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

2017 Edition, Version 4 (Effective January 29, 2019)

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Table of Contents

PCMH 2017 Standards

Appendices

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 established a new relationship with practices pursuing recognition.

NCQA convened the PCMH 2017 Advisory Committee, whose 27 members represent practices, medical associations, physician groups, health plans and consumer and employer groups, and consulted its Clinical Programs Committee, a standing multi-stakeholder panel of experts that review and approve NCQA's recognition program requirements, to shape updates to PCMH 2017 with the goal of:

1. Driving achievement of the triple aim.[1]
2. Focusing on outcomes instead of processes.
3. Accommodating a spectrum of practices (e.g., small vs large).
4. Detecting 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.

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

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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 2003–2017

1967 The American Academy of Pediatrics introduced the medical home concept.

2003 NCQA launched Physician Practice Connections, a PCMH precursor program.

2004 Family medicine called for all patients to have a "personal medical home."

2007 Leading primary care associations released the Joint PCMH Principles.

2008 NCQA launched the first PCMH Recognition program,

2011/ 2014 NCQA raised the bar with updates to PCMH Recognition.

2017 NCQA further advanced its PCMH program through Recognition Redesign.

NCQA's PCMH program is the largest, with more than 65,000 clinicians—about 18 percent of all primary care clinicians—at 14,000 sites as of June 2018. 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.

Recognition Redesign and Content Updates

NCQA PCMH Recognition is the most widely-used way to transform primary care practices into medical homes. NCQA's Recognition Redesign was based on feedback from practices, policy makers, payers, patients and other stakeholders. The new recognition process lets NCQA to respond more nimbly to changes in delivery of primary care. The redesign reduces paperwork and increases practice interaction with NCQA, while encouraging improvement in performance and outcomes at the clinician and practice levels. Although the underlying principles of PCMH remain the same, it highlights performance and quality improvement, and aligns with many other major national initiatives that impact practices, such as MACRA.

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 helps them navigate 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 progress more often, we keep performance improvement at the top of the practice's priorities list.
- **Alignment with changes in health care.** The program aligns with current public and private initiatives and can adapt to future changes.

The PCMH Standards focus on identifying best practices and core activities, signaling that a primary care practice functions as a medical home. The PCMH content update was a 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.

Concepts, Competencies, Criteria

In addition to changes to the recognition, NCQA has created a new format for articulating the PCMH standards: *concepts, competencies* and *criteria*.

- **Concepts** are the foundation of the patient-centered practice.
- **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.

Recognition levels, points and must-pass elements have been eliminated.

To achieve recognition under the new PCMH program, practices must:

- Meet all 40 core criteria ***and***
- Earn 25 credits in elective criteria across 5 of 6 concepts. A mix of 1-credit and 2-credit electives may be completed to meet the elective minimum.

This ensures a minimum set of capabilities and gives practices the flexibility to focus on activities that mean the most to their patient population and are feasible to accomplish, with consideration of practice and community resources.

Virtual Review and Annual Reporting

Of note is the introduction of a series of *virtual reviews* to achieve recognition. Rather than coordinating and submitting many documents for evaluation all at once, practices may present evidence of implementation in other ways and "tell the story" of their PCMH transformation.

Practices demonstrate continued PCMH recognition through annual reporting instead of a three-year recognition cycle. Each year, the practice shows NCQA that its ongoing activities are consistent with the PCMH model of care. To sustain recognition, the practice annually attests that it continues to adhere to practice policies and procedures and submits data to NCQA as evidence.

Public Comment

NCQA posted the draft standards on the NCQA website 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 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 its roles and responsibilities to patients/families/caregivers; and organizes and trains staff to work to the top of their license to provide patient-centered care as part of the medical home.
Knowing and Managing Your Patients (KM)	The practice captures and analyzes information about the patients and community it serves, and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.
Patient-Centered Access and Continuity (AC)	The PCMH model expects continuity of care. Patients/families/caregivers have 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team and supported by access to their medical record. The practice considers the needs and preferences of the patient population when establishing and updating standards for access.
Care Management and Support (CM)	The practice identifies patient needs at the individual and population levels to effectively plan, manage and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk.
Care Coordination and Care Transitions (CC)	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.
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.

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.

The Case for Recognition

***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 2019.

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 (APM). 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.

[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).

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 (EHR).

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.

Succeeding as a PCMH

PCMH recognition is the result of true transformation into a high-performing primary care practice. 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.

Resources

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

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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 website.
  - 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

Fee schedules are as follows:

1. **Single-Site Pricing** applies to practices applying for the first time that do not qualify for multi-site pricing. Thereafter, practices pay the annual reporting fee during their annual reporting.
2. **Multi-site Group Pricing** applies to practices applying for the first time that have the features listed below. Thereafter, practices pay the annual reporting fee during their annual check-in. Multi-site group pricing applies to practices that:
   - Have three of 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.
4. **Other Fees** that may be due under the PCMH Recognition program may include requesting a reconsideration or additional check-in, undergoing a Discretionary Audit or adding a new clinician.
   - *Extra Check-in Fee:* Practices that have not achieved recognition after the third check-in or have not completed recognition within the 12-month allotted timeframe can purchase an extra check-in within 30 days. Practices must use their extra check-in within 90 days of purchase.
   - *Reconsideration Fee:* Practices that seek reconsideration of a decision pay a fee to have the evaluation reexamined.
   - *Discretionary Audit Fee:* Practices bear the cost of the Discretionary Audit. The fee corresponds to the complexity and scope of the audit and NCQA pricing policies in effect at the time of evaluation.
   - *New Clinician Fee:* Any addition of clinicians to a current recognition will incur a fee equivalent to the per clinician fees listed in the fee schedule based on the practice's application as single site or multi-site.

NCQA periodically updates fee schedules on the program website and in resources published in the application materials. Evaluation 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 (health plans, employers and other organizations) providing support services without charging a fee for practices seeking NCQA Recognition are

acknowledged as NCQA Recognition Program Partners in Quality for as long as they provide support.

An NCQA Partner in Quality initiative encourages eligible MDs, DOs, APRNs, PAs, practices, members and program participants to achieve NCQA Recognition, by providing additional recognition, learning collaborative support, onsite training, coverage of application fees or financial incentives. The recognition programs supported by Partners in Quality may 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, a 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 initial 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). The discount code entered by the practice during enrollment is provided to eligible practices by the sponsoring organization.

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

Q-PASS Account

Once a practice is eligible and ready, its 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 and programs. Once an organization account is created, one or more affiliated sites can be enrolled in the NCQA PCMH Recognition program or in other recognition programs available in Q-PASS. In order to access Q-PASS, all users must sign a license agreement.

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 organization and program dashboards from one log-in.

Users set up practice sites and multi-site groups and provide information on the clinicians associated with each site. These clinicians determine the practice's program cost. Residents should not be included. Currently, PCMH, NYS PCMH, PCMH PRIME and SBMH are available on Q-PASS. For

organizations that previously obtained recognition for practices, their information, including organization and practice site details and affiliated clinicians, is also 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, practice NPI 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 HIPAA Business Associate Agreement is signed once and can be used for all programs the organization is enrolled in. 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. A practice that has a statutory conflict with any particular term or provision can submit evidence of the conflict to NCQA for review and consideration of a waiver or revision.

A user who is not authorized to sign agreements for an organization can invite the appropriate individual to sign for the practice. The authorized individual will receive an email from NCQA asking them to sign the agreements, along with log in information. Legal agreements must be signed in order to continue the recognition process.

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. Organizations use their recognition account to link sites in Q-PASS for multi-site submission.

Determining Multi-Site Eligibility

Practices must be able to 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?

The NCQA Representative

NCQA assigns an NCQA representative to a practice after the legal agreements are signed electronically and payment is submitted through Q-PASS and received by NCQA. The NCQA representative helps the practice coordinate its schedule and navigate resources, and is the liaison between the practice and NCQA. The representative schedules an initial introductory call with the practice to discuss the virtual check-in process and resources to create an initial PCMH transformation plan—a recommended pathway through the PCMH requirements. The representative also suggests applicable education and training.

Section 2: Transform—The Evaluation Process

Transformation Period and NCQA Evaluation

After the introductory call with the NCQA representative, the practice enters the "transform" phase demonstrating their progress toward recognition by submitting some evidence and data through Q-PASS as well as showing aspects virtually.

The Evaluation

Over the course of the transformation period, each practice or multi-site group will have up to 3 check-ins, each including a virtual review process that must be completed in a 12-month period. The NCQA representative monitors progress over the course of the 12- month period. Practices that exceed the twelve-month period or need additional check-ins to achieve recognition must pay an additional fee. Payments must be received and cleared prior to the additional check-in. Practices may only purchase one additional virtual review session or receive one 90-day time extension.

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 evaluator is an experienced content expert who, as determined by NCQA, has no conflict of interest with the practice.[4] Practices will continue with the same evaluator for each check-in to provide continuity of the practice's review. the timing of each check-in is flexible and up to the practice to determine. Before each check-in, the practice gathers and prepares evidence and uploads it through Q-PASS. At each virtual review session, the practice uses screen sharing technology to provide evidence virtually and answer the evaluator's questions about presubmitted documentation.

Note:

- *Criteria designated as "shareable" in the standards can be shared across organizations with multiple practices. The organization must identify the criteria in Q-PASS for requirements shared across practice sites. The remaining requirements are reviewed at a site-specific level.*
- *NCQA reserves the right to request review of criteria to which a practice has attested or to which transfer credit has been applied.*

Upon completion of the final check-in, the Recognition Program—Review Oversight Committee (RP-ROC), reviews findings, makes final decisions on the criteria that have been evaluated as met and determines recognition. The RP-ROC is an independent review committee composed of physicians external to NCQA who have expertise in practice systems. RP-ROC members only review practices with which they have no conflict of interest as determined by NCQA. The practice is notified of its recognition status after the RP-ROC determination.

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

[4] For NCQA's recognition process, the term "conflict of interest" means any financial or other interest that (1) could significantly impede, or reasonably be thought to impede, the individual's objectivity or (2) could create a significant unfair competitive advantage for any person or organization with which the individual is associated.

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 Recognition Guidelines* below.

Component — The individual parts of a criterion in Q-PASS where evidence is attached or demonstrated virtually.

Guidance — Information about the intent or expectation of each criterion, how the criterion relates to practice transformation or to other criteria, terminology used and aspects of the evaluation process.

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

Evidence — Describes the evidence that must be submitted to demonstrate performance against criteria. The list of evidence in each criterion is not prescriptive and does not exclude

other potential types of evidence. There may be acceptable alternatives that demonstrate performance, either in document form or through the virtual review.
Note: *Practices are encouraged to implement and document process-based criteria early in their transformation, so the process is implemented at least 3 months prior to demonstrating implementation and completing recognition. 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.

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 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. Information typically prepared for and made available to patients or clinicians (e.g., clinical guidelines, self-management and educational resources such as brochures, websites, videos, pamphlets).

   d. Examples. Representative models submitted by the practice to demonstrate performance.

   e. Screenshot. An image of a computer display showing required criteria to demonstrate performance.

   f. Virtual demonstration. A 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 through methods such as a previous NCQA recognition, corporate credit or initiatives like CPC+.

   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. Systematically collecting or sampling data on opinions taken and used for the analysis of some aspect of a population group. For example, a patient satisfaction survey conducted on a continuous basis measures

performance from the patient's perspective to evaluate delivery of care and services.

k. Data entered directly in Q-PASS. Responses entered in text boxes provided in 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 criterion. 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, email 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.*

Using Prevalidated Vendors

Using an NCQA prevalidated HIT solution supports the practice's transformation process by allowing practices to earn automatic transfer credit for some NCQA PCMH criteria. If the practice obtains a Letter of Product Implementation from their vendor and attests that it is using the prevalidated functionality, it can expedite the PCMH recognition process by allowing practices to attest to using their prevalidated HIT solution to meet certain evidence requirements.

NCQA keeps a directory of all prevalidated vendors on its' website and in Q-PASS: (http://www.ncqa.org/programs/recognition/prevalidation-program/vendor-list)

Recognition Guidelines

Recognition	To achieve 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 select elective criteria from at least 5 of the 6 program concepts.
Calculating the recognition score	Q-PASS calculates the number of core criteria that are met and adds the value of the elective criteria met to determine if the minimum score and concept distribution requirement was met.

Certificates

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

Duration of status

The practice is Recognized until its next Anniversary Date, which is based on 12 months from the Recognition decision. Recognition status does not require renewal, but continues indefinitely, contingent upon the continued adherence to the program standards, submission of annual reporting requirements and annual reporting fees.

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 website (https://reportcards.ncqa.org)

NCQA does not report practices that do not achieve NCQA Recognition NCQA reserves the right to report a change in the practice's status.

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.

NCQA also reserves the right to use information collected during evaluations, and to authorize others to use such information in connection with education, information products, decision support tools, and for NCQA's research and development purposes.

Failure to Complete

Practices that have not achieved Recognition after the third check-in or have not completed Recognition within the allotted 12-month time frame can purchase an extra check-in within 30 days. Practices must use their extra check-in within 90 days of purchase.

Practices that decide not to pursue transformation after enrolling or do not make progress on their transformation evaluation within their allotted 12-month period will need to re-enroll and come through the full transformation process, paying the full transform fee.

Section 3: Succeed—Keeping Your Recognition

Annual Reporting

Each year after earning recognition, the practice submits annual reporting requirements to demonstrate that it is committed to high-quality performance and continues to enhance the PCMH model to meet the needs of patients.

At the annual reporting date, a practice attests that it continues to meet PCMH criteria and submits key data and documentation for the six PCMH concept areas, as well as for special topics. This process sustains recognition and is designed to foster continuous improvement, highlighting how the practice strengthens its transformation and, as a result, patient care. An annual reporting fee is due at the time of submission.

Practices use Q-PASS to confirm or update clinician demographic information in addition to data submission and attestation. No virtual review is required unless the practice is selected for audit. Sustained recognition is based on a practice's overall performance. NCQA reviews the evidence and notifies the practice of its recognition status. Annual reporting requirements for a specific period of reporting dates are updated from time to time to reflect updates to the PCMH program.

Annual Reporting Date

The annual reporting date is set one month before a practice's recognition anniversary date. Practices recognized as PCMH 2014 Level 3 renew on the end date of their current recognition and are eligible to sustain Recognition through the annual reporting process.

Note: *All associated practices in a multi-site group typically share the same reporting date. The anniversary date is based on the date the first practice earned recognition. The NCQA representative works with the practice to harmonize the reporting date across all sites, if requested by the practice.*

Recognition is suspended if a practice misses its annual reporting date and does not submit prior to its anniversary date (recognition expiration date). The practice has up to three months from the original reporting date to pay a reinstatement fee and submit the requirements for annual reporting. If the practice does not submit after 90 days of its reporting date, they will have to submit under the accelerated transform process and pay the full transform fees noted in the fee schedule at the time of the submission. Practices that do not submit for annual reporting within 12 months of their original reporting date must come through the full transformation process, paying the full transform fee as though they are a practice seeking recognition for the first time.

The Audit

As part of the "succeed" phase (annual review), a sample of practices will be audited to validate evidence, procedures, attestations and other responses of a Q-PASS submission. NCQA audits a sample of practices, either by specific criteria or at random. Audits may be completed by email, teleconference, webinar or other electronic means, or through 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 practice has 30 days from the time of the notification to correct the findings. If the practice does not correct the findings within 30 days, the application for NCQA Recognition may be denied, credits may be reduced, or additional evidence may be required.
- RP-ROC, reviews audit findings, makes final decisions on the criteria that have been evaluated as met and determines if recognition will continue. RP-ROC members only review practices with which they have no conflict of interest as determined by NCQA. The practice is notified of its recognition status after the RP-ROC determination.

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."

Practices have 30 days from the time of audit findings to correct any deficiencies. If requirements are met within this period, recognition continues. A practice that chooses not to update submission within 30 days of its being notified of the audit findings loses recognition status. Failure to respond or comply with audit process may result in loss of recognition status. The practice has the option to restore recognition status through an abbreviated "transform" process within 12 months of its initial reporting date. After that period, they will be required to submit for the full transformation process as though they were a practice seeking recognition for the first time.

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

Reconsideration

Practices may request Reconsideration of any NCQA decision resulting in a denial. Practices must submit a formal Reconsideration request to NCQA via their NCQA Representative using the "Ask a Question" feature in Q-PASS within 30 days after being 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 Q-PASS, which provides the ability to pay securely online via credit card, and 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 reviews the evidence and makes a Reconsideration decision, which is final and is sent to the practice via email. There is no further right to appeal.

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 website 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 evaluation 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.
- To timely and thoroughly complete notification and reporting obligations as described in the policies and procedures
- To continue to meet the requirements of PCMH Recognition program standards as updated by NCQA, including all criteria that the practice has attested to, virtually demonstrated or submitted, and be prepared to validate during the period of recognition.

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 practices as part of their evaluation 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 evaluation process, the HEDIS measures and determination of NCQA status and level).

How to Report

- **Toll-Free Telephone:**
  - English-speaking USA and Canada: 844-440-0077 (not available from Mexico).
  - Spanish-speaking North America: 800-216-1288 (from Mexico, user must dial 001-800-216-1288).
- Website: https://www.lighthouse-services.com/ncqa
- Email: reports@lighthouse-services.com (must include NCQA's name with the report).
- Fax: 215-689-3885 (must include NCQA's name with the report).

Reportable Events Policy

The organization must notify NCQA, in writing, within 30 calendar days of any Reportable Events as defined under these policies and procedures governing NCQA Recognition or distinction, as may be updated from time to time.

A Reportable Event is defined as:

- 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 for any clinician identified with the practice's recognition.
- Any change in submitted clinicians listed with the practices recognition, including additions. 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, may be considered a separate evaluation. Addition of clinicians to current recognition will incur a fee.
- Any material changes in the structure or operation of the practice, or merger, acquisition or consolidation of the practice in accordance with these policies.
- Filing for bankruptcy under any state or federal bankruptcy law, or initiation of receivership, liquidation or state insurance supervision.

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. This Merger, Acquisition and Consolidation Policy ("MAC Policy") applies to all NCQA Recognized practices. Mergers, acquisitions, consolidations and corporate reorganizations are treated the same under NCQA's MAC Policy. The terms *merge, merged* and *merger* also refer to acquisitions, consolidations and reorganizations. For questions about this NCQA MAC Policy, use the Policy Clarification Support (PCS) system at http://my.ncqa.org.

NCQA examines mergers, acquisitions, consolidations or reorganizations on a case-by-case basis.

At its sole discretion, NCQA may amend this or any other NCQA Recognition Program policy with 90 calendar days' notice before implementation.

Timing of written notice

An NCQA-Recognized organization involved in a merger, acquisition, consolidation or reorganization must submit written notice of such action to NCQA within 30 calendar days following the merger, acquisition, consolidation or reorganization date, or earlier, if possible. Notice can be sent through http://my.ncqa.org or can be sent to the following address:

National Committee for Quality Assurance
1100 13th Street NW, Third Floor
Washington, DC 20005
Attention: Assistant Vice President, Recognition

Although written notice is required after a transaction, NCQA and the practice will discuss in advance the potential impact a pending transaction may have on recognition status and annual reporting date.

When NCQA receives notice of a merger, acquisition or consolidation, it evaluates the transaction's impact on recognition status.

Evaluation After Merger, Acquisition or Consolidation

When NCQA receives notice of a merger, acquisition, consolidation or reorganization (hereafter referred to as a *merger*), it evaluates the transaction's impact on recognition status. Evaluation considers practice data, existing recognition and distinction, expiration dates and criteria scores of recognized practices involved in the transaction. Depending on the results of the review, NCQA may not require an evaluation, may require practices to undergo a full transform evaluation, an accelerated transform evaluation, proceed directly into the succeed (annual reporting) evaluation or another type of evaluation at NCQA's discretion.

If NCQA determines that evaluation is necessary, the review includes all affected practice locations, recognition programs and distinctions the practice may have. The practice bears the cost of an evaluation and impact on any recognition status, in accordance with NCQA pricing policies in effect at the time of the evaluation. The RP-ROC makes the final decision on recognition status.

NCQA Investigation

In response to a Reportable Event or receipt of a complaint, allegation of fraud or misconduct, or other considerations that may pose an imminent threat to patients, NCQA may initiate an investigation. Organizations are required to fully cooperate in any investigation by NCQA of a patient, provider or organizations compliance with NCQA standards and guidelines. Investigation activities and outcomes may include, but are not limited to:

- Request for a review of improvements identified or implemented to improve performance (i.e. Corrective Action Plans) submitted to any state or federal agency.
- Telephone contact for gathering information or clarifying information received.
- Request for submission of documentation or reports to support compliance or monitoring activities.
- Conduct an unannounced survey or require a virtual or onsite Discretionary Audit.

RP-ROC reviews and confirms all revocations. RP-ROC members only review practices with which they have no conflict of interest as determined by NCQA. The practice is notified of its revocation after the RP-ROC determination. NCQA will notify the practice of an allegation and gives the organization an opportunity to respond to allegations within seven business days following notification by NCQA.

Discretionary Audit

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. Reportable events, such as mergers, acquisitions, consolidations and reorganizations, or NCQA investigations could result in a discretionary audit.

Structure

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

The scope and content of the review is determined by NCQA and may be completed by email, teleconference, webinar or other electronic means, or onsite review. NCQA conducts the Discretionary Audit using the standards in effect at the time of the practice's last submission.

If a Discretionary Audit requires onsite review, NCQA conducts the review within 60 calendar days of notification that it intends to conduct a Discretionary Audit.

Change in status	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 evaluation. NCQA may suspend the practice's recognition status pending completion of a Discretionary Audit. Upon completion of the Discretionary Audit and after the RP-ROC's decision, the practice's status may change. The practice has the right to Reconsideration if its status changes because of the Discretionary Audit.

Suspension of Recognition

Grounds for suspension of a practice's Recognized status include, but are not limited, to:

- 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.

Grounds for a practice's lapse in Recognized status include, but are not limited, to:

- The practice did not submit its annual reporting requirements by the annual reporting deadline. If a practice misses its annual reporting date, the practice has up to 90 days to pay a reinstatement fee and submit for annual reporting.
- The practice did not satisfy annual reporting requirements. The practice has 30 days from the date it is notified that it did not satisfy annual reporting requirements to resubmit and demonstrate that it meets reporting requirements to have recognition reinstated.

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 plan, organizations 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's recognition was suspended and does not provide required evidence to maintain Recognition after 90 days.

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 website 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 RP-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.