ 1)**.	**CO**	**3/25/13**

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2-3	Appendix 2	Glossary	Add the following immediately above **delegation:** **De-identify** Removal of individual identifiers. Under the HIPAA Privacy Rule, protected health information is de-identified if all individual identifiers are removed. There are 18 categories of identifiers that include name; street address and zip code; telephone and fax number; dates (except year) directly related to a person, including date of birth and dates of service; e-mail address and Web URL; Social Security Number; medical record number and account number; vehicle identifiers, including license plate number; device identifiers and serial number; and any other unique identifying number, characteristic or code.	**CL**	**7/29/13**
2-5	Appendix 2	Glossary	Add the following immediately above **PHO:** **PHI** Protected health information (PHI) is associated with an individual's past, present or future physical or mental health or condition, or with the provision of or payment for health care to a person, and identifies the individual. Under the HIPAA Privacy Rule, there are 18 categories of identifiers (e.g., name, street address, email address, telephone number, social security number, medical record number, health plan beneficiary or account number, birth date, dates of service and five-digit zip code). Age is not PHI, except for individuals older than 89 years; HIPAA allows the age for these individuals to be aggregated into a single category of "age 90 or above.	**CL**	**7/29/13**
2-8	Appendix 2	Glossary	Revise the definition of "taking action" to read: Designated activities by an organization based on its measurement of physician performance on quality or cost, resource use or utilization. Taking action includes: • Publicly reporting physician performance. • Using physician performance data as a basis for network design (such as tiering) or benefit design. • Using physician performance data as a basis to allocate physician rewards under a systematic, networkwide pay-for-performance program. • Reporting performance on quality, cost, resource use or utilization to physicians to support referral decisions.	**CO**	**3/25/13**

<table>
<tr><th colspan="6">PREVIOUSLY POSTED UPDATES</th></tr>
<tr><th>Page</th><th>Standard/Element</th><th>Head/Subhead</th><th>Update</th><th>Type of Update</th><th>ISS Release Date</th></tr>
<tr><td>4-1</td><td>Appendix 4</td><td>Performance-Based Designation Programs</td><td>Make the following changes.
• Add the following immediately above “NCQA Recognition Programs”.
<table>
<tr><th>Physician Quality Reporting System (PQRS) measures</th><th>Credit Toward Numerator in PQ 1, Element A</th><th>Credit Toward Denominator in PQ 1, Element A</th></tr>
<tr><td></td><td>9 measures</td><td>9 measures</td></tr>
<tr><td colspan="3">• 9 Government Agency</td></tr>
</table>
• Revise the number of measures for DRP from 11 to 8 (7 NQF and 1 NCQA).
• Update measures for HSRP from 5NQF to 3 NQF and 2 NCQA.
Updated on July 27, 2020.
• Revise NCQA Recognition Programs section as follows.
<table>
<tr><th>NCQA Recognition Programs</th><th>Credit Toward Numerator in PQ 1, Element A</th><th>Credit Toward Denominator in PQ 1, Element A</th></tr>
<tr><td>Patient-Centered Medical Home 2014</td><td>27 measures</td><td>27 measures</td></tr>
<tr><td colspan="3">• 27 NCQA</td></tr>
<tr><th>NCQA Recognition Programs</th><th>Credit Toward Numerator in PQ 1, Element A</th><th>Credit Toward Denominator in PQ 1, Element A</th></tr>
<tr><td>Patient-Centered Medical Home 2017</td><td>65 measures</td><td>65 measures</td></tr>
<tr><td colspan="3">• 65 NCQA</td></tr>
<tr><td>Patient-Centered Specialty Practice 2016</td><td>26 measures</td><td>26 measures</td></tr>
<tr><td colspan="3">• 26 NCQA</td></tr>
</table>
Updated on July 27, 2020.</td><td>CL</td><td>3/27/17</td></tr>
</table>

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~~4-1~~	~~Appendix 4~~	~~NCQA Recognition Programs~~	~~Remove 5th and 6th rows, which read:~~ ~~Back Pain Recognition Program~~ | ~~16 measures~~ ~~• 15 NQF~~ | ~~• 1 NCQA~~ ***Updated on July 27, 2020.***	~~**PC**~~	~~**11/17/14**~~
~~4-1~~	~~Appendix 4~~	~~Performance-Based Designation Programs~~	~~Revise the Performance-Based Designation Programs table to include a column indicating the standardized measure count for each program *and* a column indicating the total measure count for each program. See Appendix 4.~~ ***Updated on July 27, 2020.***	~~**CL**~~	~~**3/25/13**~~
~~4-1, 4-2~~	~~Appendix 4~~	~~Performance-Based Designation Programs~~	~~Add two new programs to the list of Performance-Based Designation Programs: Meaningful Use Stage 2 and NCQA Patient-Centered Specialty Practice Recognition. See Appendix 4.~~ ***Updated on July 27, 2020.***	~~**PC**~~	~~**3/25/13**~~
~~4-2~~	~~Appendix 4~~	~~Bridges to Excellence~~	~~Add the following at the end of the table:~~ ~~IBD Recognition~~ | ~~3 measures~~ | ~~3 measures~~ ~~• 3 AMA-PCPI~~ | ~~• 15 NQF~~ | ~~• 1 NCQA~~ ***Updated on July 27, 2020.***	~~**PC**~~	~~**4/13/15**~~
4-1	Appendix 4	Use of Performance-Based Designation Programs	Revise the paragraph to read: There are a variety of nationally recognized performance-based designation programs for physician measurement. Organizations may incorporate physician participation in these programs as a quality measure in their own physician measurement programs. The organization's program methodology must specify how it makes use of the programs, including the time frame during which a physician is recognized by or otherwise participates in the program. That period is considered the "measurement year" for the purposes of this appendix. For example, "For ABC Health Plan's 2021 Star Network, credit is given if a physician is NCQA PCMH Recognized any time from January 1–December 31, 2019." In this case, the measurement year (MY) is 2019.	**CL**	**7/27/20**

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<tr><td></td><td></td><td></td><td>Because the number of standardized quality measures in each program is known, organizations do not need to provide documentation of measurement specifications. Organizations must complete the measure workbook and indicate how they use the designation to take action.
The composition of the following performance-based designation programs changes periodically; NCQA will update this appendix as needed and will include effective and expiration dates of performance-based designation programs based on the measurement year for which they may be used.
If an organization uses a program for more than one measurement year, and the number of measures changed during the interval, the organization receives credit for the program one time for the version that has the greater number of standardized measures. Organizations enter only that single program in the worksheet.</td><td></td><td></td></tr>
<tr><td>4-2</td><td>Appendix 4</td><td>Use of Performance-Based Designation Programs—Performance-Based Designation Programs</td><td>Remove the following:<table><tr><th>Meaningful Use</th><th>Credit Toward Numerator in PQ 1, Element A</th><th>Credit Toward Denominator in PQ 1, Element A</th></tr><tr><td>Stage 1: 15 core objectives; 5 of 10 possible menu objectives; 6 clinical quality measures</td><td>26 measures</td><td>26 measures</td></tr><tr><td colspan="3">• 26 Government Agency</td></tr><tr><td>Stage 2: 17 core objectives; 6 menu objectives;</td><td>23 measures</td><td>23 measures</td></tr><tr><td colspan="3">• 23 Government Agency</td></tr></table></td><td>CL</td><td>7/27/20</td></tr>
<tr><td>4-2</td><td>Appendix 4</td><td>Use of Performance-Based Designation Programs—Performance-Based Designation Programs</td><td>Revise the name of the of the Physician Quality Reporting System (PQRS) program to Quality Payment Program (QPP).</td><td>CL</td><td>7/27/20</td></tr>
</table>

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Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**ISS Release Date**
4-2	Appendix 4	Use of Performance-Based Designation Programs—Performance-Based Designation Programs	Add an "Effective Measurement Year" column to Quality Payment Program (QPP) Measures and NCQA Recognition Programs.	**CL**	**7/27/20**
4-2	Appendix 4	Use of Performance-Based Designation Programs—Performance-Based Designation Programs	Revise the number of measures for Diabetes Recognition Program from 8 to 6, effective for measurement years 2020 and later.	**CL**	**7/27/20**
4-2	Appendix 4	Use of Performance-Based Designation Programs—Performance-Based Designation Programs	Remove the following retired NCQA-Recognition programs: – Physician Practice Connections. – Physician Practice Connections—Patient-Centered Medical Home. – Patient-Centered Medical Home 2011. – Patient-Centered Specialty Practice 2013.	**CL**	**7/27/20**
4-2	Appendix 4	Use of Performance-Based Designation Programs—Performance-Based Designation Programs	Add the following NCQA-Recognition programs: – Patient-Centered Connected Care. – Patient-Centered Specialty Practice 2019.	**CL**	**7/27/20**
4-3	Appendix 4	Use of Performance-Based Designation Programs—Performance-Based Designation Programs	Add the following above the Bridges to Excellence measures: **Release Note (July 27, 2020)** For surveys incorporating results from MY 2021 or later, organizations will no longer receive credit for Bridges to Excellence programs as a whole and must list all applicable measures individually on the worksheet.	**PC**	**7/27/20**

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Page	**Standard/Element**	**Head/Subhead**	**Update**	**Type of Update**	**ISS Release Date**
4-3	Appendix 4	Use of Performance-Based Designation Programs—Performance-Based Designation Programs	Add the following text to the Release Note from July 27, 2020: ***Update (March 29, 2021):*** NCQA has been informed that the Bridges to Excellence program ends April 2021. For information, see the pop-up notice at http://www.bridgestoexcellence.org/. This does not impact NCQA requirements. Organizations may still receive credit for Bridges to Excellence programs for surveys incorporating results from MY 2020 or earlier.	**CL**	**3/29/21**