NCQA Patient-Centered Medical Home (PCMH) Standards and Guidelines

2017 Edition, Version 1 (Effective April 3, 2017)

NCQA
Measuring quality.
Improving health care.

No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording, or any information storage and retrieval system, without the written permission of NCQA.

© 2017 by the National Committee for Quality Assurance (NCQA)
1100 13th Street, NW, Suite 1000
Washington, DC 20005
All rights reserved.

NCQA Customer Support: 888-275-7585.

Table of Contents

Overview
NCQA's Patient-Centered Medical Home 1
NCQA PCMH Evolution 2003–2014 1
Goals for PCMH 2017 and Beyond 2
PCMH Program Update 5
What's New 5
Public Comment 5
The Standards 6
The Criteria and Credits Toward Recognition 6
Optional Distinctions 6
Resources 7

Policies and Procedures
Section 1: Commit—Recognition Eligibility and Recognition Process
Definitions 11
Eligibility 11
Fee Schedule Information 12
Recognition Program Partners in Quality 12
Creating Q-PASS Accounts 13
Additional Multi-Site Details 14
Determining Multi-Site Eligibility 14
Introduction to NCQA Representative 14

Section 2: Transform—The Evaluation Process
Transformation Period and NCQA Evaluation 15
The Evaluation 15
Inside the PCMH 2017 Standards 15
The Standard's Structure 16
Recognition Guidelines 18

Section 3: Succeed—Keeping Your Recognition
Annual Reporting 20
Reconsideration 20
Applicant Obligations 21
The Audit 21

Section 4: Additional Information
Complaint Review Process 23
Reporting Hotline for Fraud and Misconduct 23
Discretionary Survey 24
Suspension of Recognition 24
Revoking Recognition 25
Mergers, Acquisitions and Consolidations 25
Revisions to Policies and Procedures 25

PCMH 2017 Standards

Team-Based Care and Practice Organization (TC) 31
Knowing and Managing Your Patients (KM) 36
Patient-Centered Access and Continuity (AC) 55
Care Management and Support (CM) 62
Care Coordination and Care Transitions (CC) 69
Performance Measurement and Quality Improvement (QI) 78

Appendices

Appendix 1: PCMH Recognition Credits
Appendix 2: PCMH Glossary
Appendix 3: Record Review Workbook Instructions
Appendix 4: Distinction in Behavioral Health Integration—*Coming Soon*
Appendix 5: Distinction in Electronic Quality Measures (eCQMs) Reporting—*Coming Soon*
Appendix 6: Distinction in Patient Experience Reporting—*Coming Soon*

The PCMH Advisory Committee and Clinical Programs Committee

The Patient-Centered Medical Home (PCMH) 2017 update aligned the program standards with the transformation of NCQA's recognition programs' processes which establishes a new relationship with practices pursuing recognition. NCQA convened the PCMH 2017 Advisory Committee in late 2015 to outline a set of guiding principles to curate the modified requirements based on current data on medical home practices, feedback from the field and the collective expertise of the committee. The 27-member committee is composed of representatives from practices, medical associations, physician groups, health plans and consumer and employer groups. The committee met throughout 2016 to discuss and analyze draft standards, PCMH Recognition data and public comment results. NCQA also consulted its Clinical Programs Committee which is a diverse, standing multi-stakeholder panel of experts that review and approve NCQA's recognition program requirements.

These committees shaped updates to accomplish the following in PCMH 2017:

1. Drive achievement of the triple aim.[1]
2. Focus on outcomes instead of processes.
3. Accommodate a spectrum of practices (e.g., small vs large).
4. Detect true practice transformation.

The importance of these committees cannot be overstated. The members gave their time, energy, enthusiasm and a willingness to hear and compromise on opposing perspectives. The PCMH 2017 standards are a reflection of their hard work and collaboration.

PCMH 2017 Advisory Committee

Yul Ejnes, MD, MACP, Chair
Coastal Medical

Jean Antonucci, MD
Physician

Alicia Berkemeyer, BS
Arkansas Blue Cross and Blue Shield

Suzanne Berman, MD, FAAP
Plateau Pediatrics

Kelly Cronin, MPH, MHP
Office of the National Coordinator for Health Information Technology

Susan Davis, MSN, APRN, CPNP-PC
Community Health Network of CT, Inc

Patrick Gordon, MPA
Rocky Mountain Health Plans

Karen Handmaker, MPP
IBM/Phytel

Jeffery Harris, BS, RCP, RCPT
Patient Advocate

Scott Hines, MD
Crystal Run Healthcare

Donald Liss, MD
Independence Blue Cross

Adriana Matiz, MD, FAAP
Columbia University Medical Center

Leslie Milteer, PA-C, MPAS, DFAAPA
Saint Catherine University

Mary Minniti, BS, CPHQ
Institute for Patient and Family Centered Care

Amy Mullins, MD, CPE, FAAP
American Academy of Family Physicians

Deborah Murph, MBA, BSN, RN
Cherokee Health Systems

Ann O'Malley, MD, MPH
Mathematica

Lori Raney, MD
Health Management Associates

Judith Steinberg, MD, MPH
UMass School of Medicine

William F. Streck, MD
Healthcare Association of New York State

[1] http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

Deborah Johnson Ingram, BA
Primary Care Development Corporation

Katelyn Johnson, MBA
Cisco Systems

Joseph Territo, MD
Kaiser Mid-Atlantic Permanente Medical Group

Brad Thompson, MA, LPC-S
HALI Project

Clinical Programs Committee

Randall Curnow, MD, MBA, FACP, FACHE, FACPE (Chair)
TriHealth

Brooks Daverman, MPP
Tennessee Division of Health Care Finance and Administration

Carol Greenlee, MD
West Slope Endocrinology

Jennifer Gutzmore, MD
CIGNA

Melissa Hogan, MPH
St. Louis Area Business Health Coalition

Jim Knickman, PhD
NYU Langone Medical School

Amy Nguyen Howell, MD, MBA, FAAFP
CAPG

Janet Lee Partridge
United Hospital Fund

Marc Rivo, MD
Population Health Innovations

Nancy Rothman, EdD, RN
Temple University

Julie Schilz, BSN, MBA
Anthem

Xavier Sevilla, MD, FAAP
My Manatee Doctors

Lina Walker, PhD
AARP

Joan Culpepper-Morgan, MD (Liaison)
Harlem Hospital Center; CMSS

Elizabeth Kraft, MD, MHS (Liaison)
NCQA RP-ROC Chair
Anthem Blue Cross of Colorado

Robert E. Ratner, MD, FACP, FACHE (Liaison)
American Diabetes Association

Overview

NCQA's Patient-Centered Medical Home

Patient-centered medical homes (PCMH) transform primary care practices into what patients want: health care that focuses on them and their needs. PCMHs get to know patients in long-term partnerships, rather than through hurried, sporadic visits. They make treatment decisions with their patients, based on patient preference. They help patients become engaged in their own healthy behaviors and health care.

Everyone in the practice—from clinicians to front desk staff—works as a team to coordinate care from other providers and community resources. This maximizes efficiency by ensuring that highly trained clinicians are not performing tasks that can be accomplished by other staff, and helps avoid costly and preventable complications and emergencies through a focus on prevention and managing chronic conditions.

A growing body of evidence documents the many benefits of medical homes, including better quality, patient experience, continuity, prevention and disease management. Studies show lower costs from reduced emergency department (ED) visits and hospital admissions. Studies also show reduced disparities in care and lower rates of provider burnout. PCMHs' power to improve the quality, cost and experience of primary care only sets a foundation for the broad change our health care system needs. Other providers and facilities must build on the PCMH foundation to establish patient-centered care throughout the health care system. This already occurs in patient-centered specialty practices, which help specialists become part of the medical home neighborhood by improving quality and access.

Medical homes are the foundation for a health care system that achieves the "Triple Aim" of better quality, experience and cost. This is the overview to our vision for achieving that goal; it chronicles the PCMH evolution to date, the challenges that lie ahead and potential solutions to those challenges—some already underway, some yet to be developed.

NCQA PCMH Evolution 2003–2014

The American Academy of Pediatrics introduced the medical home concept in 1967. A generation later, in 2004, the specialty of family medicine called for all patients to have a "personal medical home." In 2003, NCQA launched Physician Practice Connections, a PCMH precursor program. In 2007, leading primary care associations released the Joint PCMH Principles. In 2008, NCQA launched the first PCMH Recognition program, with updates to raise the bar in 2011 and 2014. NCQA further advanced its PCMH program with updates through Recognition Redesign. NCQA's PCMH program is the largest, with more than 60,000 clinicians at 12,000 sites as of March 2017—about 18 percent of all primary care clinicians. To earn NCQA Recognition, practices must meet rigorous standards for addressing patient needs; for example, offering access after office hours and on line so patients get care and advice, where and when they need it.

Year	Version	Elements of the Program
2003	Physician Practice Connections (PPC®)	This PCMH precursor recognized use of systematic processes and health IT to: • Know and use patient history. • Follow up with patients and other providers. • Manage patient populations and use evidence-based care. • Employ electronic tools to prevent medical errors.
2008	Physician Practice Connections—Patient-Centered Medical Home (PPC®-PCMH™)	The first PCMH model implemented the Joint Principles, emphasizing: • Ongoing relationship with personal physician. • Team-based care. • Whole-person orientation. • Care coordination and integration. • Focus on quality, safety and enhanced access.
2011	PCMH 2011	• Explicitly incorporated health information technology Meaningful Use criteria. • Added content and examples for pediatric practices on parental decision making, age-appropriate immunizations, teen privacy and other issues. • Added voluntary distinction for practices that participate in the CAHPS PCMH survey of patient experience and submit data to NCQA. • Added content and examples for behavioral healthcare.
2014	PCMH 2014	• More integration of behavioral healthcare. • Additional emphasis on team-based care. • Focus care management for high-need populations. • Encourage involvement of patients and families in QI activities • Alignment of QI activities with the Triple Aim: improved quality, cost and experience of care. • Alignment with health information technology Meaningful Use Stage 2.

Goals for PCMH 2017 and Beyond

NCQA PCMH Recognition is the most widely-used way to transform primary care practices into medical homes. The patient-centered medical home is a way of organizing primary care using teamwork and technology to improve quality and patients' experience of care, and to reduce costs. In 2015, NCQA initiated a process to revamp the PCMH requirements and recognition process called Recognition Redesign. NCQA based the redesign on feedback from practices, policy makers, payers, patients and other stakeholders. The new 2017 PCMH Standards focus on identifying best practices and core activities, signaling that a primary care practice functions as a medical home. Additionally, the new standards promote measurement and improvement at the clinician and practice level. It makes the program more manageable as it continues to concentrate on performance and quality improvement. It also reduces paperwork and increases practice interaction with NCQA.

The recognition process offers:

- **Flexibility.** Practices take the path to recognition that suits their strengths, schedule and goals.
- **Personalized service.** Practices get more interaction with NCQA, and are assigned an NCQA representative who works with them throughout the recognition process and is a consistent point of contact.
- **User-friendly approach**. Requirements remain meaningful, but with simplified reporting and less paperwork.

- **Continuous improvement.** Annual check-ins help practices strengthen as medical homes. By reviewing your progress more often, we keep performance improvement at the top of your priorities list.
- **Alignment with changes in health care.** The program aligns with current public and private initiatives and can adapt to future changes

The underlying principles of PCMH remain the same. Evidence shows that the PCMH model of care can result in reduced costs and healthier and more satisfied patients. Evidence demonstrates that PCMH improves staff satisfaction. The patient-centered, team based approach of PCMH creates deeper connections both between patients and providers as well as between staff members. Improvements in practice infrastructure and personnel also bolsters efficiency and teamwork, creating a sense of ownership and fulfillment. The redesigned process focuses more on performance and quality improvement, and aligns with many other major national initiatives that impact practices, such as MACRA.

***The medical neighborhood*.** Although primary care is the foundation for delivery system transformation, PCMHs cannot change the entire system alone. Data sharing among primary care, specialists, hospitals and other providers is needed to maximize coordination and management. Our current payment system drives greater use of services, especially high-volume services for hospitals and many specialists. Primary-care spending is low and a small share of the total spend on healthcare, compared with other providers, which limits access to capital for information technology and other systems to support outreach, patient engagement and analysis. Other parts of the system must also have strong incentives to change if we are to realize better outcomes.

Patient-centered specialty practices. Specialty-care clinicians provide many services and many patients seek specialists' care directly without primary care consultation. For patients with certain chronic conditions, specialists serve as primary-care providers for extended periods. Creating better ways for information to flow effectively among primary-care clinicians and specialists is critical for care coordination and reducing duplicate care. In 2016, NCQA updated the Patient-Centered Specialty Practice (PCSP) program which recognizes specialists that use systems and processes needed to support patient-centered care, including strong communication with other providers. The updates addressed the needs of self-referred patients, clarified the intent around agreements with and connecting patients to primary care. This program will be aligned with the new recognition redesign process and re-launched in 2018.

MACRA. The Medicare Access and CHIP Reauthorization Act (MACRA) created a new payment program from the Centers for Medicare and Medicaid Services (CMS) that makes patient-centered care the key to success for physicians and other clinicians. It rewards clinicians for quality care through two value-based payment models: The Merit-Based Incentive Payments System (MIPS) and Alternative Payment Models (APMs). MACRA transitions the nation's largest payer—Medicare—to paying for the value of care, instead of the volume. On the MIPS track, clinicians will get bonuses or penalties based on their performance in four measure areas: Quality; Advancing Care Information (formerly Meaningful Use); Improvement Activities; Resource Use Measures. Under the final rule, clinicians in practices that earn NCQA Recognition will automatically get full credit in the Improvement Activities category. Clinicians in NCQA PCMHs & PCSPs will likely do well in all other MIPS categories because of their commitment to high-quality, efficient, patient-centered care coordinated with the help of certified electronic health records

Clinically Integrated Networks. Clinically integrated networks (CIN), such as ACOs, are bringing communities of doctors, hospitals and other providers together to improve outcomes and lower costs. PCMHs provide the solid foundation that these networks must build on to ensure quality and patient-centered care. While CIN/ACOs build on a solid PCMH foundation to coordinate doctors, hospitals, pharmacies, other providers and community resources, there is a shift from the use of defined CIN/ACOs toward broader systems-based models of care. NCQA is exploring how to increase alignment and collaborative strategies between CIN/ACOs. This process includes exploring ways to incorporate measurement and update the evaluation process to align with current industry needs.

Behavioral healthcare. This is critical for better integration, particularly in Medicaid, where many high-cost enrollees have co-morbid behavioral conditions. Unaddressed behavioral conditions can exacerbate physical conditions, which increases disability and cost. NCQA developed a distinction module to provide a special recognition to practices that demonstrate advanced levels of behavioral health integration and focus quality measurement on behavioral health concerns.

***Public health*:** Bringing complementary strengths of public health and primary care together has great potential. Some public health providers—school-based, HIV and community health centers—provide primary care and can be PCMHs. The Health Resources and Services Administration (HRSA) helps community health centers become PCMHs. North Carolina uses public health staff to visit at-risk pregnant women in their homes, to help primary care providers engage these patients and get them better prenatal care. Vermont connects its PCMHs and providers of long-term services and supports, to deliver much-needed information and care coordination to patients. Going forward, it will be critical to help all PCMHs connect with community resources that can also improve health.

Work site, retail and urgent care clinics. In 2015, NCQA launched the Patient-Centered Connected Care program to recognize the role work-site and retail clinics, pharmacies, urgent care and other ancillary care facilities in the care of patients. Work-site clinics increasingly serve as employees' main primary care setting. Retail clinics that treat minor problems in drug stores and other convenient settings are expanding to address wellness, health promotion and chronic care management. Many refer patients back to community primary-care clinicians for follow-up. Pharmacies are also taking on new roles with immunizations, health and wellness screenings, adherence and other medication management services. This program recognizes practices that support clinical integration and communication, creating a roadmap for how sites delivering intermittent or (non-PCMH) outpatient treatment can effectively communicate and connect with primary care and fit into the medical home "neighborhood."

Broad support. Many public- and private-sector initiatives support PCMH transformation. The Department of Health and Human Services is helping hundreds of community health centers and Federally Qualified Health Centers to become PCMHs. The Office of the National Coordinator for Health Information Technology's Regional Extension Centers provide technical assistance to practices. Congress passed legislation to move Medicare beyond demonstration programs in selected states to support PCMHs nationwide, with new payments to reward value and non-face-to-face chronic care management services. In addition, states and private insurers have programs in place to support PCMHs in more than three dozen states.

Attributes for success. There are many paths to becoming a successful PCMH—they do not all look alike and generally consider local circumstances and preferences. NCQA has identified several attributes that contribute to PCMH success:

- Financial assistance, technical assistance, or both, to help create and sustain the transformation. Practices value practical examples and support for meeting requirements, and worry about maintaining their financial viability.
- Organization leadership, a team-based approach, health information technology and delegating self-management education and proactive care reminders to non-physician team members.
- Involving patients and families in practice improvement efforts through advisory committees, ombudsmen or navigators.
- A systems approach to QI that results in data, standard measurements, technical assistance, leadership and personnel.

PCMH Program Update

What's New

The redesigned PCMH requirements focus on assessing a practice's transformation into a medical home and specify goals for improvement. Along with changes to the process of recognition, NCQA has created a new format for articulating the PCMH standards: concepts, competencies and criteria.

- Concepts are the foundation on which a practice builds a medical home.
- Competencies organize the criteria in each concept area.
- Criteria are the individual structures, functions and activities that indicate a practice is operating as a medical home.

Changes to PCMH also include the elimination of recognition levels, points and must-pass elements. To achieve recognition under the new PCMH program, practices must 1) meet all core criteria and 2) earn 25 credits in elective criteria across 5 of 6 concepts. This ensures a minimum set of capabilities and gives practices the flexibility to focus on activities that not only mean the most to their patient population, but are feasible to accomplish with regard to their resources and the resources of their community.

The changes also complement the redesign of the overall program and of the recognition process specifically. Of note is the introduction of a series of virtual reviews to achieve recognition. Rather than coordinating and submitting many documents for evaluation by a reviewer, practices may present evidence of implementation in other ways and "tell the story" of their PCMH transformation. Practices will demonstrate continued PCMH recognition through annual reporting instead of the current program's three-year recognition cycle. Each year, the practice checks in with NCQA to show that its ongoing activities are consistent with the PCMH model of care. The annual check-in includes attesting to certain policies and procedures and submission of key data. This process will sustain the practice's recognition.

The PCMH standards include detailed guidance, evidence requirements and relevant examples to guide practices through their recognition. The PCMH content update was a rigorous process that included significant research; input from an engaged, multi-stakeholder advisory committee and from many others; results of an open public comment period; and surveys of PCMH Certified Content Experts.

Public Comment

We posted the draft standards on the NCQA Web site and solicited comments from a wide group of stakeholders. We received more than 1,300 comments from more than 90 respondents, including health care providers, health plans, consumer groups and government agencies. There was a high degree (nearly 90 percent of comments received) of support for the proposed standards, especially the new program format, flexibility and focus on key features of the medical home.
In addition to the formal public comment period, we received useful suggestions from many others for revisions and changes, which we incorporated into the final version of the standards after review by our multi-stakeholder advisory committee, NCQA's Clinical Programs Committee and the NCQA Board of Directors.

The Standards

The PCMH recognition program's six concepts align with the principles of primary care.

Table 1: Summary of NCQA PCMH Standards

Concept	Brief Concept Description
Team-Based Care and Practice Organization (TC)	The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/caregivers, and organizes and trains staff to work to the top of their license and provide effective team-based care.
Knowing and Managing Your Patients (KM)	The practice uses information about the patients and community it serves to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.
Patient-Centered Access and Continuity (AC)	The practice provides 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team, considers the needs and preferences of the patient population when modeling standards for access.
Care Management and Support (CM)	The practice systematically tracks tests, referrals and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with specialists and other providers in the medical neighborhood.
Care Coordination and Care Transitions (CC)	The practice systematically tracks tests and coordinates care across specialty care, facility-based care and community organizations.
Performance Measurement and Quality Improvement (QI)	The practice establishes a culture of data-driven performance improvement on clinical quality, efficiency and patient experience, and engages staff and patients/families/ caregivers in quality improvement activities.

The Criteria and Credits Toward Recognition

As part of the redesign of PCMH recognition, the new PCMH program removes recognition levels and moves to a single recognition status. The intent of the single level of recognition is to bring a clear meaning to what PCMH recognition represents: transformation into a medical home.

To receive recognition, practices must complete at least 25 Elective credits in addition to the 40 Core criteria. A mix of 1-credit and 2-credit Electives may be completed to meet the Elective minimum. Practices must also select a mix of Elective criteria from at least 5 of the 6 program concepts. Each criterion in the standards is noted with its assigned value (e.g., Core, 1 Credit, 2 Credit).

Optional Distinctions

NCQA offers special acknowledgment for practices that excel in specific areas. Practices may receive distinction in behavioral health integration, reporting of electronic quality measures (eCQMs) or patient experience reporting. These distinctions signify to the public and others how the practices are going above and beyond the standards of the medical home by demonstrating their additional commitment.

Table 2: PCMH Distinction Modules

Distinction Name	Distinction Details
Behavioral Health Integration	The Behavioral Health Integration Module calls for a care team in primary care that can manage the broad needs of patients with behavioral health related conditions. The expectation of this model is integration of behavioral health expertise including staff to enhance the care provided in a primary care setting and to improve access, clinical outcomes and patient satisfaction.
Electronic Quality Measures (eCQM) Reporting	The eCQMs distinction module uses a curated list of 35 electronic clinical quality measures relevant for primary care practices. Practices must submit measures in the industry standard QRDA III format. This program will evolve over the years to include actual performance results demonstrating excellence and/or meaningful improvement. Distinction will be awarded for one year to PCMH practice sites that submit, for each clinician in the practice, at least 6 measures from our list of 35. This approach is consistent with MIPS reporting requirements.
Patient Experience Reporting	NCQA has developed the Distinction in Patient Experience Reporting to gather feedback on patient experiences using HEDIS®[2] specifications for the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS®*[3] 3.0), with or without the PCMH Supplemental Item Set, known by NCQA as the "HEDIS Survey for PCMH." The collection and reporting of data from the HEDIS Survey for PCMH is voluntary.

Resources

For additional references maintains a summary of available PCMH-related evidence on www.NCQA.org.

Perry R, et al. June 24, 2012. Examining the Impact of Continuity of Care on Medicare Payments in the Medical Home Context. Presented at the AcademyHealth Annual Research Meeting, Orlando, FL. http://www.academyhealth.org/files/2012/sunday/perry.pdf

Gabbay, R.A., et al. 2011. Multipayer patient-centered medical home implementation guided by the chronic care model. *Jt Comm J Qual Patient Saf.* 37(6):265-73. http://ww.bailit-health.com/articles/062211_bhp_mpcmhi.pdf

Maeng, D.D., et al. 2011. Can a Patient-Centered Medical Home Lead to Better Patient Outcomes* The Quality Implications of Geisinger's Proven Health Navigator. *Am J Med Qual.* epub ahead of print Aug 18. http://ajm.sagepub.com/content/27/3/210.abstract?patientinform-links=yes&legid=spajm;27/3/210

DeVries, A., et al. 2012. Impact of Medical Homes on Quality Healthcare Utilization and Costs. *AMJC.* http://www.ajmc.com/publications/issue/2012/2012-9-vol18-n9/Impact-of-Medical-Homes-on-Quality-Healthcare-Utilization-and-Costs#sthash.vuXFYJRA.dpuf

Takach, M.. July 2011. Reinventing Medicaid: State Innovations To Qualify And Pay For Patient-Centered Medical Homes Show Promising. *Health Affairs*. http://content.healthaffairs.org/content/30/7/1325.abstract

Harbrecht, M., et al. September 2012. Colorado's Patient-Centered Medical Home Pilot Met Numerous Obstacles, Yet Saw Results Such as Reduced Hospital Admissions. *Health Affairs.* http://content.healthaffairs.org/content/31/9/2010.abstract

Patient Centered Primary Care Collaborative. February 2016 The Patient-Centered Medical Home's Impact on Cost & Quality: Annual Review of Evidence, 2014-2016. https://www.pcpcc.org/sites/default/files/resources/The%20Patient-Centered%20Medical%20Home%27s%20Impact%20on%20Cost%20and%20Quality%2C%20Annual%20Review%20of%20Evidence%2C%202014-2015.pdf

Department of Vermont Health Access/Vermont Blueprint for Health. http://hcr.vermont.gov/sites/hcr/files/pdfs/VTBlueprintforHealthAnnualReport2013.pdf

Berenson, J., et al. May 2012. Achieving Better Quality of Care for Low-Income Populations: The Role of Health Insurance and the Medical Home for Reducing Health Inequities. Commonwealth Fund.

Soman, et al. May 2010. The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction and Less Burnout For Providers. *Health Affairs*.

Jackson, G.L., et al. November 27, 2012. The Patient-Centered Medical Home: A Systematic Review [Internet]. Philadelphia, PA: *Ann Intern Med*. http://annals.org/article.aspx?articleID=1402441

[2]HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[3]CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Institute on Medicine. “Crossing the Quality Chasm: A New Health System for the 21st Century.”
Martin, et al. March/April 2004. The Future of Family Medicine: A Collaborative Project of the Family Medicine Community. *Annals of Family Medicine.* http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf
Rittenhouse, D.R., et al. 2011. Small and medium-size physician practices use few patient-centered medical home processes. *Health Affairs.* 30(8): 1575–84.
United Hospital Fund. July 2013. Advancing Patient-Centered Medical Homes in New York, United Hospital Fund. http://www.uhfnyc.org/assets/1165
Scholle, S.H., et al. May/June 2013. Support and Strategies for Change Among Small Patient-Centered Medical Home Practices. *Ann Fam Med.* 11:S6-S13.
Pham, et al. 2009. Primary Care Physicians' Links to Other Physicians Through Medicare Patients: The Scope of Care Coordination. *Annals of Internal Medicine.*
Mehrotra, A., et al. 2011. Dropping the Baton: Specialty Referrals in the United States. *The Milbank Quarterly.*
Agency for Healthcare Research and Quality. Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanism. http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/ahrq_commissioned_research
Foy, R., et al. 2010. Meta-analysis: effect of interactive communication between collaborating primary care physicians and specialists. *Annals of Internal Medicine.* 152 (4), 247–58.
American College of Physicians. The Patient-Centered Medical Home Neighbor. http://www.acponline.org/advocacy/where_we_stand/policy/pcmh_neighbors.pdf
American College of Physicians. 2010. The Patient-Centered Medical Home Neighbor; The Interface of the Patient-centered Medical Home with Specialty/Subspecialty Practices.
Agency for Healthcare Research and Quality. 2011. Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanisms.
Savage, A.I. 2013. Examining Selected Patient Outcomes and Staff Satisfaction in a Primary Care Clinic at a Military Treatment Facility After Implementation of the Patient-Centered Medical Home. *Mlitary Medicine.* 178, 2:128. http://militarymedicine.amsus.org/doi/pdf/10.7205/MILMED-D-12-00188

Recognition Programs
Policies and Procedures

Section 1: Commit—Recognition Eligibility and Recognition Process

The NCQA Recognition programs are clinical practice site-based evaluations for clinicians and care organizations who provide care to patients as part of the medical neighborhood. Each program evaluates how care is provided to all patients in the practice based on the role of the entity as a medical home/ neighbor.

Definitions

Practice

One or more clinicians (including all eligible primary care clinicians) who practice together and provide patient care at a single geographic location and must include all eligible primary care clinicians at the site. "Practicing together" means that all the clinicians in a practice:

- Follow the same procedures and protocols.
- Have access to (as appropriate) and share medical records (paper and electronic) for all patients treated at the practice site.

Electronic and paper-based systems and procedures support clinical and administrative functions (e.g., scheduling, treating patients, ordering services, prescribing, maintaining medical records and follow-up).

Multi-site group

Three or more primary care practice sites using the same systems and processes, including an electronic medical record system.

Eligibility

Clinicians who qualify for PCMH

- Clinicians who hold a current, unrestricted license as a doctor of medicine (MD), doctor of osteopathy (DO), advanced practice registered nurse (APRN), or physician assistant (PA).
- Only clinicians who can be selected by a patient/family as a personal clinician are eligible to be listed, in addition to the practice Recognition, on NCQA's Web site.
  - The practice can define a "personal clinician" as:
    - A residency group under a supervising clinician or faculty physician (residents are not identified individually for selection as personal clinicians).
    - A combination physician and APRN or PA who share a panel of patients.
- Physicians, APRNs (including nurse practitioners, clinical nurse specialists) and PAs who practice internal medicine, family medicine or pediatrics, with the intention of serving as the personal clinician for their patients.

  These clinicians will be identified individually with the recognized practice.
- Physician-led practices applying with identified APRNs or PAs:
  - Patients may choose the APRN or PA as their primary care clinician, ***or***
  - ARPNs or PAs share a panel of patients as a primary care team with the physician.

Note: *Clinicians who are part of the practice but are not considered personal clinicians (e.g., behavioral healthcare clinicians, dentists, OB/GYNs) will not be identified individually, but their work on behalf of patients can be used to demonstrate the practice meets PCMH criteria.*

Clinicians who do not qualify

- Nonprimary care specialty clinicians and APRNs and PAs who do not have a panel of patients.

Special circumstances

- Practices that do not have a physician with a panel of patients at the site may achieve NCQA Recognition with the following considerations:
  - It is allowed according to the scope of practice determined by state law.
  - Practices are reviewed against the same requirements as physician-led practices.

Note: *Physicians providing oversight of a practice where required by state law do not need to be identified in the practice application unless they actively practice in the site and patients are able to choose them as their primary care clinician.*

Fee Schedule Information

There are three fee schedules.

1. **Single-Site Pricing** applies to practices applying for the first time and for annual recognition thereafter that do not qualify for multi-site pricing.
2. **Multi-Site Group Pricing** applies to practices applying for the first time and for annual recognition thereafter that:
   - Have three or more practice sites operating under the same legal entity.
   - Share an EHR system.
   - Have at least some of the same policies and procedures.
3. **Discounted Partners in Quality Pricing** applies to single or multi-site practices applying for the first time that provide an assigned discount code from a qualifying initiative.

NCQA periodically updates fee schedules on the program Web site and in resources published in the application materials. Survey pricing is determined by the fee schedule in effect when a practice enrolls in PCMH Recognition on Q-PASS. Current PCMH Recognition Pricing is available online at: www.ncqa.org.

Recognition Program Partners in Quality

What is a Partner in Quality?

Entities providing support services without charging a fee for practices seeking NCQA Recognition are acknowledged as NCQA PCMH Recognition Program Partners in Quality for as long as they provide support.

An NCQA Partner in Quality initiative encourages eligible MDs, DOs, nurse practitioners, PAs, practices, members and program participants to achieve NCQA Recognition, by providing additional recognition, learning collaborative support, onsite training, coverage of application fees or other financial rewards. The recognition programs Partners in Quality may support include PCMH, PCSP, PCCC, ACO, DRP and HSRP.

Who can lead an initiative?

Initiatives may be led by a health plan, a coalition of plans, state medical societies, regional extension centers or other government entity, a business coalition, a collaboration of plans and businesses, a professional organization or a nonprofit quality improvement or disease awareness organization.

Some initiatives are funded by grants or legislation and are part of a broader health care strategy. NCQA supports these positive collaborations among clinicians and organizations by offering a discount on recognition fees.

Caveats

- Only eligible clinicians and practices are accepted for evaluation.
- NCQA shares clinician or practice status with the initiative, to the extent authorized by the supported clinician or practice.
- NCQA approves the Recognition Program Partner in Quality's external communications regarding its initiative, to ensure alignment with NCQA policies and procedures.

Discounted recognition fee

NCQA offers a discount to applicants sponsored by NCQA Partners in Quality (health plans, employers and other organizations that provide resources and services to support practices in pursuit of true transformation). Request a discount code from your sponsor organization.

Practices seeking recognition for the first time pay the recognition fee at the time of enrollment. Thereafter, they pay the recognition fee at the time of their annual report date.

Q-PASS Account

Once a practice is eligible and ready, the next step is to enroll in a Recognition Program through the Quality Performance Assessment Support System (Q-PASS). Q-PASS includes a series of dashboards to manage organizations, sites and programs to pursue recognition. Once an organization account is created, the user can enroll one or more affiliated sites in the NCQA PCMH program or other Recognition Programs available in Q-PASS.

A user's email address is their account log-in identification for Q-PASS. Users that access other NCQA systems may already have an account in Q-PASS. If a user does not have an account, they can create one. Both an organization and any individuals working on its behalf, must set up accounts in Q-PASS. A user working with multiple organizations can view all of their organization and practice site dashboards from one log-in. In order to access Q-PASS, all users must sign a license agreement.

Within Q-PASS, users will set up practice sites and multi-site groups providing information on the clinicians associated with each site. For the PCMH program, organizations should only add primary care clinicians (MDs, DOs, NPs, and PAs) that manage a panel of patients to their practice sites. These clinicians will determine the practice's program cost. Residents should not be included.

Currently, only PCMH 2017 is available on Q-PASS. For organizations that previously obtained Recognition for practices, their organization information, including organization and practice site details as well as affiliated clinicians will be available in Q-PASS.

If the organization does not have an existing account, the user will be able to create the organization in Q-PASS. You must have organization details, name, address, telephone, tax ID number and HRSA H-code (if a HRSA grantee) to complete the creation process.

NCQA PCMH Recognition and HIPAA Business Associate Agreements. The legal agreements establish the terms and conditions that clinicians and practices must accept in order to participate in the NCQA PCMH Recognition program. The practice must complete the Agreement for NCQA PCMH Recognition Program and the HIPAA Business Associate Agreement. The practice may also need to complete a legal agreement for optional distinctions. NCQA does not accept edits to its agreements and requires all applicants to participate on the same terms and conditions. If your practice has a statutory conflict with any particular term or provision you can submit evidence of the conflict to NCQA for review and consideration of a waiver or revision. If the user is not authorized to sign agreements for the organization, the user can invite the appropriate individual to sign for the practice. The authorized individual will receive an email asking them to sign the agreements, along with log in information. You cannot continue without signing the legal agreements.

Additional Multi-Site Details

The multi-site application process is an option for organizations or medical groups with three or more practice sites that share an electronic record system and standardized policies and procedures across all practice sites. Practice sites do not all have to submit in Q-PASS at the same time or be the same specialty or size.

The multi-site application process does not allow organization-wide recognition; instead, it relieves eligible organizations from providing repetitive responses and evidence that would be the same for all sites.

Determining Multi-Site Eligibility

Organizations use their recognition account to link sites in Q-PASS for Multi-Site submission.

Practices must answer "yes" to these questions

- Can your organization sign one PCMH program agreement to cover all sites applying for recognition?
- Do all the practice sites applying for recognition share and use in the same way, a practice management system, registry or EHR to document patient care for administration and billing?
- Do all the practice sites applying for recognition operate under at least some of the same policies and procedures?

Introduction to NCQA Representative

NCQA assigns an NCQA Representative to a practice after the practice signs the legal agreements electronically and submits payment through Q-PASS. The NCQA Representative assists the practice to coordinate their schedule, navigate resources and is the liaison between the practice and NCQA. The Representative will schedule an initial call with the practice to introduce themselves, discuss the virtual check-in process and outline a practice's initial PCMH transformation plan. The transformation plan is a recommended pathway through the requirements. The Representative will additionally suggest education and training applicable to the practice.

Section 2: Transform—The Evaluation Process

Transformation Period and NCQA Evaluation

After the introductory call with the NCQA Representative the practice will enter the transform phase demonstrating their progress toward recognition by submitting evidence and data through Q-PASS as well as showing aspects virtually, designed to reduce paperwork and administrative hassles.

The Evaluation

Over the course of the transformation period, each practice or multi-site group will have up to three (3) check-ins that must be completed within a twelve-month period. Practices that exceed the twelve-month period or need additional check-ins to achieve recognition must pay an additional fee to continue.

A check-in is conducted virtually online with an NCQA Evaluator who will evaluate the practice's progress towards recognition and provide immediate personalized feedback. The timing of each check-in is flexible and up to the practice to determine. Prior to each check-in, the practice will gather and prepare evidence. The practice must attach some evidence prior to each virtual check-in session. At each virtual check in session, the practice will share their computer screen with the NCQA Evaluator and discuss evidence and completion of the requirements together.

Practices participating in a Multi-Site submission, must identify within Q-PASS evidence for the requirements that are shared across the practice sites. The remaining requirements are reviewed at the site-specific level.

The NCQA representative monitors the practice's progress over the course of the 12 months to see if the practice is on track.

Upon completion of the final check-in, NCQA's peer review committee, the RP-ROC, will review the evaluation for a final determination of recognition. Once confirmed, the practice is notified of its recognition status.

NCQA will publish the practice and clinicians in the list of Recognized Patient-Centered Medical Homes on NCQA's Web site.

Now the final part of the process, Succeed. Each year, you check in with us and demonstrate that your practice is functioning as patient-centered medical home and is committed to high quality performance. Your Representative will assign your annual reporting date and provide more details about the process when you reach this stage.

Inside the PCMH 2017 Standards

There are six PCMH concepts within the program standards. Each concept is composed of specific criteria to outline the features of the practice's transformation and how NCQA evaluates a practice's ability to function as a patient-centered medical home.

1. Team-Based Care and Practice Organization (TC).
2. Knowing and Managing Your Patients (KM).
3. Patient-Centered Access and Continuity (AC).
4. Care Management and Support (CM).
5. Care Coordination and Care Transitions (CC).
6. Performance Measurement and Quality Improvement (QI).

The Standard's Structure

Concept

A brief title describing the criteria; uses a two-letter abbreviation (XX).

Concept Description

A brief statement of the intent of the concept.

Competency

A brief description of criteria subgroup, organized within the broader concept. This level is used for organization of the criteria into more meaningful groupings. Practices are not scored at this level.

Criteria

A brief statement highlighting PCMH requirements.

This is the scorable aspect of a concept that provides details about performance expectations. NCQA evaluates each completed criterion to determine how well the practice meets the requirements.

Each criterion is allocated a credit value:

- **Core:** Must be completed by all practices seeking recognition
- **Elective:** A selection of additional criteria a practice may choose from to indicate it is functioning as a medical home. Electives will be noted with their credit value.

Of the 100 criteria in PCMH, 40 are Core and 60 are Electives. Refer to *The Scoring Guidelines* below.

Guidance

The guidance provides information to the practice about the intent or expectation of each criterion, how the criterion relates to practice transformation or other criteria, terminology used and aspects of the criterion evaluation process.

When guidance notes inclusion of a goal, source, standard response time, description, or specific detail expected by the criterion, those should appear in the demonstrated evidence. Note if a specific number of examples is expected.

Evidence

Describes the evidence practices must submit to demonstrate performance against specific criteria. The list of evidence in each criterion is not prescriptive, nor does it exclude other potential types of evidence. There may be acceptable alternatives that demonstrate performance either in document form or through the virtual review.

Practices are encouraged to implement and document process-based criteria early in their transformation so the process will be implemented at least 3 months prior to demonstrating implementation and completing the recognition process. Generally, reported data should be no more than 12 months old.

Types of evidence

Practices may use the following types of evidence to demonstrate performance.

1. *Documented process.* Written statements describing the practice's policies and procedures (e.g., protocols, practice guidelines, agreements or other documents describing actual processes or forms [e.g., referral forms, checklists, flow sheets]). The documented process must include a date of implementation and provide practice staff with instructions for following the practice's policies and procedures. Written statements describing the practice's policies and procedures (e.g., protocols or other documents describing actual processes or forms [e.g., referral forms, checklists, flow sheets]). The documented process must include a date of implementation or revision (at least three months prior to submission of the survey tool) and provide practice staff with instructions for following the practice's policies and procedures.

2. *Evidence of implementation.* A means of demonstrating systematic uptake and effective demonstration of required practices, including but limited to:

   a. Reports. Aggregated data with a numerator, denominator and rate; showing evidence of action, including manual and computerized reports the practice produces to measure its performance or data to manage its operations (i.e., list of patients who are due for a visit or test).

   b. Patient records. Actual patient records or registry entries that document an action. A record review is measured using the sample selection process provided by NCQA—instructions for choosing a sample and a log for reviewing records are in the Record Review Workbook.

   c. Materials. Informational materials typically prepared for and made available to patients or clinicians (e.g., clinical guidelines, self-management and educational resources such as brochures, Web sites, videos and pamphlets).

   d. Examples. A sample of the expected submitted by the practice to demonstrate performance of specific criteria.

   e. Screen shots. An image that shows the required criteria on a computer display that's captured by the practice as a means of demonstrating its performance.

   f. Virtual demonstration. Live display of evidence using screen sharing technology during an NCQA check-in session with an Evaluator.

   g. Attestation. A declaration acknowledging and/or validating the implementation of certain criteria.

   h. Electronic Clinical Quality Measures (eCQM). Measurement data submitted through electronic health records (EHR) to NCQA in support of a practice's recognition process. eCQMs may be submitted through and EHR, health information exchanges, qualified clinical data registries (QCDRs) and data analytics companies if they can use the electronic specifications as defined by CMS for ambulatory quality reporting programs.

   i. Transfer Credit. The application of credit towards criteria or facets of a criterion, received for use of a pre-validated HIT vendors.

   j. Surveys. A systematic collection or sampling of data on opinions taken and used for the analysis of some aspect of a population group. One of the most common surveys is the patient satisfaction survey, conducted on a continuous basis to measure performance from the patient's perspective to be used in evaluating the delivery of health care services within medical practices.

   k. Data entered directly in Q-PASS. A practice's response related to required criteria entered in text boxes provided within the survey platform.

   l. Not applicable (NA). Specific criteria or facets of a criterion that may be scored NA if they do not apply to the practice, as determined by NCQA and identified in the guidance where applicable. The NA meets the requirement in a core criteria. A practice may not achieve score for an elective criterion with NA as evidence.

Note

- *Protected health information (PHI), as defined by the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations, must be removed or blocked out from documents submitted to NCQA, unless NCQA requests the information. If NCQA requests an aspect of PHI (e.g., a date of service), include only the minimum information necessary to satisfy the intent of the criteria. Do not include additional patient identifiers as part of the evidence (e.g., a member's chart number or account number).*
- *NCQA does not require (and practices should never submit) evidence with patient names, social security numbers, dates of birth, street addresses, e-mail addresses or telephone numbers.*
- *If the best evidence is a screen shot from a computer the practice uses,* ***only submit de-identified patient data and examples.*** *Create a Word document; cut and paste screen shots to the document; or scan documents and create a PDF. Save Word documents using text boxes to block PHI as read-only. For more information, refer to the definitions of* PHI *and* de-identify *in the Glossary.*
- *During the virtual reviews, NCQA and the practice will use screen sharing. NCQA may see PHI during the virtual check-ins. NCQA does not record the session or download or save files shared during a virtual check-in.*

Recognition Guidelines

Recognition

To receive recognition, practices must complete all Core criteria and at least 25 Elective credits.

A mix of 1-credit and 2-credit Electives may be completed to meet the Elective minimum. Practices must also select Elective criteria from at least 5 of the 6 program concepts.

Calculating the recognition score

Q-PASS confirms all Core criteria are met and adds the value of the Elective criteria met to determine if the minimum score and concept distribution requirement was met.

The NCQA Recognition Program Review Oversight Committee (RP-ROC) reviews findings and makes scoring decisions which generates the practice's results.

RP-ROC members are physicians who have expertise in practice systems and who, as determined by NCQA, have no conflict of interest with the practice.

Certificates

NCQA issues an electronic Recognition Certificate (with the ability to print-on-demand) acknowledging that the practice met the standards.

Duration of status

Recognition status continues indefinitely and is contingent upon the continued submission of annual reporting requirements.

Reporting results

…to the practice

NCQA gives the practice a final decision and access to the final results for each of the criterion.

…to the public

Recognized practices and associated eligible clinicians are added to the Recognition Directory, a list of practices and eligible clinicians on NCQA's Web site (https://reportcards.ncqa.org)

NCQA does not report practices whose status is Not Recognized.

NCQA reserves the right to release and to publish, and authorize others to publish, results of the practice's performance under specific competencies, criteria, and reporting categories, including distinctions.

…to organizations NCQA periodically provides data about enrolled practices and eligible clinicians to organizations that use or reward NCQA Recognition.

Data may include type of recognition program, progress toward achieving recognition, effective dates, practice site address, tax identification number, clinician names, specialties, state, license number and NPI.

Section 3: Succeed—Keeping Your Recognition

Annual Reporting

The practice continues to implement and enhance its PCMH model to improve how it meets the needs of patients. Each year, the practice will show that its ongoing activities are consistent with the PCMH model of care. At the annual check-in, a practice will submit select information, attest to continuing to meet PCMH criteria, and submit key data and documentation that covers six PCMH concept areas as well as special topics. This process will sustain the practice's recognition and is designed to foster continuous improvement. This process exhibits how the practice succeeds in strengthening its transformation, and as a result, patient care.

Practice renewal is one year after earning NCQA recognition. Practices achieving PCMH 2014 Level 3 Recognition will renew on the end date of their current recognition and are eligible to sustain Recognition through the annual reporting process. The annual check-in date is set for one month prior to their recognition anniversary date for the practice submission. For a multi-site group, all associated practices may share the same check-in date. The annual check-in date is based on the date the first practice earned recognition.

Practices will use Q-PASS to confirm or update clinician demographic information and submit evidence that supports meeting requirements annually. Data submission and attestation are all done through Q-PASS and will not require a virtual check-in unless selected for audit. An annual reporting fee is due at the time of submission. NCQA reviews the evidence and notifies practices of their sustained recognition status. Sustained recognition will be based on a practice's overall performance.

If a practice misses their annual check-in, the recognition will be suspended. The practice then has up to three months to pay a reinstatement fee and perform the annual check-in.

During the review process, some practices will be selected for an audit. Practices selected must provide evidence that demonstrate meeting the requirements for which the practice attested. NCQA may conduct audits by e-mail, teleconference, webinar or other electronic means, or onsite review.

If a practice does not pass the audit, the practice will be suspended for three months, which will allow the practice to improve performance or provide additional evidence for requirements. If the requirements are met within the three month window, the recognition continues. If a practice chooses not to update the submission within three months of their annual check-in date, the practice will lose their recognition status. A practice will have the option to restore their Recognition status through an abbreviated Transform process.

Note: *Even though some criteria do not require a practice to submit evidence, practices must be able to produce evidence if selected for audit.*

Reconsideration

Practices may request Reconsideration of any NCQA decision. Practices must submit a formal Reconsideration request to NCQA via email within 30 days after a practice is notified of an adverse decision. The decision receipt date will govern as the start of the 30-day reconsideration request window.

A Reconsideration fee is required in accordance with the fee schedule in effect at the time of the Reconsideration request. The fee schedule can be found on NCQA's website, along with instructions for remitting payment via the Recognition Programs Payment Portal. The portal provides the ability to pay securely online via credit card, and also includes instructions for mailing in a paper check.

For the Reconsideration requests, the practice must describe the reason for requesting the Reconsideration and list criteria for which it requests Reconsideration. Additional evidence may not be submitted.

NCQA refers Reconsideration requests to the Reconsideration Committee, made up of NCQA staff and Review Oversight Committee (RP-ROC) members who were not involved in making the original

Recognition decision and do not have a conflict of interest with the practice. The Reconsideration Committee members review the evidence and make a Reconsideration decision. The Reconsideration Committee's decision is final and is sent to the practice via email. No further right to appeal exists.

NCQA updates a practice's evaluation to reflect the new status, if applicable, and if the Reconsideration results in Recognition, the practice will be considered Recognized and the NCQA Web site and data feeds are updated accordingly.

Applicant Obligations

By submitting the PCMH application to NCQA, the applicant agrees to the following:

- To the best of its knowledge and belief, the information submitted for survey is true, accurate and correct and was obtained using procedures specified in the PCMH Recognition program standards.
- To release the information to NCQA that NCQA deems pertinent.
- To read and agree to abide by the terms and conditions of the NCQA PCMH Recognition program. The terms are established in the signed legal agreements, PCMH Recognition program standards, NCQA's guidelines for advertising PCMH recognition, these policies and procedures, and all other published NCQA policies, procedures and rules governing NCQA's PCMH Recognition program.
- To function in a manner consistent with the Joint Principles for Patient Centered Medical Homes (AAFP, AAP, ACP, AOA, 2007), modified to focus on team-based care led by an eligible clinician operating within the appropriate scope of practice of the state.
- For any clinician identified with the practice's recognition, to notify NCQA within 30 calendar days of receiving notice of a final determination by a state or federal agency with respect to an investigation, request for corrective action, imposition of sanctions or change in licensure or qualification status.
- To notify NCQA of any change in submitted clinicians listed with the practice's recognition. Addition of clinicians under a current recognition is subject to the same approval process and eligibility verification as that used with the initial set of clinicians applying for recognition. Added clinicians must be of the same specialty type as one or more currently recognized clinicians. If they are not, this is considered a separate survey.
- To notify NCQA of any material changes in the structure or operation of the practice, or merger, acquisition or consolidation of the practice, in accordance with these policies.
- To continue to meet the requirements of PCMH Recognition program standards as updated by NCQA, and be prepared to demonstrate such during the period of recognition.

The Audit

NCQA reserves the right to audit a practice that has NCQA Recognition. This will take place during the Succeed phase (annual check-in). Audit validates evidence, procedures and responses of a Q-PASS submission. NCQA audits a sample of practices, either by specific criteria or randomly. Audits may be completed by e-mail, teleconference, webinar or other electronic means, or onsite review.

Practice sites selected for audit are notified and sent instructions. The first level of review is verification of the Q-PASS submission. The practice may be asked to forward copies of the source documents and explanations, to substantiate the information in the Q-PASS submission.

- *If an audit requires a virtual or on-site review,* NCQA conducts the review within 30 calendar days of notifying the practice of its intent to conduct an audit.
- *If audit findings indicate that information submitted by the practice is incorrect or evidence does not meet the PCMH standards,* the application for NCQA Recognition may be denied, credits may be reduced or additional evidence may be required.

NCQA notifies the practice of audit findings and the recognition status within 30 days after conclusion of the audit. Failure to agree to an audit or failure to pass an audit may result in a status of “Not Recognized.”

Section 4: Additional Information

Complaint Review Process

NCQA accepts written complaints from members of the public, including patients, members and practitioners, regarding recognized clinicians and practices. Upon receipt of such a complaint, NCQA will:

1. Review the complaint to determine that the clinician or practice is recognized by NCQA.
2. Determine if the complaint is germane to the recognition held by the clinician or practice.
3. Obtain a release to share the complaint with the clinician or practice, if the complaint involves PHI or quality of care.
4. Forward the complaint to the clinician or practice within 30 calendar days, with a request that the clinician or practice review and respond directly to the individual filing the complaint, and copy NCQA on the response.
5. Review the response from the clinician or practice to determine whether the complaint was handled in accordance with NCQA requirements and whether 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 recognition status.

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)

Discretionary Survey

At its discretion, NCQA may review a practice while a Recognized status is in effect. The purpose of such a review is to validate the appropriateness of an existing Recognition decision.

Structure

Discretionary surveys are targeted to address issues indicating that a practice may not continue to meet the NCQA standards in effect at the time of recognition.

The scope and content of the review are determined by NCQA and may be completed by e-mail, teleconference, Webinar or other electronic means, or done by onsite review. NCQA conducts the discretionary review using the standards in effect at the time of the practice's last submission.

If a discretionary survey requires an on-site review, NCQA conducts the review within 60 calendar days of the notification by NCQA of the intent to conduct a discretionary survey.

Review costs are borne by the practice and correspond to the complexity and scope of the review and NCQA pricing policies in effect at the time of survey.

Change in status

NCQA may suspend the practice's Recognized status pending completion of a discretionary survey. Upon completion of the review and after the RP-ROC's decision, the practice's status may remain the same as it was before notification of the review, or it may change. The practice has the right to Reconsideration of the determination if its Recognized status changes because of the discretionary survey.

Suspension of Recognition

Grounds for suspending a practice's Recognized status pending a Discretionary Survey include, but are not limited, to the following circumstances:

- Facts or allegations suggest an imminent threat to the health and safety of patients.
- Allegations of fraud or other improprieties in information submitted to NCQA to support recognition.
- The practice has been placed in receivership or rehabilitation.
- State, federal or other duly authorized regulatory or judicial action restricts or limits the practice's operations.

A practice's PCMH Recognition status may also be suspended when the practice does not:

- Submit its annual reporting requirements by the annual reporting deadline. The practice's recognition status will be **suspended** if the practice does not submit the annual reporting requirements by the assigned date.
- Satisfy the annual reporting requirements. The practice's recognition status will be **suspended** if it does not meet the annual reporting requirements. The practice will have 30-days from the date it is notified it has not satisfied its annual reporting requirements to resubmit and demonstrate it has met the unsatisfactory annual reporting requirements to reinstate recognition.

Revoking Recognition

NCQA may revoke PCMH recognition in the following circumstances:

- The practice submits false data.
- The practice misrepresents the credentials of a clinician.
- The practice misrepresents its NCQA PCMH Recognition status.
  - When communicating with patients, third-party payers, health plans and others, practices that earn PCMH recognition may represent themselves as having been recognized by NCQA for meeting PCMH standards, but may not characterize themselves as "NCQA approved," "NCQA endorsed" or "NCQA Certified." Mischaracterization or other similarly inappropriate statements are grounds for revocation of status.
- An eligible clinician is suspended or the professional license is revoked.
- The practice has been placed in receivership or rehabilitation and is being liquidated.
- State, federal or other duly authorized regulatory or judicial action restricts or limits the practice's operations.
- NCQA identifies a significant threat to patient safety or care.
- The practice fails to remain in compliance with PCMH standards.
- The practice does not submit annual reporting requirements within 30-days of the annual reporting deadline. After 30 days, the practice's recognition will be suspended.
- The practice does not provide required evidence to maintain Recognition after 60 days, the practice's recognition status will be revoked.

Mergers, Acquisitions and Consolidations

Recognized practices must report to NCQA any merger, change in practice location, acquisition or consolidation activity in which they are involved. NCQA considers the circumstances and determines the need for additional information and for further evaluation.

Revisions to Policies and Procedures

At its sole discretion, NCQA may amend any PCMH policy and procedure. Notice of and information about modifications or amendments are posted publicly on NCQA's Web site 30 calendar days before the effective date of the modification or amendment. Practices that do not agree with policy changes may withdraw from the recognition program, but fees paid to NCQA will not be refunded.

Disclaimer

A recognition decision and the resulting status designation are based on the exercise of NCQA's professional evaluative judgment and the determination of the ROC.

NCQA is not bound by any numerical or quantitative scoring system or other quantitative guidelines or indicators that in its sole discretion it may have used, consulted or issued to assist reviewers and others during the course of the evaluative process.

NOTE

NCQA RECOGNITION DOES NOT CONSTITUTE A WARRANTY OR ANY OTHER REPRESENTATION BY NCQA TO THIRD PARTIES (INCLUDING, BUT NOT LIMITED TO, EMPLOYERS, CONSUMERS OR PATIENTS) REGARDING THE QUALITY OR NATURE OF THE HEALTH CARE SERVICES PROVIDED OR ARRANGED FOR BY THE PRACTICE. THE PROVISION OF MEDICAL CARE IS SOLELY THE RESPONSIBILITY OF THE PRACTICE AND ITS CLINICIANS. RECOGNITION IS NOT A REPLACEMENT FOR THE PRACTICE'S EVALUATION, ASSESSMENT AND MONITORING OF ITS PROGRAMS AND SERVICES.