



**For Public Comment**  
**June 4—July 10, 2026**

**Comments due 11:59 p.m. ET**  
**July 10, 2026**

# Overview of Proposed Updates to Health Plan Accreditation Standards

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## Health Plan Accreditation: *Overview of Proposed Updates*

### **NCQA's Mission: Improve the Quality of Health Care**

For almost 40 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 signifies that organizations deliver high-quality care and maintain strong member protections.

### **Stakeholders Participating in Public Comment**

NCQA shares these proposed updates for public comment to generate thoughtful input from stakeholders, including health plans, regulators and industry partners. Feedback is used to strengthen standards, improve clarity and ensure requirements are feasible and aligned with market needs.

### **Background**

For Standards Year 2027, NCQA proposes a targeted set of reductions and limited updates to Health Plan Accreditation standards to reduce administrative burden, streamline evidence expectations and encourage continued alignment with external regulatory requirements while maintaining program rigor, evaluative clarity and consistent performance standards.

Proposed updates focus on improving the efficiency and clarity of the current program by refining requirements, reducing redundant review and preserving meaningful evaluation of core organizational capabilities across the Accreditation life cycle.

### **A Guide to Proposed Updates**

- Targeted requirement reductions and retirements, primarily focused on Renewal Surveys.
- Clarifications and refinements to existing requirements to improve evaluative clarity and reduce prescriptive documentation expectations.

- A conditional update to Utilization Management (UM) pharmacy timeliness requirements to align with a CMS proposed rule.
- Alignment of changes across other NCQA Accreditation programs, where appropriate, to reduce duplication and support consistency.

### **Approach to Burden Reduction**

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Proposed reductions focus on requirements that:

- Demonstrate consistently high performance, limiting the ability to distinguish across organizations.
- Overlap with other standards or external regulatory requirements, resulting in duplicate review.
- Require highly prescriptive or documentation-heavy evidence (e.g., screenshots, call logs, committee minutes) that can be resource-intensive to produce and maintain for survey submission.

In several cases, updates remove documentation expectations embedded in explanations, preserving the evaluative intent of a standard while improving flexibility in how organizations demonstrate performance.

### **Focus on Renewal Surveys**

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To maximize impact, proposed reductions concentrate on Renewal Surveys, which represent the largest portion of Accreditation activity. This approach reduces burden where it will have the greatest effect while maintaining evaluation of foundational capabilities during First and Interim Surveys to preserve life cycle rigor.

In cases where requirements are retired from Renewal Surveys, organizations are still expected to maintain the underlying capabilities as part of their ongoing operations and program responsibilities. These requirements reflect foundational practices that are established through initial evaluation and supported through organizational policies, procedures and ongoing oversight. Removal from Renewal Survey activity does not eliminate these expectations, but rather reduces repeated evaluation where capabilities are stable and consistently demonstrated.

### **Proposed Updates**

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- Retire elements or standards where performance is consistently high or evaluation is addressed through other requirements.
- Narrow scope at Renewal to reduce repeated evaluation of stable, foundational capabilities.
- Clarify requirements without changing intent or scoring.
- Improve flexibility by removing prescriptive documentation expectations.
- Preserve core expectations for quality and oversight while allowing organizations to demonstrate performance using more relevant, operational evidence.

### **Utilization Management Pharmacy Timeliness Update**

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NCQA proposes a targeted, conditional update to pharmacy timeliness requirements to align with a CMS-proposed rule for commercial and Exchange plans.

The proposed update shortens the time frame for urgent preservice pharmacy decisions (from 72 hours to 24 hours), reflecting current industry practice and supporting consistency across regulatory and Accreditation frameworks.

This update is included in the 2027 standards package to enable timely alignment, contingent on finalization of the CMS rule.

### **Transparency of AI-Supported Utilization Management**

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NCQA proposes a targeted update to introduce expectations for transparency of AI-supported UM processes. This update adds a factor to UM 1, Element A (Program Structure), requiring that AI-generated output be explainable at the individual case level, including the ability to identify criteria and sources used to inform decisions. This approach reinforces accountability and supports transparency expectations while aligning the use of AI with existing UM oversight requirements.

### **Medicaid Module**

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In addition to updates to core Health Plan Accreditation standards, NCQA includes a Medicaid Module to support evaluation of requirements specific to Medicaid programs and federal regulations.

The module is incorporated as a distinct section in the survey, and may be applied when required by a state or selected by an organization. This approach supports alignment with state and federal requirements and reduces duplication of effort by allowing states to rely on NCQA's review in place of conducting separate evaluation of similar requirements.

Consistent with this approach, NCQA may move selected requirements from the core program to the Medicaid Module when they are primarily driven by state-specific or federal regulatory oversight. This enables the core standards to remain focused on broadly applicable requirements and preserve a mechanism for evaluating Medicaid-specific expectations when needed.

### **Alignment Across Accreditation Products**

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Where appropriate, NCQA aligned proposed reductions across other Accreditation programs to:

- Promote consistency in expectations across products.
- Reduce duplicate documentation requirements.
- Support a more streamlined experience for organizations with multiple accreditations.

Updates maintain product-specific intent while improving overall usability and coherence across the NCQA portfolio.

## Scoring Considerations

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Analysis indicates limited overall impact on scoring outcomes, including organizations' ability to meet accreditation thresholds. Any sensitivity is concentrated among a small number of organizations near threshold levels, indicating that proposed reductions maintain program rigor while reducing unnecessary burden.

## Summary

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Collectively, proposed updates:

- Reduce administrative burden, particularly at Renewal.
- Eliminate redundancy and requirements that provide limited additional evaluative insight.
- Improve clarity and flexibility in evidence expectations.
- Align standards with evolving regulatory and industry practices.
- Maintain rigorous evaluation of key organizational capabilities.

These changes represent a targeted, evidence-based step toward a more streamlined and modernized Health Plan Accreditation program.

The table that follows summarizes proposed updates to Health Plan Accreditation for 2027.

Refer to the Proposed Standard Updates document for detailed revisions to standard language.

Summary of Proposed Updates to Health Plan Accreditation 2027

Category	Standard/Element	Proposed Update	Summary Rationale	Impact Across Products
<b>Quality Improvement</b>				
QI 3, Element E	Continuity and Coordination of Care—Transitions to Other Care	Retire element	Applies infrequently and provides limited additional evaluative value; continuity and coordination are more effectively assessed through existing outcome-based elements.	Behavioral Health Accreditation
<b>Population Health Management</b>				
PHM 5, Element A	Complex Case Management—Access to Case Management	Retire for Renewal; maintain for First and Interim	Demonstrates consistently high performance; does not substantially enhance evaluation at Renewal, while First/Interim Surveys preserve life cycle evaluation.	Behavioral Health Accreditation
PHM 5, Element C	Case Management Process	Remove factor-level conclusion requirement (Explanation update)	Removes prescriptive documentation expectations that do not impact scoring; preserves evaluation and increases flexibility.	Health Plan Accreditation LTSS Distinction Behavioral Health Accreditation Case Management Accreditation Case Management for LTSS Accreditation
PHM 5, Element D	Initial Assessment	Remove factor-level conclusion requirement (Explanation update)	Eliminates prescriptive documentation; maintains evaluation through file review.	Health Plan Accreditation LTSS Distinction Behavioral Health Accreditation Case Management Accreditation Case Management for LTSS Accreditation

Category	Standard/Element	Proposed Update	Summary Rationale	Impact Across Products
<b>Network Management</b>				
NET 4, Elements A, B	Continued Access to Care	Retire for Renewal; maintain for First	Consistently high performance with limited differentiation at Renewal; retains initial evaluation at First Survey.	Behavioral Health Accreditation Accreditation in Credentialing and Provider Network
NET 5, Element G	Directory Usability Testing	Retire element	Baseline operational practice with consistently high performance; removal avoids duplicate review.	Behavioral Health Accreditation Accreditation in Credentialing and Provider Network
NET 5, Element H	Availability of Directories	Retire element	Baseline operational practice with consistently high performance; reduces documentation burden.	Behavioral Health Accreditation Accreditation in Credentialing and Provider Network
<b>Utilization Management</b>				
UM 1, Element A	UM Program Description	New factor	Establishes expectations for oversight of AI-supported UM processes for appropriate governance, transparency and accountability.	None
UM 2, Element A	Clinical Criteria for UM Decisions	Retire for Renewal; maintain for First and Interim	Foundational requirement evaluated elsewhere; removal reduces duplicate policy review at Renewal.	Behavioral Health Accreditation Utilization Management Accreditation
UM 4, Element F	Use of Board-Certified Consultants	Retire for Renewal; maintain for First and Interim	Frequently not applicable or baseline practice; does not substantially enhance evaluation at Renewal.	Behavioral Health Accreditation Utilization Management Accreditation

Category	Standard/Element	Proposed Update	Summary Rationale	Impact Across Products
UM 5, Element C	Pharmacy Timeliness—Notification of Pharmacy Decisions	Update time frame (72 → 24 hours) for urgent preservice decisions	Aligns with CMS proposed rule and current industry practice; promotes consistency across regulatory and Accreditation frameworks.	Utilization Management Accreditation
UM 10, Element A	Pharmaceutical Management Procedures	Retire for Renewal; maintain for First and Interim	Foundational policies are stable over time; repeated review at Renewal provides limited incremental insight.	Utilization Management Accreditation
UM 10, Element B	Pharmaceutical Restrictions/Preferences	Clarify requirement	Improves clarity and consistency without changing expectations.	Utilization Management Accreditation
UM 10, Element D	Reviewing and Updating Policies	Retire element	Substantially overlaps with other requirements; removal reduces redundancy.	Utilization Management Accreditation
UM 10, Element E	Considering Exceptions	Retire for Renewal; maintain for First and Interim	Exception processes are standard and commonly regulated; does not substantially enhance evaluation at Renewal.	Utilization Management Accreditation
<b>Credentialing</b>				
CR 2, Element A	Credentialing Committee	Replace meeting minutes with committee charter/process	Reduces reliance on lengthy documentation; maintains evidence of governance structure and oversight.	Behavioral Health Accreditation
CR 7, Elements A, D-E	Assessment of Organizational Providers	Allow virtual reviews (Explanation update)	Reflects current operational practice and reduces burden; maintains evaluation of provider assessment processes.	Behavioral Health Accreditation Accreditation in Credentialing and Provider Network
<b>Member Experience</b>				
ME 3, Elements A-C	Marketing Information	Retire elements; move to Medicaid module	Requirements are often subject to state oversight; removal reduces duplication without impacting member protections.	None

Category	Standard/Element	Proposed Update	Summary Rationale	Impact Across Products
ME 4, Elements A, B	Claims Processing Functionality	Retire elements	Documentation (e.g., screenshots, call logs) is resource-intensive and demonstrates consistently high performance.	Behavioral Health Accreditation
ME 5, Elements A-C	Pharmacy Benefit Information	Retire elements	Similar to ME 4: Eliminates repetitive documentation for a baseline capability.	None
ME 6, Elements A, B	Personalized Information on Services	Retire for Renewal; maintain for First	Removes repeated evaluation of baseline functionality; maintains initial expectations.	None
ME 7, Elements C, E	Member Experience—Annual Assessment	Remove prescriptive categorization requirements	Reduces documentation created solely for survey; maintains evaluation of complaint and appeal analysis.	Behavioral Health Accreditation

## 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. Do you support NCQA's proposed Health Plan Accreditation 2027 reductions?
2. Do proposed reductions help reduce administrative burden, improve clarity and support more focused, meaningful evaluation?
3. Do proposed reductions preserve meaningful oversight of core capabilities across the Accreditation life cycle (First Surveys, Interim Surveys, Renewal Surveys)?
4. Do you support carrying proposed changes through to affected NCQA Accreditation programs, where applicable?
5. Could proposed reductions create unintended risks, gaps or confusion for organizations or surveyors?

### Documents

Find the complete list of questions at: [HPA 2027 Public Comment Questions](#)

Find the draft standards rationales at: [HPA 2027 Standards Public Comment](#)

### 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 <https://my.ncqa.org/>.
2. Once logged in, click to select **Public Comments**.
3. Click **Add Comment**.
4. Select the name of the organization you are submitting comments for.
5. Click the **Instructions** link to view public comment materials, including instructions and proposed measure specifications.
6. Click **Take Survey**.
7. Review the process instructions and click the **Begin** button.
8. Answer the questions you would like to provide feedback on; required questions will be marked with a red asterisk.
  - a. Select your support option (Support, Support With Modifications, Do Not Support.)

**Note:** If you chose **Do Not Support**, include the reason in the text box. If you chose **Support With Modifications**, enter suggested modifications in the text box.

b. Enter comments in the **Comments** box.

**Note:** Comments allow up to 50,000 characters.

9. Click **Next** at the bottom of the page. Repeat **step 8** for each page.

**Note:** Use the **Back** button if you would like to change a response.

10. On the final page, click **Submit**.

**All comments must be entered by 11:59 ET on July 10, 2026.**

## Next Steps

The final Standards and Guidelines for Health Plan Accreditation will be released in summer 2026, following approval by the NCQA Evaluation Programs Committee and the Board of Directors.

Requirements for all programs will take effect for surveys starting July 1, 2027.