

The “Medical Neighborhood”  
Advanced Alternative Payment Model  
(AAPM) Proposal

Respectfully submitted by  
The American College of Physicians (ACP)  
and  
The National Committee for Quality  
Assurance (NCQA)

November 2018

# The Medical Neighborhood AAPM Proposal

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## The Medical Neighborhood AAPM Proposal Abstract

**Overview:** The Medical Neighborhood APM is a multi-payer model that focuses on specialists that: a) receive referrals from primary care providers in the Centers for Medicare & Medicaid Services' (CMS') Comprehensive Primary Care Plus (CPC+) model and b) have achieved a set of robust clinical transformation standards such as NCQA's MACRA-recognized Patient-Centered Specialty Practice (PCSP) Recognition Program. The model could be initially pilot tested in a few specialties, then expanded to additional specialties as interest and sufficient high-value, electronically-specified, specialty-specific measures allow.

### **Problems to Solve:**

**1) Poor coordination between primary care clinicians and specialists** to whom they make referrals is well-documented and a significant contributor to poor quality. MACRA-recognized PCSP practices document that they meet rigorous criteria specifically designed to address this problem and promote high quality coordination with primary care clinicians who make referrals to them. PCSP standards also emphasize timely patient and caregiver-focused care management, shared decision-making, continuous quality improvement, and use of certified electronic health records (EHR) technology (CEHRT) to promote interoperability. All these features improve primary-specialty coordination, close gaps in care and improve outcomes.

**2) There are to date few APMs for most types of specialists.** The Medical Neighborhood APM addresses this because it can apply to many specialties.

**Quality:** Quality measurement would mirror CPC+ with a core set of cross-cutting measures and a menu of high-value specialty-specific electronic clinical quality measures (eCQMs). Measures will focus on high-priority domains including utilization, behavioral health, patient-reported outcomes, patient experience, and care coordination (where applicable). ECQMs minimize burden and leverage richer clinical data in EHRs and specialty-specific registries.

**Payment:** All participants would receive a small monthly per beneficiary per month care coordination fee, similar to CPC+ care management fee that would allow practices to invest in enhanced care coordination supports. Participants would be eligible for a performance-based incentive payment based on performance on quality and utilization metrics. Practices in Track 1 would bill Medicare fee-for-service as usual. Practices in Track 2 would elect a reduction in their Medicare FFS payments in exchange for prospective quarterly comprehensive specialty care payments based on projected spending.

**Scalability:** The MNM model is easily scalable. It could be pilot tested in one or two CPC+ regions and/or one or two specialties and evaluated, then be scaled nationally or to new specialties. One CPC+ state has expressed interest in participating, as has a large health system in a second CPC+ state. The American Academy of Neurology is interested in participating and has sufficient eCQMs, financial modeling for 90-day payment bundles, and a MACRA-approved registry. Other specialties have expressed interest in future participation.

# Medical Neighborhood Model (MNM) Pilot Proposal

## I. Outline

### 1. Model Description

The American College of Physicians (ACP) and National Committee for Quality Assurance (NCQA) propose the “Medical Neighborhood” Advanced Alternative Payment Model (AAPM). Our goal is to connect CMS’ Comprehensive Primary Care Plus (CPC+) practices to high-functioning specialty practices that meet rigorous clinical transformation and care coordination criteria comparable to the Transforming Clinical Practice Initiative and MIPS-eligible Patient-Centered Specialty Practices (PCSPs) to improve care, appropriately reduce costs, and promote seamless care for patients. Medical Neighborhoods build on the strong foundations of CPC+ to improve primary/specialty clinician coordination on patient referrals.<sup>1 2</sup> This proposal aligns with CPC+ and can be further adjusted based on the updates for CPC+ we understand CMS is now developing. [NCQA's PCSP program](#) complements [NCQA's PCMH program](#), which is now significantly aligned with CPC+.

### 2. Background and Model Overview

**Problem to Solve:** This proposal addresses two challenges.

The first is poor communication between primary care clinicians and the specialists to whom they make referrals. The Medical Neighborhood Model (MNM) promotes meaningful collaboration between primary care clinicians and specialists, which is critical because visits to specialists constitute more than half of all outpatient visits,<sup>3</sup> primary care clinicians typically coordinate with 229 physicians in 117 practices,<sup>4</sup> and Medicare beneficiaries see on average seven different physicians each year.<sup>5</sup>

Yet poor coordination on referrals is common. Primary care clinicians report sending referral information to specialists 69.3% of the time but specialists report receiving it just 34.8% of the time, while specialists report sending reports back 80.6% of the time but primary care clinicians report receiving them only 62.2% of the time.<sup>6</sup> Up to 50% of physicians do not know if patients actually see specialists to which they make referrals.<sup>7</sup> Research suggests that a standard structure

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<sup>1</sup> [The Patient-Centered Medical Home Neighbor](#), American College of Physicians, 2010.

<sup>2</sup> [Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanism](#), AHRQ, 2011.

<sup>3</sup> [Expenses for Office-Based Physician Visits by Specialty](#), 2004, Machlin et al, AHRQ, 2007

<sup>4</sup> [Primary Care Physicians' Links to Other Physicians Through Medicare Patients: The Scope of Care Coordination](#), Pham et al. al., Annals of Internal Medicine 2009

<sup>5</sup> [Chronic Conditions: Making the Case for Ongoing Care Partnership for Solutions](#), Partnership for Solutions, Johns Hopkins Univ. 2002.

<sup>6</sup> [Referral and Consultation Communication Between Primary Care and Specialist Physicians](#), O'Malley et al, Archives of Internal Medicine, 2011.

<sup>7</sup> [Dropping the Baton: Specialty Referrals in the United States](#), Mehrotra et al, Milbank Quarterly, 2011.

and guidelines for specialty-primary care coordination could have as much or more return-on-investment as better clinical care.<sup>8</sup>

MNM standards would directly address these primary-specialty communication gaps that harm quality. To earn PCSP Recognition, practices must document that they meet specific consensus-based standards for high-quality patient-centered care through streamlined referral and care coordination. The standards emphasize timely patient and caregiver-focused care management, shared decision-making, continuous quality improvement, and use of CEHRT to promote interoperability. All these features improve primary-specialty coordination, help close gaps in care and lead to better health outcomes.

This proposal addresses an important second challenge which is the limited number of specialty-focused APMs. Initially, the model focuses on specialties with a sufficient number of high-value electronic clinical quality measures (eCQMs) from the Quality Payment Program and/or appropriate specialty-oriented Qualified Clinical Data Registries. The approach can easily expand to additional specialties as more high-value eCQMs become available for additional specialties.

**Quality:** This proposal improves quality by closing communication gaps and strengthening primary and specialty physician collaboration through application of the PCSP program and alignment with key aspects of the CPC+ and PCMH models of care. We recommend use of metrics that align with CPC+ including cross-cutting, utilization, and patient-reported outcomes measures that also meet ACP criteria for valid performance measures. We believe that the use eCQMs collected from electronic health records and registries such as ACP's [Genesis Registry](#) will help minimize burden of reporting. As with CPC+, we would risk adjust results using HCC risk score quartiles.

**Payment and Incentives:** The payment model emulates CPC+. All participants would receive a small monthly care coordination fee in addition to a performance-based incentive payment that would be adjusted retroactively each year based on financial and quality performance. A lower risk track would operate on a normal fee for service (FFS) basis with opportunities for small incentives based on strong quality, cost and utilization performance, while a higher-risk track would feature greater financial incentives and quarterly prospective population based payments in exchange for reduced FFS pay. CMS could also extend regulatory waivers as non-financial incentives as it does with other Advanced APMs including CPC+ because participants would be held accountable for cost and quality.

### *3. How the model would work from the patient's perspective*

A MNM would promote much-needed, high-quality collaboration between primary care clinicians and the specialists to whom they refer patients, reducing gaps in coordination and communication that could directly harm patients. MNM practices would be expected to meet rigorous standards to pre-screen visits to ensure clarity around the reason for the referral, address any outstanding clinical questions related to the transfer, and ensure the receipt of necessary

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<sup>8</sup> [Meta-Analysis: Effect of Interactive Communication Between Collaborating Primary Care Physicians and Specialists](#). Foy et al, Annals of Internal Medicine, 2010.

supporting information including any test results. These steps help to ensure that the patient is seen by the most appropriate specialty care clinician in the most appropriate time frame, which in turn enables specialty practice staff to prioritize urgent cases, eliminate duplicative testing, and reduce wait times, particularly for the most at-risk patients. All this ultimately leads to better patient outcomes and an improved experience for patients and their families.

*4. How the model would work from eligible professionals, patient's primary care provider, and other providers' perspective*

Specialists participating in the model would be required to meet a set of robust clinical transformation standards similar to those used in specialty practice certification programs such as NCQA PCSP. We recommend using specialty practice certification programs that are eligible for use in MIPS and include validation of practice transformation activities. Such standards require specialists to pre-screen incoming patient referrals and close referral loops and better communicate with referring primary care clinicians. We believe participants will immediately see the positive impact this will have on patient outcomes and experience. In addition, participating clinicians would benefit from care coordination fees and optional prospective comprehensive specialty care payments that would provide them with the advanced funds necessary to invest in additional care coordination staff, technologies, or deploy other practice improvements to further improve care coordination and patient quality outcomes, which would be further incentivized by the prospect of performance-based incentive payments.

CPC+ clinicians who refer patients to MNM participants would benefit from better communication and coordination with the specialist, which results in improved patient experience and outcomes that in turn boosts performance scores for CPC+ clinicians. In addition, PCP+ referring clinicians could benefit from reimbursements for electronic consultation services that are incorporated into this model, explained in more detail in the payment methodology section.

## II. Response to Criteria

### 1. *Scope (High Priority Criterion\*)*

#### Relevant to Physicians:

The model expands the APM portfolio for specialties that currently have limited opportunities for APM participation and is easily scalable. The MNM could be piloted in a limited number of CPC+ locations or for a select number of specialties and eventually expanded to numerous specialties and locations. As part of a “Phase 2” CMS could consider expanding the model beyond CPC+ referrals. Initially, this model could apply to a few select specialties for which there are a sufficient number of high-value eQMs, a MACRA-approved registry. We recognize that a population-based model may be more appropriate for some specialties that typically treat chronic conditions and/or have more consistent patient populations than others, such as gastroenterology and rheumatology. We have had productive conversations with the American Academy of Neurology, which meets these criteria. Eventually, it could be scaled to any number of specialties that meet this criteria. A number of other specialties have expressed interest in participating in this model should it move forward. The MNM would build on the current CPC+ model, which currently has 2,932 primary care practices and over 12,370 practitioners participating in 18 geographic regions with 61 aligned payers. We have tentative interest from a current CPC+ state and one large health system in a second CPC+ state. Patient population for the initial pilot would be a subset of patients in CPC+ sites referred to a PCSP clinicians in selected specialties. If successful, the model could expand to a much larger patient population in multiple sites and specialties with expansion of CPC+, eQMs, registries and population based payments models.

NCQA has 2,269 unique clinicians at 424 Recognized PCSP sites. However, with AAPM rewards and development of high-value eQMs that allow for expansion of this AAPM to additional specialties, we expect interest to parallel that of NCQA’s growing Patient-Centered Medical Home program, which now has 65,604 clinicians – including approximately 20% of all primary care physicians – at 14,724 sites. The PCSP designation has support from several public and private payers. Private payers support PCSP through myriad ways including training, technical assistance, care management infrastructure, and a variety of incentive payment mechanisms. Blue Cross Blue Shield North Carolina, through their Blue Quality Physician Program, increases reimbursements for E&M codes for providers who achieve PCSP recognition. Other private payers, such as University of Pittsburgh Medical Center Health Plan and Anthem Blue Cross demonstrated reductions in overutilization, enhanced access to care, and improved care coordination with PCSPs.

The majority of current PCSPs are small practices, with an average of just less than 4.5 clinicians per practice site. Practices participating in the program would have standard PCSP fees waived to further facilitate participation by small practices. Cost of reporting eQMs via registries vary by EHR vendor but are not expected to significantly prevent small practice participation. For

example, ACP's Genesis Registry costs \$299-\$699 per physician per year. NCQA's QPASS system that will accept Quality Reporting Document Architecture (QRDA) files could be an alternative for practices with EHR vendors lacking registry interfaces. One-time integration fees may apply for some EHRs, although we would not charge fees to participants during the initial piloting phase of the model.

The payment model would be the same for employed and independent clinicians.

Participation would be based on physical practice site similar to CPC+, e.g. "the single 'brick and mortar' physical location where patients are seen, which engages the entire team of both clinical and non-clinical staff in the outcomes of the model.

#### Relevant to Patient Populations:

Every aspect of the MNM was designed to ensure that patients receive better care. Patients in our model would receive superior access to care or clinical advice whenever they need it due to expanded access standards. Our standards outline expectations that practices pre-screen appointments for medical necessity, adequate information, and urgency to prioritize the most at-risk patients, have available same day appointments, offer timely after-hours clinical advice, provide electronic access to medical record, and ensure culturally and linguistically appropriate team-based care. Participants collaborate with patients and their families to develop care plans, identify gaps in care or barriers to treatment, and connect with nonmedical community support services.

The MNM also heavily emphasizes coordination with primary care clinicians to co-manage patients and ensure a timely exchange of information, including tracking referrals and follow ups, sharing summaries of care, and tracking and sharing lab results, as well as entering this information electronically in the patient's medical record. MNM participants must have specified and systematic methods of identifying patients who have experienced acute incidents, exchange clinical information with admitting hospitals, obtain discharge summaries, and send electronic summaries of care to other facilities following transitions. This is critical in order to close gaps and eliminate fragmentation across settings. Ultimately, these interventions drive better patient outcomes, including better experience of care, improved quality (leading to better health), and reduced costs.

Poor care coordination greatly contributes to gaps in care, inappropriate care, and medical errors--all of which increase spending while harming patients. Currently, 25-50% of referring physicians do not know if patients see specialists to whom they made referrals.<sup>9</sup> PCPs report sending history and reasons for referral to specialists nearly 70% of the time, yet specialists report receiving this information only about 35% of the time. Conversely, specialists report sending consult notice and patient advice to PCPs 80% of the time, but PCPs report receiving

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<sup>9</sup> Dropping the Baton: Specialty Referrals in the United States, Mehrotra, A., Forrest, C.B., Lin, C.Y. 2011, Milbank Quarterly



such information just 62% of the time.<sup>10</sup> The average Medicare beneficiary sees seven different physicians and fills upwards of 20 prescriptions per year.

The National Quality Forum has said that “Care coordination is essential to reducing medical errors, wasteful spending, and unnecessary pain and procedures for patients.” Peer-reviewed literature suggests that its emphasis on enhanced access, team-based care management and coordination, and whole person comprehensive care improves quality and reduces costs. There also is substantial evidence that poor coordination between specialists and primary care clinicians can adversely affect patient quality, which leads to increased spending.

## 2. *Quality and Cost (High Priority Criterion)*

The model improves quality and decreases cost by targeting primary-specialty care coordination gaps that harm quality and increase cost by causing avoidable complications.

### Quality

The MDM model attacks quality assessment and improvement from several angles to not only ensure patients are protected and receiving the services they need but also to maximize incentives to not only maintain but improve the quality of care delivered.

Acceptance to the model would be contingent on certification of proven clinical practice transformations, such as NCQA’s rigorous PCSP designation. Under proposed criteria for this model explained in more detail in Appendix II, participants must demonstrate that they:

- Maintain referral agreements and care plans with primary care practices.
- Communicate timely information helps practices agree on a plan for coordinating and sharing care management for patient referrals.
- Provide superior access to care when patients need it, including electronically and via same-day appointments when necessary.
- Use systems to support tracking patients over time and across clinical encounters, including tracking and following up on specialist-to-specialist referrals, with a focus on chronic conditions.
- Provide patient-centered care that includes the patient (and family or caregiver, if appropriate) in planning and goal setting.

Another feature of this model is the required pre-consultation that would be expected when a referral from any CPC+ practice is received. Before a patient is even seen by the practice, the referral explanation and any supporting documentation will be reviewed to ensure that the specialty practice has all of the necessary supporting documentation including any test results

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<sup>10</sup> Referral and Consultation Communication between Primary Care and Specialist Physicians: Finding Common Ground, O’Malley, A.S., Reschovsky, J.D. 2011 Arch Intern Med

from the referring practice, and is confident that scheduling an appointment would be the most appropriate next step in a patient's treatment plan. If the specialty practice feels that referring the patient to a different specialty provider, implementing a patient self-monitoring protocol, or that the referral was inappropriate for another reason and should be referred back to the primary care clinician, they will perform an e-consultation with the referring primary care practice to agree on a course of action. This screening process helps to reduce unnecessary testing and appointments, which both frees practices to see more urgent patients sooner and ensures a patient's treatment is not unnecessarily delayed, leading to improved patient outcomes.

High-impact specialty-specific eQMs and registry measures will also enable CMS to monitor and reward ongoing improvements in quality of care delivery over the course of the model. Quality performance will be based on a number of metrics including: 1) utilization measures calculated from claims data, 2) patient-reported outcomes measures, 3) patient experience measures, and 4) eQMs. Two to three cross-cutting, care-coordination focused eQMs would be required of all model participants. Participants would then report up to three additional measures from a list of approved menu measures relevant to their [specialty, including condition-specific measures](#). Similar to CPC+, participants would be expected to meet minimum quality standards to share in any performance-based incentive payments, then would receive an increasing proportion relevant to their score on quality and utilization metrics. More research would be needed to determine appropriate "floors" for our specialty-focused measures, but it would likely be similar to CPC+, which is the thirtieth percentile of national performance rates for all quality measures, and the fiftieth percentile (national average) for all utilization measures.

A list of proposed measures in Appendix I have been vetted by ACP for statistical and clinical validity using the ACP criteria for reviewing performance measures across multiple high-value domains including specialty-specific, behavioral health; patient-reported outcomes, cross-cutting; and care coordination, where applicable. This list of measures is intended to serve as a starting point; ACP and NCQA believe a collaborative process to develop a robust set of available eQm measures for a range of participating specialties with CMS and other specialty societies would be instrumental to developing accurate and comprehensive quality measurement for this model. However, it is important that all measures be carefully evaluated for statistical validity and reliability according to rigorous criteria such as ACP's measure review criteria. Aligning measures with MIPS when possible would also help to ensure the model meets the criterion of an Advanced APM for comparable quality measurement and would also support evaluation of the model against comparable, non-participating practices if specialty practices report the same quality measures through MIPS.

ACP could pilot any new measures developed or adapted for the purposes of this model on our *Genesis QCDR*. This could help to facilitate the development and testing of novel measures in key strategic areas such as social determinants of health, tracking outcomes across the continuum of care, or assessing progress in patient-directed, goal-oriented care and help to facilitate participation by new specialties in the model. We would also support and encourage other specialty societies to submit their own measures to be used for the model. Measures under testing

would be evaluated on a pay-for-reporting basis. Additionally, we recommend that CMS expand the CPC+ Web Interface to include and accommodate relevant subspecialty measures. This interface would provide an inexpensive option for practices to synthesize and report data to CMS and receive feedback about performance, which would help to facilitate higher participation rates in the model, particularly for small and rural specialty practices with more limited financial resources to purchase specialty-specific EHR registry products. We also encourage CMS to open up the existing CPC+ dashboard to MNM participants to facilitate communication between MNM participants themselves about their experience in the model, to communicate with the CPC+ clinicians with whom they work with to coordinate patient care, and to communicate with CMS directly regarding critical program information including access to performance feedback. This portal could also be used as another way to report quality data.

### Cost

Cost will be evaluated by retrospectively reconciling actual spending against expected spending, i.e. a benchmark that is based on the practice's historic spending and trended forward based on regional growth rates. Further, utilization measures will help to measure not only improved patient outcomes, but system-wide savings generated by reducing unnecessary emergency department admissions and other downstream system costs.

Assessments of PCSP on cost or quality are ongoing and NCQA will be pleased to share the results when they are available. PCMH studies document positive cost and quality results when paired with financial or other incentives for improvement. As is typical with system-wide quality improvement initiatives, it took most PCSPs three years to begin to realize cost savings, so CMS should consider this when evaluating the program. The Urban Institute estimated that efforts to improve care coordination for the chronically ill or disabled could save the federal government \$252 billion over a decade. The bulk of these savings would be for people dually eligible for Medicare and Medicaid.

### Program Evaluation

Once the model is scaled and implemented by CMS, we would recommend a third-party review of the model's impact on spending and quality of care, similar to the current CPC+ program. Mathematica performed the most recent annual report of the CPC+ Program.<sup>11</sup>

### Program Integrity

For initial recognition, participants must document that they have met rigorous clinical transformation standards for at least 90 days, then document that they continue to meet program standards on an annual basis. CMS could also conduct audits on a random sample of practice submissions, as they do with CPC+.

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<sup>11</sup> <https://www.mathematica-mpr.com/download-media?MediaItemId=%7B21687631-05DF-4855-9D4C-0EC3810B8CDB%7D>

Consistent with CPC+ monitoring protocols,<sup>12</sup> the following additional monitoring tactics would be deployed for the MNM:

- (1) Annual submission of program integrity data;
- (2) Quarterly attestations of care delivery achievements;
- (3) Quarterly “flag reports;”
- (4) Bi-annual submissions of revenue and expense data;
- (5) Annual review of cost, utilization, patient experience and quality data; and
- (6) Audits on an ad hoc basis, as necessary.

ACP members participating in CPC+ report that the level of monitoring strikes the appropriate balance in that it is rigorous enough to ensure program integrity standards are being met, but is not unduly burdensome for participants.

### Spillover Effects

Like CPC+, the MNM would be a multi-payer model with similar payment incentives across all participating payers to align incentives across multiple patient populations. As with CPC+, we would expect some positive spillover impact on patients covered by non-participating payers, as the care coordination payments could be used to fund practice-wide transformations that would not be limited to patients covered by insurers that are formally participating in the model.

### *3. Payment Methodology (High Priority Criterion)*

Specialty referrals play a critical role in patient care. Without adequate infrastructure, the referral processes between primary care and specialty care can contribute to unnecessary costs and worse outcomes. Patients arrive at their specialty referral appointment only to find out:

- Their condition or health status did not rise to the level of warranting a visit with a specialist at this time and additional monitoring or ongoing co-monitoring is recommended;
- The specialist does not have the necessary information or test results and must either re-order tests or consult the referring PCP, which requires a follow-up visit in either case;
- The condition could be more appropriately treated with medication, virtual advice, or another type of non-face-to-face intervention; or
- The patient needs to see a different type of specialist or sub-specialist.

Specialist visits that could have been more appropriately resolved out of the office wastes time and money for everyone. Poor communication leads to frustration and dissatisfaction for clinicians, but the patients ultimately pay the largest price, with worse outcomes and wasted time and money.

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<sup>12</sup> <https://innovation.cms.gov/Files/x/cpcplus-rfa.pdf> (page 28)

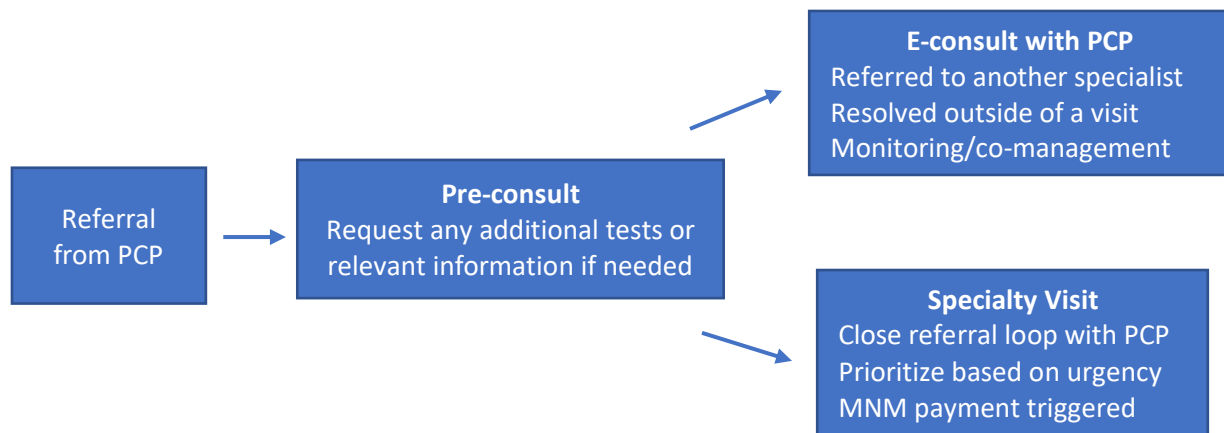
The MNM features three critical infrastructure elements to minimize waste and maximize efficient and effective referrals to reduce spending and ensure the integrity of this payment model. The model addresses patient selection issues by setting clear criteria for visits that would prevent participants from purposefully selecting disproportionately low-risk patients:

1. **Pre-Consultation Review:** Review every referral request based on clearly defined criteria that determine whether a visit with this specialty is the most effective and clinically appropriate next step for the patient. Specialty practice staff will request more information if necessary and either schedule an appointment or electronically consult with the referring primary care clinician if they believe another course of action would be more appropriate.
2. **Appointment tracking and ranking system to prioritize urgent cases:** Institute referral tracking and triage to prioritize the most urgent conditions and to ensure that the referral loop is closed on each and every referral.
3. **Care Coordination Agreements (CCAs):** Define expectations for bilateral communication and information exchange between specialists and referring primary care clinicians to improve the accuracy and efficiency of information transmitted during referrals, as recommended in ACP's [high-value care coordination toolkit](#).

#### Screening Referrals:

Referral requests that do not require a face-to-face visit that should be directed to another specialist, or can be addressed without an appointment are communicated back the CPC+ practice by means of an e-consultation paid at the FFS rate to the specialist and primary care clinician. These patients would not be attributed to the MNM. The electronic consultation (econsult) would consist of communication between the CPC+ practice and the MNM practice via the EHR, phone, or other viable electronic communication options over a seven-day window that begins once the specialist reviews the CPC+ generated inquiry. The econsult may include diagnosing and clarifying the extent of the patient's condition, obtaining and reviewing additional records, suggesting management options, communicating with other professionals and clinical staff involved in the patient's care team, and responding to clinical questions from the referring PCP or others. If the patient is subsequently seen by the specialist within seven days, the econsult would not be separately reimbursable.

For one ACP member practice that deployed appropriate referral criteria by means of a care coordination agreement, receipt of a clinical question increased from 0 to 75% and receipt of adequate supporting data increased from 30 to 60% within about six months and continued to improve. The percentage of patients with insufficient information at their referral appointment declined from 70% to less than 5%, which allowed the practice to essentially eliminate duplicate testing and the associated follow-up appointments, saving costs. By receiving more complete referral information and utilizing pre-consultation review, the practice reduced inappropriate referrals from 20% to near 0%, saving those patients time and money and allowing the practice to reduce wait times by more than two months and see more urgent cases sooner. These changes allow for improved patient outcomes and saving downstream system costs by avoiding unnecessary emergency room visits.



Beneficiary Attribution:

Only qualifying patients referred by CPC+ participating primary care clinicians that are deemed to have an appropriate referral and have an office visit billed through the participating MDM specialist will be attributed to the specialty practice and qualify for payment under the model. Pre-consultation review referrals that do not meet the appropriate referral criteria, are communicated back the CPC+ practice by means of an e-consultation and paid at the FFS rate and not attributed into the MNM. Beneficiary attribution would occur on a quarterly basis to align with performance-based incentive payments.

Payment Structure:

The MNM blended payment structure would incentivize the delivery of high-quality, coordinated care with a focus on cost reduction across settings.

All MNM participants would receive:

1. **Care Coordination Fee (CCF):** All participating practices would receive a non-visit-based CCF paid per-beneficiary-per month (PBPM) on all patient visits originating from referrals from CPC+ practices. This fee should be calculated and paid on a monthly basis (or at least quarterly, as is the case with CPC+) and should be without risk to the physician and free of patient-cost sharing, as is the case with CPC+. The amount would be risk-adjusted for each practice to account for the intensity of care management services required for the practice’s specific patient population. Track 2 participating practices would receive a higher CCF in return for accepting more downside risk. The amount of the care management fee would be determined by: (1) the number of beneficiaries referred to a given practice per month; (2) the case mix of the attributed beneficiary population; and (3) the track to which the practice belongs.
2. **Performance-Based Incentive Payment (PBIP):** MNM would pay a PBIP based on how well a practice performs on quality and utilization measures, each weighted equally. As in the CPC+ model, success would be measured by assessments of cost-effective care relative to benchmarks based on a practice’s historic spending that are trended forward based on regional spending and performance on quality and utilization measures based on national benchmarks. For quality, the MNM entity would have to first meet the minimum quality

expectations to share in any of the PBIP. Once the minimum is met, the entity would become eligible to keep an increasingly larger proportion of the PBIP based on their percentile scores. For the utilization component, the entity would similarly have to meet a performance floor, and thereafter would share in an increasing proportion of the PBIP based on their utilization score. MNM entities that meet or exceed benchmarks would retain their full incentive payments. Failure to meet agreed upon benchmarks would involve the MNM entity repaying all or part of their incentive payments (depending on the level of performance) and the potential of being excluded from the model.

Similar to CPC+, MNM participants would choose between one of two risk tracks:

**Track 1:** Practices would receive the CCF, PBIP and continue to bill and receive Medicare FFS payment. PBIPs would be retroactively reconciled based on cost and quality performance.

**Track 2:** Practices would also receive the CCF, PBIP and continue to bill as usual, but the FFS payment will be reduced to account for CMS shifting a portion of Medicare FFS payments into prospective quarterly Comprehensive Specialty Care Payments (CSCP), as explained below. In addition, Track 2 practices could receive higher care coordination fees and PBIPs, which they would be expected to invest back into enhanced care coordination activities.

**Comprehensive Specialty Care Payment (CSCP):** Track 2 participants would be paid a prospective CSCP in a lump sum on a quarterly basis based on 25% of anticipated FFS costs for that quarter. Track 2 practices would then have their FFS payments reduced to 75% when services are actually provided. Anticipated costs would be based on historical costs over a 24 month period with a 10% increase to account for providing more comprehensive coordination services.

MNM Payment Summary

Track	Care Coordination Fee (CCF)	Performance-Based Incentive Payment (PBIP)	Medicare Physician Fee Schedule	Comprehensive Specialty Care Payment (CSCP)
1	Average per beneficiary per month (PBPM) fee to support enhanced care coordination supports	PBPM payment that is retroactively reconciled based on performance on quality and utilization metrics	Regular FFS	none
2	Average PBPM fee, with an additional increased PBPM tier to support patients with complex needs	PBPM that is retroactively reconciled based on performance on quality and utilization metrics	Hybrid payment featuring reduced FFS payments and a prospective CSCP	Quarterly prospective lump sum payment based on portion of anticipated FFS revenue



### Risk Adjustment:

Adequate risk adjustment is essential to protect against cherry picking patients, inappropriate underutilization of services, and undue risk on practices. The CCF would be risk adjusted based on patient complexity (e.g., comorbidities, cognitive impairment, self-care ability as measured by activities of daily living); patient demographics (e.g., age, gender); and other factors, such as socioeconomic factors that are social determinants of health.

For the CCFs, the MNM will utilize Hierarchical Condition Category (HCC) scores to determine which risk tier each patient will be assigned. Similar to CPC+, the CCF amount will be tied to risk quartiles, with the payment amount increasing based on increased patient risk scores. Track 2 will have an additional complex tier to account for patients at or above the 90<sup>th</sup> percentile risk score or those with a diagnosis of dementia or a related disorder. The model will utilize the most recent HCC score available at the time of attribution. Details on how CMS determines risk scores and tiers in CPC+ can be found in the CPC+ payment methodologies guide.<sup>13</sup>

### Qualifying as an Advanced APM under the Quality Payment Program:

As in CPC+, APM entities in the MNM-APM would be “at risk” for up to the entire amount of their performance-based incentive payment. Thus, both tracks of the MNM-APM would meet the general financial risk standard required of advanced APMs.

### Reconciliation against benchmarks:

The PBIP is paid as a lump sum on a semi-annual basis based on the amount of attributed beneficiaries from the preceding six months and the track in which the practice participates. It is later reconciled based on performance against national quality and utilization benchmarks following the end of the program year once performance results become available. Quality and utilization are calculated and reconciled separately. Like CPC+, the amount of incentive payment retained by a practice is calculated on a continuous scale between the minimum and maximum benchmark for each measure. Scoring below the minimum results in ineligibility for the incentive and scoring above the maximum results in retaining the full incentive. More research would be needed to determine appropriate “floors” for our specialty-focused measures, but it would likely be similar to CPC+, which is the thirtieth percentile of national performance rates for all quality measures, and the fiftieth percentile (national average) for all utilization measures.

### Other Payers:

The MNM-APM would include other payers as does CPC+, and all participating payers will use the same payment methodology. However, each payer will determine the amount of each payment mechanism in negotiation with the APM entity or entities.

## *4. Value over Volume*

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<sup>13</sup> CPC+ Payment Methodologies: Beneficiary Attribution, Care Management Fee, Performance-based Incentive Payment, and Payment under the Medicare Physician Fee Schedule for Program Year 2018. December 2017. Accessed at: <https://innovation.cms.gov/Files/x/cpcplus-methodology.pdf>.



## Financial Incentives

The model would incentivize practitioners to deliver high-quality care by retroactively adjusting PBIPs for cost, quality, utilization, and patient experience metrics.

## Non-Financial Incentives

Because the model would hold participants accountable for cost and quality, like other APMs, this model could qualify for several non-financial incentives that would reduce the present administrative burden imposed on practices by eliminating restrictive Medicare billing requirements for certain high-value services such as telehealth services, and help to facilitate the development and growth of the model by waiving constricting fraud and abuse requirements. For example, the model could include waivers from telehealth and home health billing requirements, prior authorization and appropriate use criteria, anti-kickback and Stark restrictions, and MIPS reporting requirements (by virtue of being designated as an Advanced APM). As with other population-based payment models in which the practice is already being held accountable for cost, CMS could exert its waiver authority to permit MNM practices to deploy beneficiary incentive programs at their discretion to incentivize high-value services that drive down total costs.

Timely, useful feedback on cost and quality performance would be another powerful incentive for model participants. In addition to feedback about individual performance, model participants could receive information about the aggregate performance of the model and how they compare to their peers, mirroring CPC+ regional reports.

## *5. Flexibility*

### Accommodation across clinical specialties and patient subgroups

One of the defining characteristics of this model that separates it from other proposed specialty models is that it can be easily scaled to a variety of geographic locations and specialties. The model can accommodate virtually all patient-facing specialty types and patients who need referrals to these specialties. The model's flexible design allows for expansion to a range of subspecialties, designed as a population based payment model, multiple specialties have expressed interest in participating in this model should it move forward. We purposefully designed the program to address the breadth and depth of different clinical settings and patient subgroups. It accommodates a range of specialist-patient referral relationships, from one-time consults, ongoing collaboration with PCPs, and cases such as cancer in which the specialist provides the bulk of care. By creating a consistent payment structure and model framework, but allowing population based payment amounts to differ by specialty, this model has the flexibility to accommodate a wide range of specialties while also maintaining consistency across specialties and not imposing undue complexity or burden on practices.

### Building the infrastructure

The MDM would not require any infrastructure changes for a physician or other eligible professionals to succeed other than those required to meet MACRA-qualified PCSP criteria, which both Congress and Medicare have specifically endorsed in legislation and regulation. For this reason, we expect that once CMS has conducted the financial bundling for a given specialty, uptake for the model would be relatively straight-forward and quick. CPC+ already has over 12,370 practitioners in over 2,932 primary care practices since the creation of its predecessor program CPC in 2012.

### Adapting to changing technologies

Because participating practices are incentivized to provide high-quality, efficient care, they would be incentivized to employ cost-effective emerging technologies and standards of care. Use of health IT in particular is a cornerstone of the MNM and its focus on care coordination across settings. As health IT and other technologies evolve, PCSPs are well-positioned to incorporate upgrades appropriate for their practice. As the model expands to incorporate new specialty partners, we can expand the number of QCDRs and qualified registries that are connected with our model. Additionally, if this model can build onto the CPC+ online platform and CMS Web Interface, it offers a promising way to connect data from multiple systems and vendors, participating practices, patients, and CMS.

### Addressing operational burdens and reporting requirements

We are working aggressively to reduce the burden of reporting clinical quality measures for all clinicians, including those in this model, by:

- Promoting measurement alignment across public and private payers for clinicians, networks and plans;
- Facilitating quality measurement and reporting to digital formats allows for quicker, more efficient and accurate quality measurement while minimizing burden by leveraging information that clinicians routinely document in their health IT systems for quality reporting purposes; and
- Encouraging the use of data intermediaries to extract quality measure data from electronic health records, health information exchanges and other digital sources so that clinicians can focus on caring for their patients.

This approach has several advantages over the current reporting system including:

- **Reduced Clinician Burden:** Clinicians leverage data that they ordinarily enter into electronic health records and systems in the routine delivery of care to patients.
- **More Accurate Results:** Automated systems assess all data pertinent to each measure more comprehensively than most clinicians do when submitting quality measure data on their own. This greatly reduces chances for underreporting performance, enhances the accuracy of risk adjustment, and helps to ensure that clinicians' are appropriately evaluated based on the true quality of care they provide.
- **More Meaningful Measures:** Data in electronic systems are much richer than data in claims that are the source for most measurement today. Very importantly, they include outcomes data that are considered the gold standard for assessing quality.
- **More Rapid Feedback:** This approach allows for more rapid and meaningful performance feedback to clinicians. Today, clinicians deliver care in one year, report on that care the next, and see their performance scores yet another year after that. Data aggregators should be able to provide feedback in nearly real-time so clinicians can much more quickly identify gaps and make needed improvements.

## 6. *Ability to be Evaluated*

### Evaluating the MNM as a successful Advanced APM

To ensure transparency, we would ask CMS to order an annual evaluation of this model by a third party such as Mathematica, similar to CPC+.

At an aggregate level, the program will be evaluated on the basis of whether it results in more or less spending to the Medicare Program and how quality performance of participating practices compares to non-participating practices. In line with goals for other APMs, the goal would be to improve quality without increasing spending, to lower spending without impacting quality, or to both improve quality while reducing spending. In addition, we hope that evaluations of the model will include a thoughtful analysis of data related to possible inequities of care due to social determinants of health and evaluate the effectiveness of various intervention strategies.

In addition to comparing practice's performance relative to their benchmarks at an aggregate level and comparing aggregate performance on quality metrics to national averages, there are multiple approaches CMS could use for possible evaluation, each with advantages and disadvantages. We discuss some choices below.

- CMS could mirror its evaluation methodology for CPC+ in which it sorts half of applicants into a "control group." This approach provides the most direct "apples to apples" comparison and collects the most information on referral patterns, quality and cost metrics from non-participating practices. However, ACP did not endorse this policy

for CPC+ because it drastically limits participation in the model, which would be of particular concern with this being a specialty-focused model in certain geographic areas. Should CMS adopt this policy, at a minimum, CMS should award control group practices with Advanced APM credit.

- CMS could compare participating practices to practices that accept patients from CPC+ practices that are not participating in the program. This would allow for a comparison of practices with similar patient populations and importantly, practices that interact with the same CPC+ referring practices, so it would isolate the impact of the model’s care coordination protocols on patient outcomes and costs. It is less clear that quality metrics could be effectively compared, as non-participants would not be required to report the same quality measures. However, given our model would leverage existing eCQM specialty-focused measures it is reasonable to assume that enough non-participating practices would report the same quality measures, provided they overlap with MIPS. CMS could compare participating practices to non-participating practices with PCSP designations. The clinical transformation criteria would be similar, which would help to isolate the impact of the care coordination, pre-consult and payment elements of the model. However, these practices would not necessarily report the same quality measures.
- CMS could compare participating MNM practices to all non-participating specialty practices in the same region based on claims data. This would provide the largest sample size but runs into concerns about how comparable participants would be to the non-participants and the amount of data CMS would be able to collect from non-participating practices would be limited.

#### Evaluating the quality and cost performance of individual model participants

Similar to CPC+, program evaluation would occur at the practice site level, specifically the “bricks and mortar” location. As explained in greater detail in the payment section, participating practices will be evaluated financially against pre-determined financial benchmarks based on the practice’s own historic spending trends based on regional growth rates. The model will measure a number of evidence-based metrics on patient quality of care outcomes. Practice sites will be evaluated against quality and utilization metrics on a percentile basis compared to national performance rates.

#### *7. Integration and Care Coordination*

Care coordination is the cornerstone of the MNM. As noted earlier, as a condition of participating in the model, participants would be required to meet rigorous criteria for improving integration and coordination that should directly translate to better cost, quality and patient experience. Specialists participating in the model would be required to meet a set of robust clinical transformation standards similar to those used in specialty practice certification programs

such as NCQA's PCSP. We recommend using specialty practice certification programs that are eligible for use in MIPS and include validation of practice transformation activities.

By defining participation at the practice site level, each practice is responsible for ensuring care coordination with all team members and the entire practice site is engaged in transformation and held accountable for results.

The model requires that practices formally document care coordination agreements with other clinicians involved in the patient's care, facilitate discussions with patients and their families, and explicitly outline expectations for referrals through checklists, processes and agreements, consistent with the tenants of [ACP's High Value Care Coordination Toolkit](#). Participating clinicians must implement formal and informal agreements with a subset of referring clinicians based on established criteria, and that they specify methods of communication for referring clinicians as well as patients and families about care plans. Participating practices would determine care plans in collaboration with the patient and the primary care clinician, which is shared with the referring clinician, along with the referral response. The specialist's plan of care may include care management, patient education and secondary referrals. For select patients, MNM practices must also specify strategies co-management and transitions across settings of care.

Participating practices must notify referring clinicians of acceptance, as well as the dates and times of appointments. This tracking process is vitally important in establishing effective communication and collaboration and provides primary care specifics about the appointment in case follow-up is necessary. MNM practices must also establish the type, method, and a timeframe for communication with patients to give them test results and discuss treatment options. The specialist's response to the referring clinician must contain details about follow-up needed with the referring clinician and/or with the specialist. This may include additional coordination or recommendations regarding co-management. For transitions of co-managed patients back to primary care, MNM practices must share clinical information with the PCP such as medication management, follow-ups and other aspects of the care plan.

To protect patient safety, MNM practices must systematically track tests and labs as part of coordinating care with referring clinicians and facilities. Participating practices must track lab and imaging tests from ordering through results, and flag test results that have not been made available. They must follow up with the lab or diagnostic center and if necessary, with the patient, to determine why results are overdue. The practice must immediately flag abnormal results to bring them to the attention of the referring clinician to ensure timely follow-up with the patient. Medical Neighborhood practices must share normal and abnormal results in a timely manner and document those results electronically in the patient record. To prevent duplicative testing, practices must request relevant test results (if they did not accompany the referral), such as screening test results or diagnostic imaging. For tests ordered, the MNM practice must transmit results back to primary care or the referring clinician in a timely manner.

MNM practices must discuss secondary referrals with the primary care clinician and the patient before sending a referral to another specialist to help limit gaps in care and reduce overuse. In order to successfully and efficiently manage referrals to secondary specialists, the practice must provide the clinical reason for the referral, as well as pertinent clinical information about the patient. Participating practices would track and follow up to retrieve any results or reports from the secondary specialist. For co-managed patients, the referring and secondary specialists exchange information within a timeframe agreed to by both parties and the practice documents this information in the medical record. Some patients may also see other specialists without referral. For this reason, MNM practices would routinely ask patients if they are receiving care from a specialist and, if so, request a report from the specialist and document the information in the medical record.

Many patients have an ongoing relationship with a specialist during acute care transitions. Practices participating in our model would be required to have specified and systematic methods of identifying these patients and coordinating their care across settings. For example, MNM practices would be expected to share clinical information with admitting hospitals and emergency departments, consistently obtain discharge summaries, and provide electronic summaries of care following transitions. Failure to coordinate and manage these transitions often results in costly gaps in care and negatively impacts patient outcomes. This section of the model's standards helps practices design meaningful and efficient workflows to close those costly gaps and ensure patients receive the care they need to recover from acute incidents.

### Workforce changes

Medical Neighborhood practice transformation often entails workforce changes. It first requires committed leadership willing to engage in practice culture change. It can entail hiring of additional staff to conduct care coordination activities and analysis of performance feedback. It also features all members of a care team practicing at the top of their license to both extend the effectiveness of staff while improving employee satisfaction and reducing burn-out.

### *8. Patient Choice*

The model will have no impact on freedom of choice for patients. Patients would remain free to see PCSP specialists or non-PCSP specialist, regardless of where a CPC+ clinician made a referral. However, it is our hope that patients will see the advantages of a coordinated team of clinicians working to improve their care and will choose to see clinicians participating in the model. Additionally, if CMS allows participants a waiver to create beneficiary incentive programs, MNM participants could offer patients further incentives to receive care within the model, including possible lower copays for certain high-value services and additional supplementary services not typically reimbursed by Medicare.

### Addressing disparities

Studies on PCSPs' impact on disparities are ongoing. For related PCMHs, evidence shows that the patient-centered approach to care reduces income-related health care disparities for important services like preventive screenings.<sup>14</sup> Our hope with this model is that by collecting more sophisticated quality data from our participating practices, we can learn more about some of the causes for these disparities and help to address them. Moreover, while we expect that all patient populations would benefit from possible, additional services funded by care coordination fees (including care managers and reimbursement for transportation to appointments, etc.), we expect these services would yield particular returns for at-risk patient populations. Addressing social determinants of health to help mitigate current inequities in care is one of ACP's top priorities.

### Patient diversity

Our model will build off the CPC+ model to engage specialty care providers, helping to fill a current void for specialty focused APMs. This model would start in the geographic areas in which CPC+ currently operates and with a handful of specialty partners, but over time can be expanded to all geographic areas and specialty types.

### *9. Patient Safety*

The MNM will protect and improve patient safety through its focus on improved integration and coordination. Similar to CPC+, our model would feature a multi-pronged approach to data collection on quality of patient care and outcomes to ensure only the highest quality standards are being upheld, and that patients are receiving at a minimum the same quality of care they would experience outside of the model. It would mirror CPC+ standards of patient safety monitoring, including: (1) annual submission of program integrity data; (2) quarterly attestations of care delivery achievements; (3) quarterly "flag reports"; (4) bi-annual submissions of revenue and expense data; (5) annual review of cost, utilization, patient experience and quality data; and (6) audits on an ad hoc basis as necessary. Finally, our model would feature risk adjustment, which is critical to averting adverse patient selection issues.

### *10. Health Information Technology*

Like CPC+, the MNM would consider data collection and transparency a center of its design, particularly tracking care across multiple settings. The model would require use of CEHRT, which facilitates e-Consults between clinicians across care settings and the general storing and sharing of patient data across care settings, as well as the sharing of aggregate data to public health agencies and registries to inform ongoing quality and clinical improvement.

Our model would also support reporting of data and communication between clinicians across care settings through multiple QCDRs and qualified registry products such as ACP's Genesis registry, as well as ideally through the existing online CPC+ platform and CMS Web Interface

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<sup>14</sup> Markovitz et al 2015, Journal for the American Medical Association Internal Medicine; Garcia-Huidobro et al 2016, Pediatrics

portals. The variety of reporting options, particularly the availability of an online platform that is made available to participants at no cost by CMS, ensures that participants have a range of technology options available to them that offer flexibility and affordability. Reporting and sharing of data through the existing CPC+ online portal or through the CMS Web Interface would allow for maximum data transparency for model participants, CMS, and the public at large. We also underscore the positive impact that access to real-time Medicare claims data feed would mean in terms of using data to drive improvements in care quality and outcomes and encourage CMS to make this data available to all model participants to the maximum extent possible.



## Appendix I: Quality Measures for Possible Inclusion

### I. Utilization measures

- Inpatient hospital utilization
- Emergency Department utilization
- NQF ID # 1789: Hospital Wide All-cause Readmission Rate

### II. Patient-reported outcomes measures

Patient-reported outcomes measures are relatively nascent and largely still under development, but are critical to moving away from check-the-box quality measures and to capturing data that may not otherwise be reflected in more traditional claims-based measures but are critical to a patient's well-being and recovery, such as a patient's quality of life or level of pain. CMS has expressed interest in adding PROMs to CPC+ in the future, and it would accordingly be appropriate for the MNM model as well.

### III. Patient experience measures

Our model would feature a subset of patient experience questions that specifically relate to the range of services offered in the specialty setting and care coordination with the referring primary care clinician and the patient that could include but would not be limited to CG CAHPS measures. Questions would cover topics such as: timely appointments, sufficient transmission of patient medical records, test results, and another pertinent documentation when patients are transferred to new care settings, and supporting patient and family-centered care.

### IV. Electronic CQMs

**Core measures (required):** Our model would require up to three core measures that would be reported by all participants, regardless of specialty to capture the effectiveness of transitioning patients across care settings, including entering any test results, medications or other relevant updates into the patient's care record, collaborating on care plans with the referring primary care clinician and the patient, and coordination between the referring clinician and specialist, including sharing of any relevant documentation to avoid duplicative testing.

**Menu measures (must select 2-3):** In addition to the required set of core measures, each participant would select from a set number of specialty-specific measures. These specialty measure menu sets would leverage eCQMs from specialty-focused QCDRs and qualified registries and would be tested for validity and reliability. By way of an example, specialty-specific menu measures might include:

- Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients (NQF 0658)
- Overuse of Neuroimaging for patients with Primary Headache and a Normal Neurological Evaluation (QPP/MIPS 414)
- Use of Imaging Studies for Low Back Pain (QPP 312)

**Appendix II: Sample practice transformation criteria for admittance into MNM based on  
NCQA Patient-Centered Specialty Practice (PCSP) Standards & Guidelines**

*(Attached)*

# **PCSP 2016 Standards & Guidelines**

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**PCSP 1: Working With Primary Care and Other Referring Clinicians** **22.00 points**

The practice coordinates with primary care and referring clinicians to ensure timely information exchange.

**Element A: Establishing Relationships With Primary Care and Other Referring Clinicians** **4.00 points**

The practice:	<b>Yes</b>	<b>No</b>
1. Works with frequently referring clinicians to set expectations for information sharing and patient care.	<input type="checkbox"/>	<input type="checkbox"/>
2. Has agreements with a subset of primary care or other referring clinicians.	<input type="checkbox"/>	<input type="checkbox"/>

<b>Scoring</b>	<b>100%</b>	<b>75%</b>	<b>50%</b>	<b>25%</b>	<b>0%</b>
	The practice meets factor 1 or factor 2	No scoring option	No scoring option	No scoring option	The practice meets 0 factors

**Explanation** To promote effective communication and care coordination, specialists should establish relationships or agreements with primary care and other clinicians. Most specialty practices will have a range of clinical interactions or relationships with primary care and other referring clinicians, though the mix of interaction types may vary.

Specialty practices of *all types* are expected to have a protocol for coordinating with primary care and other referring clinicians regardless of the type of specialty (e.g., procedure-focused, behavioral health, obstetrics-gynecology) or the nature of the specialty practice clinical interactions (consultative, referral and treatment, co-management or temporary or long-term principal care).

**Factor 1:** The practice collaborates with primary care practices and other referring clinicians on an ongoing basis.

**Factor 2:** The practice has jointly agreed-upon procedures (agreements) for working with referring clinicians.

**Agreements** define the general referral guidelines and exchange of information to expedite timeliness and appropriateness of referrals and improve coordination of patient care as agreed upon by the primary care or other referring clinicians and the specialty practice.

**Note:** *This factor does not specify a number of agreements with referring clinicians; that is determined by the specialist. The factor’s focus is on the specialty practice having established and implemented agreements with referring clinicians, also determined by the specialist.*

**Documentation**

**Factor 1:** NCQA reviews materials and descriptions of activities that demonstrate the practice is working with referring clinicians to set expectations for information sharing and patient care, including, but not limited to, interaction and communication between the practices, sharing information for patient care and methods for exchange of patient information.

**Factor 2:** NCQA reviews at least two examples of the agreements with primary care or other clinicians.

**Element B: Managing Initial Referrals (MUST-PASS) 4.00 points**

The practice has a written process that it implements for managing all initial referrals that includes:	Yes	No
1. How the specialist confirms the receipt and acceptance of the referral, with the date and time of the patient's appointment.	<input type="checkbox"/>	<input type="checkbox"/>
2. What information the specialist needs from the referring clinician to answer the clinical question.	<input type="checkbox"/>	<input type="checkbox"/>
3. When the specialist will send a response to the referring clinician and what information will be included.	<input type="checkbox"/>	<input type="checkbox"/>
4. Which clinician is responsible for communicating with the patient/family/caregiver about test results and the specialist's plan of care.	<input type="checkbox"/>	<input type="checkbox"/>
5. The co-management or transition strategy for selected patients.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	The practice meets all 5 factors	The practice meets 4 factors	The practice meets 2-3 factors	No scoring option	The practice meets 0-1 factors

**Explanation** **MUST-PASS** elements are considered essential to a patient-centered specialty practice. Practices must earn a score of 50% or higher. **All six must-pass elements** are required for recognition.

**Note:** Reference to "patient/family/caregiver" does not imply that all must be included in the communication process.

The practice's protocols for managing initial referrals address referrals from primary care and other clinicians, as well as those from self-referred patients. Processes addressing self-referred patients include coordinating care with the patient's primary care clinician or connecting patients with a primary care practice, if they do not have a primary care clinician. (Refer to Element F: Connecting Self-Referred Patients With Primary Care.)

There is a written process for staff to share information with referring primary care and other clinicians, patients and families or caregivers. The process includes the workflow for managing the referral activities and practice staff responsible for managing the activities.

Multi-specialty practices that are part of an integrated system may operate under prescribed procedures established by their governing organization, including a single electronic system, have a documented process for staff to manage referrals that includes how communication and coordination of care take place.

**Note**

- *Element B includes factors that relate to one another.*
  - *Factors 1–3 and 5 involve coordinating and communicating with primary care and the referring practice.*
  - *Factor 4 relates to communication between the practice and the patient.*
- *If the specialty practice and all referring clinicians share access to the same electronic health record system, the practice should have a method to ensure timely communication of information between primary care and the specialty practice. This may include automated alerts when new information has been shared.*

**Factor 1:** This factor addresses the response to the referring clinician by acknowledging receipt of the referral. The practice has a process for notifying primary care, or the referring clinician, of receipt and acceptance of the referral. The referral receipt includes the date and time of the patient's appointment. This tracking process establishes effective communication and collaboration, and gives specifics about the appointment, in case follow-up is needed.

**Factor 2:** Specialists request the necessary patient information from primary care. This includes "the clinical question" to be answered by the specialist, along with a relevant history and test results.

**Factor 3:** The practice specifies when the primary care or the referring clinician can expect to receive a referral summary, and the type of information that will be included in the summary.

**Factor 4:** The practice has a process for identifying whether the specialist or referring clinician is expected to communicate with the patient/family/caregiver (as appropriate for the patient) regarding test results, treatment and the specialist's plan of care, including changes during the treatment process.

The process includes the type, method and time frame for communication with the patient/family/caregiver.

**Factor 5:** The practice has a general written strategy for specialist and primary care patient co-management. The strategy specifies the components of care that will typically be managed by the specialist and those that will remain with primary care (if any). It defines timely sharing of changes in patient status and the treatment plan, and specifies information to be entered in the medical record.

**Note:** *If the referring clinician is not the primary care practice, there is clear delineation in the care provided by primary care, the referring clinician and the specialist.*

#### **Documentation**

*NCQA reviews the Organizational Background "Practice Information" in the ISS survey tool, to gain a better understanding of the patient population and how the practice functions. Completing this information is recommended, but is not required.*

*For all factors that require a documented process, the documented process must include a date of implementation or revision and must be in place for at least three months prior to submitting the PCSP 2016 survey tool.*

**Factors 1–5:** For each factor, NCQA reviews:

- A documented process, materials or agreements for staff, **and**
- Three de-identified materials or agreements demonstrating that the process has been implemented.
  - Examples may collectively demonstrate that each factor is met or show individually that each factor is met.

**Element C: Assessing Initial Referral Content****3.00 points**

The practice sets expectations and monitors against those expectations to confirm receipt of information needed in referrals from clinicians:

Yes No

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 1. Clinical questions to be answered by the referral.                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Type of referral.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Urgency of referral.  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Patient demographics.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Clinical information.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Current primary practice care plan, treatment, test results and procedures.     | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Which clinician is responsible for communicating with patient/family/caregiver. | <input type="checkbox"/> | <input type="checkbox"/> |

**Scoring**

100%	75%	50%	25%	0%
The practice meets 5-7 factors	The practice meets 3-4 factors	The practice meets 1-2 factors	No scoring option	The practice meets 0 factors

**Explanation**

According to The American College of Physicians (ACP), the clinical interactions between primary care and a specialty practice take the following forms:

1. Consultation:
  - *Pre-consultation exchange*: To expedite/prioritize care; may provide guidance on urgency of the consult.
  - *Formal consultation*: To answer a clinical question or perform a procedure limited to one or a few visits.
2. Co-management:
  - *Co-management with shared care*: Shared management of a specific condition with clearly defined specialty practice and medical home responsibilities.
  - *Co-management with principal care for the disease*: The specialty practice has responsibility for managing the referred health problem.
  - *Co-management with principal care for a consuming disease*: May assume first contact for the patient; usually time limited.
3. Transfer: Transfer of the patient to the specialty practice for whole-person care management and coordination; usually involves a long-term, complex condition.

The specialty practice asks the referring clinician for necessary information about referred patients, and tracks the information it receives from the referring clinician.

Specialists establish the foundation and expectations for successful communication and information exchange with primary care and conveying the expectations to primary care or referring clinicians. The specialty practice can help the referring clinician and primary care determine what constitutes an “urgent” referral and care that is specific to the specialty, and the information needed for the specialist to complete the referral in a reasonable period.



Tracking information will enable the specialist to provide feedback to primary care and other referring providers about the appropriateness and completeness of referrals received.

**Factor 1:** The referring clinician provides a concise reason for the referral, which may be stated as “the clinical question” to be answered by the specialist.

**Factor 2:** The primary care practice or referring clinician specifies the type of referral, which may be for a consultation, referral and treatment; co-management; or temporary or long-term principal care for an indefinite or a limited amount of time.

For information about the different types of referrals and patient relationships, refer to the American College of Physicians (ACP) white paper, “The Patient-Centered Medical Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/ Subspecialty Practices, 2010, pp. 6-7

[http://www.acponline.org/advocacy/where\\_we\\_stand/policy/pcmh\\_neighbors.pdf](http://www.acponline.org/advocacy/where_we_stand/policy/pcmh_neighbors.pdf).

**Factor 3:** The referring clinician specifies the urgency of the appointment in the referral and the rationale for an urgent visit. The specialist may have categories of referrals, and criteria to help primary care determine urgency. For example, a visit may be urgent and warrant an immediate appointment if the patient’s symptoms are ABC and the test results are XYZ.

**Factor 4:** Patient demographics include, but are not limited to, communication needs, primary language and relevant cultural or ethnic information, in addition to the more typical information, such as date of birth, sex, contact and health insurance.

**Factor 5:** Relevant clinical information may include, but is not limited to, current medications, diagnoses (including mental health), allergies, medical and family history, substance abuse and behaviors affecting health, and will give the specialist an understanding of the patient, the reason for the referral and evaluation details.

**Factor 6:** Including the referring clinician’s care and treatment plan with test results/ procedures in the referral will help avoid duplication of services, tests or treatments. If the referring clinician is not the primary care practice, the care provided by primary care, the referring clinician and the specialist must be clearly defined.

**Factor 7:** The referral states who will be responsible for communicating with the patient/family/caregiver, and may include information about the level of patient/family/caregiver understanding of the reason for the referral, diagnosis and possible treatment options.

**Note:** *Specialty practices have a written process for patients who self-refer that includes coordinating care with the primary care clinician, or connecting patients who do not have a primary care clinician with a primary care practice.*

### **Documentation**

*For all factors that require a documented process, the documented process must include a date of implementation or revision and must be in place for at least three months prior to submitting the PCSP 2016 survey tool.*

**Factors 1–7:** For each factor, NCQA reviews:

- A documented process for the practice staff to follow when communicating expectations in the referral from primary care or referring clinician.
- and**
- A report containing referral information, based on at least 1 month of data or data from 30 recent referrals.

**Element D: Assessing Initial Referral Response (MUST-PASS) 4.00 points**

The practice has a written process and monitors against it to ensure a timely response to PCPs and referring clinicians that includes:	Yes	No
1. Tracking when the referring provider was notified of the receipt of the referral and the time and date of the patient appointment.	<input type="checkbox"/>	<input type="checkbox"/>
2. Answers to clinical questions in the referral.	<input type="checkbox"/>	<input type="checkbox"/>
3. Diagnosis.	<input type="checkbox"/>	<input type="checkbox"/>
4. Procedures and test results.	<input type="checkbox"/>	<input type="checkbox"/>
5. The specialist's recommended plan of care.	<input type="checkbox"/>	<input type="checkbox"/>
6. Follow-up needed with the specialist, including further coordination.	<input type="checkbox"/>	<input type="checkbox"/>
7. Tracking and monitoring timeliness of referral response.	<input type="checkbox"/>	<input type="checkbox"/>
8. Electronic transmission of a summary of care record to another provider, for more than 10 percent of referrals.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	The practice meets 6-8 factors	The practice meets 4-5 factors	The practice meets 3 factors	The practice meets 1-2 factors	The practice meets 0 factors

**Explanation**

**MUST-PASS** elements are considered essential to a patient-centered specialty practice. Practices must earn a score of 50% or higher. All six must-pass elements are required for recognition.

**Element C** specifies the information needed by the specialist from the referring clinician. The specialty practice has a process for tracking data it receives from the referring clinician or primary care.

**Element D** specifies the information the specialist sends to the referring clinician or primary care practice and when the referral response was sent. Reports from PCSP 1, Element D may be used in PCSP 6, Element A, as documentation for factor 2.

**Note**

- Practices that do not have an EHR are expected to have a written process for identifying the expected content of referrals from primary care or other referring clinicians, and the information in the response to the referring clinician. An EHR is not needed to track data included in the referral response or to notify the referring clinician of the receipt of the referral and the date and time of the appointment.
- In order to share information with primary care and referring clinicians, behavioral health practices may need to obtain a release from the patient. The need for this release does not relieve the practice of the requirements in this element.

**Factor 1:** The practice has a process for tracking receipt of a referral, notifying the referring provider that the referral was received, and recording the date and time of the appointment.

**Factor 2:** The practice responds to the clinical question in the referral.

**Factor 3:** The response includes the diagnosis determined or confirmed by the specialist.

**Factor 4:** In the written response to the referring clinician, the specialist presents the results of procedures or tests performed as part of patient evaluation and treatment.

**Factor 5:** The practice care plan is determined in collaboration with the patient/family/caregiver, as well as with the primary care clinician, and is shared with the referring clinician, along with the referral response. The specialist's plan of care may include care management, patient education and secondary referrals.

**Care plan** is defined by CMS as "The structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome)."

**Factor 6:** The specialist's response contains details about follow-up needed with the referring clinician and/or with the specialist. This may include coordination with the specialist or recommendations regarding co-management. Actions to be taken by the patient are clearly stated.

**Factor 7:** The practice has a process for tracking and monitoring the timeliness of its response to the referring clinician.

**Factor 8:** The practice provides an electronically transmitted summary-of-care record for more than 10 percent of transitions of care or referrals. In this factor, the specific reference is transitions back to the primary care clinician or the referring clinician, following consultation with the specialty practice.

#### **Note**

- *Factor 8 may appear to duplicate PCSP 5, Element B, factor 9 and Element C, factor 5; however, this element underscores the importance of the specialist providing a summary of care to primary care or the referring clinician, particularly if the patient is being transitioned back to primary care.*
- *To count in the numerator of any of the three measures, the practice must verify that the three fields listed below are not blank and include the most recent information known by the practice as of the time when the summary of care document was generated:*
  - Current problem list.
  - Current medication list.
  - Current medication allergy list.

#### **Documentation**

*For all factors that require a documented process, the documented process must include a date of implementation or revision and must be in place for at least three months prior to submitting the PCSP 2016 survey tool.*

**Factors 1–7:** NCQA reviews the practice's documented process for providing a timely response to the referring clinician and patients, **and**

**Factor 1:** NCQA reviews a report from a tracking system based on at least 1 month of data or data from 30 new referrals, showing when the referring clinician was notified of receipt of the referral request and the date and time of the patient's appointment.

**Factors 2–6:** NCQA reviews a report from a tracking system based on at least 1 month of data or data from 30 new referrals, containing information provided to the primary care or referring clinician. If the patient was self-referred or the referring clinician did not include a clinical question or reason for referral, NCQA reviews findings from the consultation, along with the patient's reported complaint.

**Factor 7:** NCQA reviews a report from a tracking system based on at least 1 month of data or data from 30 new referrals, showing when the referral was received by the specialist and when the specialist sent the referral response to the referring clinician.

**Factor 8:** NCQA reviews a report with a numerator, denominator and percentage from at least three months of transitions and referrals.

- *Denominator* = Number of transitions back to referring clinician/primary care.
- *Numerator* = Number of transitions back to referring clinician/primary care in the denominator where a summary-of-care record was exchanged electronically.

**Element E: Transition to Primary Care** **4.00 points**

<p>The practice has a documented process for transitioning co-managed patients back to primary care by:</p> <ol style="list-style-type: none"> <li>1. Identifying patients who are ready to transition back to primary care.</li> <li>2. Sharing clinical information with the primary care clinician.</li> <li>3. Communicating with the patient/family/caregiver about the care transition.</li> </ol>	<table border="0"> <tr> <td style="padding-right: 10px;">Yes</td> <td style="padding-right: 10px;">No</td> <td>NA</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	Yes	No	NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes	No	NA											
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>											

<b>Scoring</b>	<b>100%</b>	<b>75%</b>	<b>50%</b>	<b>25%</b>	<b>0%</b>
	The practice meets 3 factors	The practice meets 2 factors	The practice meets 1 factor	No scoring option	The practice meets 0 factors

**Explanation** This element is NA for practices that do not co-manage patients or do not provide long-term principal care for conditions or courses of treatment it manages. In this case, points assigned to this element are redistributed to the other elements in PCSP 1. The practice must provide a written explanation for an NA response.

**Factor 1:** The practice has a documented process for identifying and transitioning patients back to primary care after they complete treatment for conditions managed by the specialist.

**Factor 2:** The practice has a documented process for sharing patients' clinical information (e.g., medication management, follow-up tests and care, other aspects of the care plan developed by the specialty practice) with primary care.

For patients transitioning from specialty care to primary care, the transition plan includes medication management, follow-up tests and care and other aspects of the care plan developed by the specialty practice.

**Factor 3:** The practice has a documented process for communicating with the patient/family/caregiver (as appropriate for the patient) regarding transition of care from the specialist to the primary care practice.

**Documentation**

**Factors 1–3:** NCQA reviews the documented process for identifying patients, sharing information and communicating about the care transition.

**Element F: Connecting Patients With Primary Care****3.00 points**

The practice implements a documented process for connecting self-referred patients with primary care clinicians that includes:

	Yes	No	NA
1. Identifying and documenting the patient's primary care clinician.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Determining if a patient's primary care clinician needs to be contacted prior to treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Communicating to patients the importance of following up with their primary care clinician.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Providing information on available primary care clinicians to patients without a primary care clinician.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. For self-referred patients with a primary care clinician, providing a summary of care report to the primary care clinician.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Scoring**

100%	75%	50%	25%	0%
The practice meets all 5 factors	The practice meets 4 factors	The practice meets 3 factors	The practice meets 1-2 factors	The practice meets 0 factors

**Explanation**

This element is NA for practices that do not accept self-referred patients. In this case, points assigned to this element are redistributed to the other elements in PCSP 1. The practice must provide a statement or materials describing its policy for not accepting self-referred patients for an NA response.

**Factor 1:** The specialist asks patients if they have a primary care clinician and documents the following information in patient files:

- The name of and contact information for the primary care clinician.
- Whether the patient declines to provide the information or does not have a primary care clinician.

If this information is collected through a patient questionnaire and there is no information about the patient's primary care clinician, the specialist follows up to determine if the patient has a primary care clinician.

**Factor 2:** The specialist has a process to determine if the patient's scope of care requires consultation with the primary care clinician prior to treatment.

**Factor 3:** The specialist communicates the importance of follow-up with a primary care clinician.

**Factor 4:** The specialist gives information about primary care clinicians to patients without a primary care clinician, and documents that patients received the information. The information may be contained in brochures, printed lists or through the Web, and:

- Lists available clinicians in patient communities.
- Encourages patients to contact their insurance provider to verify coverage before choosing a primary care clinician.

**Factor 5:** The specialty practice provides summary-of-care reports to self-referred patients' primary care providers, post treatment.

**Documentation**

*For all factors that require a documented process, the documented process must include a date of implementation or revision and must be in place for at least three months prior to submitting the PCSP 2016 survey tool.*

**Factors 1–5:** NCQA reviews the specialist's documented process for staff, **and:**

**Factor 1:** NCQA reviews three examples *or* a report:

- *Examples:* Three de-identified patient records showing that information on the primary care clinician was recorded. This factor is met if records show that the patient declined or does not have a primary care clinician.
- *Report:* A report including measurement period, rate, numerator and denominator. The percentage should be based on at least three months of recent data. The practice may use the following methodology to calculate the percentage:
  - *Denominator:* Number of patients seen by the practice at the practice location at least once during the reporting period.
  - *Numerator:* Number of patients in the denominator for whom the specified data are entered in the medical record (including patients who identify their primary care clinician, state they do not have a primary care clinician or decline to provide a response).

**Factor 2:** An example demonstrating implementation of procedures or conditions where input and consultation with the primary care clinician is necessary prior to providing treatment or completing a procedure.

**Factor 3:** An example of written materials given to patients about why it is important to follow up with a primary care clinician *or* the script or other guidance for staff, if this information is provided to patients verbally.

**Factor 4:** An example of materials given to patients about available primary care clinicians; this may include Web sites or links, or brochures.

**Factor 5:** A de-identified summary of care report sent to a primary care clinician post-treatment of a self-referred patient.

**PCSP 2: Provide Access and Communication****18.00 points**

The practice provides timely access to culturally and linguistically appropriate team-based clinical advice and care that meets the needs of patients/families/caregivers.

Element A: Access	5.00 points	
The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards to:	Yes	No
1. Provide patient appointments based on patient need.	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide same day appointments.	<input type="checkbox"/>	<input type="checkbox"/>
3. Provide nonvisit consultations with referring clinicians.	<input type="checkbox"/>	<input type="checkbox"/>
4. Provide timely clinical advice to patients who contact the office when the office is open.	<input type="checkbox"/>	<input type="checkbox"/>
5. Provide timely clinical advice to patients who contact the office when the office is closed.	<input type="checkbox"/>	<input type="checkbox"/>
6. Document clinical advice to established patients in the patient medical record.	<input type="checkbox"/>	<input type="checkbox"/>
7. Provide equal access to accepted patients regardless of source of payment.	<input type="checkbox"/>	<input type="checkbox"/>
8. Provide uninsured patients with information about obtaining coverage.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	The practice meets 6-8 factors	The practice meets 4-5 factors	The practice meets 2-3 factors	The practice meets 1 factor	The practice meets 0 factors

**Explanation**

Timely access to specialists is a challenge for patients and for primary care clinicians or referring clinicians. The intent of this element is for the practice to evaluate the needs of patients and the demand for appointments (both urgent and not), and balance the supply of time slots, specialist appointment capacity and demand for appointments of all types.

**Factor 1:** The practice has a process for determining patient need and degree of urgency indicated by the referring clinician or the patient.

**Factor 2:** The practice reserves time for same-day appointments (also referred to as “same-day scheduling”). Adding ad hoc or unscheduled appointments to a full day of scheduled appointments does not meet the requirement. Same-day appointments are not required specifically to accommodate patient preference, but for patients who need to be seen that day. The practice is encouraged to assess the demand over time of patients needing same-day appointments.

**Factor 3:** Specialists may consult with a primary care clinician or referring clinician about management of a patient or the value of the patient being seen by the specialist. These informal consultations can be an educational opportunity for primary care or the referring clinician and enable specialists to concentrate on more complex patients. If the specialist determines that a patient should be seen, the conversation may also prepare the patient for assessment by the specialist.



Based on the conversation with the primary care clinician or the referring clinician, the specialist may determine that the patient needs to be seen.

**Factors 4, 5:** Clinicians return calls in a timely manner, as defined by the practice to meet the clinical needs of the patient population, during and after office hours. Factors 4 and 5 require the practice to define the time frame for a response, **and** to monitor the timeliness of the response against the defined time frame and process.

**Factor 6:** All clinical advice given to established patients, during or after office hours, is documented in the medical record. **Established patients** are patients who have been seen by the practice. If an after-hours service gives the patient advice, the practice has a mechanism for ensuring that the information is documented in the patient record.

**Factor 7:** The practice provides equal access to patients accepted into the practice, regardless of insurance status.

**Factor 8:** The practice has a process for providing information about potential sources of coverage to uninsured patients, such as a state Medicaid or CHIP (Children's Health Insurance Program) office, and materials (brochures, point of contact).

### Documentation

*NCQA reviews the Organizational Background "Practice Information" in the ISS survey tool, to gain a better understanding of the patient population and how the practice functions. Completing this information is recommended, but is not required.*

*For all factors that require a documented process, the documented process must include a date of implementation or revision and must be in place for at least three months prior to submitting the PCSP 2016 survey tool.*

**Factor 1:** NCQA reviews:

- A documented process for staff to follow in providing patient appointments based on an assessment of the needs of the patients, **and**
- A report showing appointments that covers at least five days of data showing relative patient need and appointment urgency.

**Factor 2:** NCQA reviews:

- A documented process for staff to follow for scheduling same-day appointments, and
- A report that contains at least five days of data showing how patients are accommodated for their appointment needs.

**Factor 3:** NCQA reviews:

- A documented process for staff, including clinicians, to demonstrate how it provides nonvisit consultations to referring clinicians, **and**
- Three de-identified examples **or** a report of consultations from at least five days of data.

**Factors 4–5:** NCQA reviews:

- A documented process for staff including clinicians to follow for providing timely clinical advice by telephone when the office is open (factor 4) and when the office is closed (factor 5) that defines the time frame for the response (including the practice's definition of "timely"), **and**
- A report of actual response times for responding to patients, containing at least five days of de-identified data.

**Factor 6:** NCQA reviews:

- A documented process for staff to follow for entering clinical advice in the medical record of established patients, **and**
- A report that covers at least five days of data, or five examples.

**Factor 7:** NCQA reviews a documented process for how the practice provides equal access to all patients.

**Factor 8:** NCQA reviews:

- A documented process, **and**
- Materials that the practice provides to uninsured patients about potential sources of coverage; for example, the Medicare office or the state Medicaid office.

**Element B: Electronic Access** **3.00 points**

The practice provides the following information and services to patients/families/caregivers through a secure electronic system.	Yes	No	NA
1. More than 50 percent of patients have timely access to their health information.+	<input type="checkbox"/>	<input type="checkbox"/>	
2. The capability to view, download or transmit their health information to a third party.+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Clinical summaries are provided to patients/families/caregivers upon request.	<input type="checkbox"/>	<input type="checkbox"/>	
4. The capability to send a secure message.+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Two-way communication between patients/families/caregivers and the practice.	<input type="checkbox"/>	<input type="checkbox"/>	
6. Requests for appointments, prescription refills, referrals and test results.	<input type="checkbox"/>	<input type="checkbox"/>	

Scoring	100%	75%	50%	25%	0%
	The practice meets 5-6 factors	The practice meets 4 factors	The practice meets 3 factors	The practice meets 1-2 factors	The practice meets 0 factors

**Explanation** + Meaningful Use Modified Stage 2 Alignment

Element B assesses the practice’s ability to offer information and services to patients, families and caregivers via a *secure* electronic system. Patients can view their medical record, access services and communicate with the health care team electronically.

**Factor 1:** More than 50 percent of patients/families/caregivers have timely online access to their health information after the information is available to the practice.

Factor 1 requirements do not address legal issues of access to medical record information, such as by guardians, foster parents or caregivers of pediatric patients, or adolescent privacy rights.

**Factor 2:** Patients can electronically view, download or transmit health information to a third party.

If a practice meets the exclusion criteria for the current final rule for Meaningful Use, it may respond NA to the factor. If the practice enters NA for submissions, it must provide written explanation.

**Factor 3:** A **clinical summary** of a visit should be made available to patients/families/caregivers upon request. Patients may access the information through a secure, interactive system such as a Web site, patient portal, secure e-mail or electronic media (e.g., CD, flash drive). If the summary is available electronically, the practice provides patients with a paper copy upon request.

**Factor 4:** The practice demonstrates the capability for patients to send a secure message. Patients may be notified that the capability is available through a secure, interactive system, such as a Web site or patient portal.

If a practice meets the exclusion criteria for the current final rule for Meaningful Use, it may respond NA to the factor. If the practice enters NA, it must provide written explanation.

**Factor 5:** The practice has a secure, interactive electronic system, such as a Web site, patient portal or secure e-mail system that allows two-way communication between patients/families/caregivers (as appropriate for the patient) and the practice.

**Factor 6:** Patients can use the secure electronic system (e.g., Web site or patient portal) to request appointments, medication refills, referrals to other providers and test results. The practice must demonstrate capability of at least two functionalities.

### **Documentation**

*Practices with a Web site or patient portal provide the URL to NCQA as part of the documentation.*

*Reports must be based on at least three months of recent data in the practice's electronic system and must include the reporting period, rate, numerator and denominator.*

**Factor 1:** NCQA reviews a report showing the percentage of patients who have timely online access to their health information.

- *Denominator* = Number of patients seen by the practice.
- *Numerator* = Number of patients in the denominator who obtain timely on-line access to their health information.

**Factor 2:** NCQA reviews a screen shot demonstrating use or capability, **or** reviews a report showing the percentage of patients who view or download their health information or transmit it to a third party.

- *Denominator* = Number of patients seen by the practice.
- *Numerator* = Number of patients in the denominator who view their health information on line, download the information or transmit to a third party.

**Factor 3:** NCQA reviews at least one example of a de-identified clinical summary to demonstrate capability, **or** reviews a report showing the percentage of clinical summaries provided to patients upon request. If a patient opts out of receiving a clinical summary of a visit, the practice notes it in the medical record and the patient may be included in the numerator.

- *Denominator* = Number of office visits.
- *Numerator* = Number of office visits in the denominator for which patients were provided a clinical summary upon request.

**Factor 4:** NCQA reviews a screen shot demonstrating use or capability, **or** reviews a report showing the percentage of patients who sent a secure message in a recent three-month reporting period.

- *Denominator* = Number of patients seen by the practice.
- *Numerator* = Number of patients in the denominator who sent a secure message.

**Factor 5:** NCQA reviews a screen shot demonstrating the practice's capability for two-way communication with patients/families/caregivers.

**Factor 6:** NCQA reviews a screen shot demonstrating functionality.

**Element C: Specialty Practice Responsibilities 3.00 points**

The practice has a process for informing patients/families/caregivers about the role of the specialist and gives patients/families/caregivers materials that contain the following information:

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | Yes                      | No                       |
| 1. Instructions for obtaining care and clinical advice during office hours and when the office is closed.                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Methods, content and frequency of communication with the patient.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Coordination of care between the primary care clinician and the referring clinician, the specialist and the patient/family/caregiver. | <input type="checkbox"/> | <input type="checkbox"/> |

**Scoring**

100%	75%	50%	25%	0%
The practice meets all 3 factors	No scoring option	The practice meets 2 factors	The practice meets 1 factor	The practice meets 0 factors

**Explanation**

It is vitally important for primary care to be viewed as the provider of whole person care and that care provided by the specialist is in collaboration with primary care.

The practice has a documented process for staff to follow for giving patients/families/caregivers (as appropriate for the patient) information about the roles and responsibilities of the specialist, compared with that of the patient’s medical home. The information states what the patient can expect from the specialist regarding whom to contact for concerns, questions and information, and when the patient should contact primary care. The practice is encouraged to provide information in multiple formats to accommodate patient preference and language needs.

The practice helps patients find a primary care clinician if they do not have one.

**Factor 1:** The practice:

- Provides information about its office hours; where to seek after-hours care; and how to communicate with the personal clinician and team, including requesting and receiving clinical advice during and after business hours.
- Instructs its patients to give their other providers or facilities the personal clinician’s information when they seek care outside the practice.

**Factor 2:** The practice provides information about:

- How, when and how often the practice will communicate with the patient/family/caregiver (as appropriate for the patient) about test results and care management.
- Practice office hours.
- Where to seek after-hours care.
- How to communicate with the specialist and specialty practice team, including requesting and receiving clinical advice during and after business hours.

**Factor 3:** The practice provides information to the patient/family/caregiver (as appropriate for the patient) about how care will be coordinated.

**Documentation**

*For all factors that require a documented process, the documented process must include a date of implementation or revision and must be in place for at least three months prior to submitting the PCSP 2016 survey tool.*

**Factors 1–3:** NCQA reviews:

- A documented process for providing patients with information and materials about the specialist’s obligations, **and**
- Materials the practice provides to patients, such as:
  - Patient brochure.
  - Letter to the patient/family/caregiver.
  - Web materials.

**Element D: Culturally & Linguistically Appropriate Services (CLAS) 3.00 points**

The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families/caregivers.	Yes	No	NA
1. Assessing the diversity of its population.	<input type="checkbox"/>	<input type="checkbox"/>	
2. Assessing the language needs of its population.	<input type="checkbox"/>	<input type="checkbox"/>	
3. Providing interpretation or bilingual services to meet the language needs of its population.	<input type="checkbox"/>	<input type="checkbox"/>	
4. Providing printed materials in the languages of its population.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	<b>100%</b>	<b>75%</b>	<b>50%</b>	<b>25%</b>	<b>0%</b>
	The practice meets all 4 factors	The practice meets 3 factors	The practice meets 2 factors	The practice meets 1 factor	The practice meets 0 factors

**Explanation**

**Note:** Literacy and health literacy are not addressed in this element because it is expected that care management processes in other elements will be tailored to the level of understanding and needs of the individual patient. Nor have experts agreed on the need for a standardized assessment or the course of action that should be taken based on findings of the health literacy assessment.

**Diversity** is a meaningful characteristic of comparison for managing population health that accurately identifies individuals within a non-dominant social system who are underserved. These characteristics of a group may include, but are not limited to, race, ethnicity, gender identity, sexual orientation and disability.

Identifying and meeting the cultural and linguistic needs of patients/families/caregivers (as appropriate for the patient) is as important for specialty practices as it is for primary care.

**Factors 1, 2:** The practice uses data to assess the diversity and linguistic needs of its population so it can meet those needs adequately. Data may be collected from all patients directly or may refer to the community served by the practice.

**Note:** Patient race, ethnicity and language preference are tracked in Element 3A: Patient Information.

**Factor 3:** Language services may include third-party interpretation services or multilingual staff. Under Title VI of the Civil Rights Act, clinicians who receive federal funds are responsible for providing language and communication services to their patients as required to meet clinical needs.

Asking a friend or family member of the patient to interpret does not meet the intent of this standard. Studies demonstrate that patients are less likely to be forthcoming with a family member present, and the family member may not be familiar with medical terminology. A third party tends to be more objective.

**Factor 4:** The practice identifies individual languages spoken by at least 5 percent of its patient population and makes materials available in those languages. For patients with limited English proficiency, the practice provides forms that patients must sign, complete or read for administrative or clinical needs in the preferred language of the patient.

Factor 4 is NA if no single language (other than English) is spoken by 5 percent or more of the patient population. The practice must provide a written explanation of an NA response.

**Documentation**

*NCQA reviews the Organizational Background “Practice Information” in the ISS survey tool, to gain a better understanding of the patient population and how the practice functions. Completing this information is recommended, but is not required.*

**Factors 1, 2:** NCQA reviews a report showing the practice’s assessment of the diversity (including racial, ethnic and at least one other meaningful characteristic of diversity) and language composition of its patient population.

**Note:** *If the practice selects an aspect of diversity in factor 1 that is not used to evaluate a potential health disparity in PCSP 6, it provides an explanation for the selection.*

**Factor 3:** NCQA reviews documentation of the availability of interpretive services, or the practice’s policy or statement that it uses bilingual staff. The policy or statement explains the practice’s procedures when a patient needs assistance in a language not spoken by bilingual staff.

**Factor 4:** NCQA reviews materials or access to materials in languages other than English, a screenshot of a link to online materials or a Web site in languages other than English.



**Element E: The Practice Team (MUST-PASS) 4.00 points**

The practice uses a team to provide a range of patient care services by:	Yes	No
1. Defining roles for clinical and nonclinical team members.	<input type="checkbox"/>	<input type="checkbox"/>
2. Having regular team meetings or a structured communication process focused on patients.	<input type="checkbox"/>	<input type="checkbox"/>
3. Using standing orders for services.	<input type="checkbox"/>	<input type="checkbox"/>
4. Training and assigning members of the care team to coordinate care for individual patients.	<input type="checkbox"/>	<input type="checkbox"/>
5. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change.	<input type="checkbox"/>	<input type="checkbox"/>
6. Involving care team staff in the practice’s performance evaluation and quality improvement activities.	<input type="checkbox"/>	<input type="checkbox"/>
7. Holding regular practice team meetings.	<input type="checkbox"/>	<input type="checkbox"/>

**Scoring**

100%	75%	50%	25%	0%
The practice meets 5-7 factors	The practice meets 4 factors	The practice meets 3 factors	The practice meets 1-2 factors.	The practice meets 0 factors

**Explanation**

**MUST-PASS** elements are considered essential to a patient-centered specialty practice. Practices must earn a score of 50% or higher. All six must-pass elements are required for recognition.

Managing patient care involves a team of clinical and nonclinical staff (e.g., physicians, nurse practitioners, physician assistants, nurses, medical assistants, educators, schedulers) interacting with patients and working to achieve stated objectives. The clinician leading the team is integral to determining and enacting the processes established by the practice. The emphasis is on “teamness”—ongoing interactions of team members to discuss roles, responsibilities, communication and patient handoffs. All staff are involved as team members, and the role of physician assistants who are under physician supervision is articulated to patients.

**Factor 1:** Job descriptions and responsibilities of the care team emphasize a team-based approach to patient care and promote training of team members to meet the highest level of function allowed by state law. The care team includes practice staff that interact with patients and may include the receptionist or others who have telephone contact with patients.

**Factor 2:** Regular team meetings focused on patient care may include daily huddles or a review of daily schedules, with follow-up tasks that may precede patient visits. A **huddle** is a team meeting to discuss patients on the day’s schedule (e.g., in the morning before patients arrive or in the afternoon, to discuss patients coming in the following day). A structured communication process may include regular e-mail exchanges, tasks or messages about a patient in the medical record.

Excellent communication and coordination among the members of the team has been found to be an important feature of successful patient-centered practices.

**Factor 3:** Standing orders (e.g., test protocols, defined triggers for prescription orders, medication refills) may be preapproved by the clinician or may be executed without prior approval of the clinician, as permitted by state law.

**Factor 4:** Care coordination may include obtaining test results and communicating with primary care, community organizations, health plans, facilities (hospital, ER, nursing homes) or other specialists or organizations.

**Factor 5:** Care team members are trained in evidence-based approaches to self-management support, such as patient coaching and motivational interviewing.

The practice determines how frequently care team members are trained and retrained. Training accommodates the addition of new team members.

**Factor 6:** The care team receives performance measurement and patient survey data and has the opportunity to identify and discuss areas for improvement and establish methods for quality improvement (e.g., regular participation by staff in quality improvement meetings, action plan implementation).

**Factor 7:** The practice holds regular team meetings that include clinical staff (e.g., physicians, nurse practitioners) and nonclinical staff. Meetings discuss the operations of the practice and the staff, team member training, areas for improvement and what is working well. For example, an ongoing discussion may revolve around staff roles and responsibilities, performance measurement data and related quality improvement efforts (factor 6). The frequency of these team or staff meetings will vary (e.g., monthly, bimonthly, quarterly), but meetings are part of the routine operations of the practice.

### **Documentation**

**Factors 1, 4, 5:** NCQA reviews materials describing staff roles and functions of clinical team members in providing team-based care (e.g., job descriptions, organizational chart, description of the team structure and team members).

**Factor 2:** NCQA reviews:

- A description of the structured clinical team communication processes about patients that occur regularly, and
- Three examples of the communication based on the process implemented, such as appointment notes, huddle notes, agenda, memos or e-mails.

**Factor 3:** NCQA reviews an example of written standing orders.

**Factors 4, 5:** NCQA reviews a description of the training process **and** training schedule or materials showing how staff are trained in each area identified in the factors.

**Factor 6:** NCQA reviews a description of staff roles in the practice evaluation and improvement process, **or** minutes from team meetings showing staff involvement.

**Factor 7:** NCQA reviews:

- A description of the team meetings, **and**
- Three samples of meeting summaries, agendas or memos to staff.

NCQA encourages the practice to highlight the information relevant to each factor in the documentation.

**PCSP 3: Identify and Coordinate Patient Populations 10.00 points**

The practice systematically records patient information and uses it to coordinate care for patient populations.

Element A: Patient Information	2.00 points		
The practice uses an electronic system that records the following as structured (searchable) data for more than 80 percent of the patients.	Yes	No	NA
1. Date of birth.	<input type="checkbox"/>	<input type="checkbox"/>	
2. Sex.	<input type="checkbox"/>	<input type="checkbox"/>	
3. Race.	<input type="checkbox"/>	<input type="checkbox"/>	
4. Ethnicity.	<input type="checkbox"/>	<input type="checkbox"/>	
5. Preferred language.	<input type="checkbox"/>	<input type="checkbox"/>	
6. Telephone numbers.	<input type="checkbox"/>	<input type="checkbox"/>	
7. E-mail address.	<input type="checkbox"/>	<input type="checkbox"/>	
8. Name and contact information of primary caregiver.	<input type="checkbox"/>	<input type="checkbox"/>	
9. Occupation (NA for pediatric practices).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Presence of advance directives.	<input type="checkbox"/>	<input type="checkbox"/>	
11. Health insurance information.	<input type="checkbox"/>	<input type="checkbox"/>	
12. Name and contact information of primary care clinician.	<input type="checkbox"/>	<input type="checkbox"/>	
13. Name and contact information of other specialists.	<input type="checkbox"/>	<input type="checkbox"/>	
14. Practice-patient relationship status.	<input type="checkbox"/>	<input type="checkbox"/>	

Scoring	100%	75%	50%	25%	0%
	The practice meets 10-14 factors	The practice meets 8-9 factors	The practice meets 5-7 factors	The practice meets 3-4 factors	The practice meets 0-2 factors

**Explanation** The practice uses an electronic system that records the data for some factors as structured (searchable) data for more than 80 percent of patients.

The practice uses a practice management, EHR or other electronic system that collects and records patient information for *factors 1–12* in searchable data fields. To meet these factors, the practice must generate a report showing the percentage of patients seen by the practice for whom data were entered. Documentation in the medical record of “none,” “no” or “patient declined to provide information” counts toward the numerator. All data fields must be populated. Fields that have no data do not count.

**Searchable data** means that the information is entered into a field in an electronic system that will allow the practice to conduct data searches and create reports.

**Structured data fields** have specified data type and response categories within a record or file.

**Note:** *Factors 13 and 14 do not need to be in searchable or structured data fields.*

**Factor 1:** The practice records patient date of birth.

**Factor 2:** The practice records patient sex.

**Factors 3, 4:** The practice records race and ethnicity data, in addition to language, which contributes to its ability to understand its patient population. The practice may align race and ethnicity categories with those used by the Office of Management and Budget (OMB). Patients who prefer not to provide race/ethnicity may be counted in the numerator if the practice documents in the record that the patient declined to provide the information.

**Factor 5:** The practice documents the patient's preferred language. Patients are not required to discuss their language needs, but documentation helps identify patients who need interpretation or/and translation services. The practice must document that the patient declined to provide language information, that the patient's primary language is English or that the patient does not need language services. A blank field cannot be assumed to mean that the patient speaks English.

**Factor 6:** The patient's primary telephone number may be a mobile number. A blank field does not assume the patient has no telephone number.

**Factor 7:** The practice records patient e-mail addresses and enters "none" in the field for patients who do not have an e-mail address or decline to provide one. This counts toward the numerator.

**Factor 8:** A **primary caregiver** provides day-to-day care for the patient and must receive instructions about care. Documentation of the name and contact information of the primary caregiver is recorded in the health care record. The practice enters "none" in the field if there is no caregiver. This counts toward the numerator.

**Factor 9:** The practice records the patient's field of employment. If a patient is not currently employed, the practice indicates a status (i.e., retired, disabled, unemployed, student). This factor may be marked "NA" if the practice sees only pediatric patients, and the practice will be considered to have met the factor. The practice must provide a written explanation for an NA response.

**Factor 10:** The practice documents in the medical record whether the patient/family provided an advance directive (includes living wills, Physician Orders for Life Sustaining Treatment [POLST], durable power of attorney, health proxy). The advance directive must be on file at the practice to meet the factor. Documentation in the field that the patient declined to provide the information counts toward the numerator.

**Factor 11:** The practice documents patient/family health insurance coverage (e.g., health plan name, Medicare, Medicaid, "none").

**Factor 12:** The practice records the name and contact information of the patient's current primary care clinician. If the patient does not have a primary care clinician, the practice records this in the medical record. The practice encourages the patient to seek a primary care clinician and provides assistance as needed.

**Factor 13:** The practice records the name and contact information for other specialty clinicians providing care. This factor does not require the field to be searchable or structured data.

**Factor 14:** The practice records the manner in which it provides care to the patient by indicating the relationship status is most closely characterized as one of the following:

- Consultation with primary care.
- Evaluation and treatment.
- Formal co-management.
- Care management.

This factor does not require the field to be searchable or structured data.

**Documentation**

NCQA reviews the Organizational Background “Practice Information” in the ISS survey tool, to gain a better understanding of the patient population and how the practice functions. Completing this information is recommended, but is not required.

**Factors 1–12:** NCQA reviews reports from the electronic system showing the percentage of *all* patients for each populated data field. The report contains each required data fields to determine how many are consistently entered in the practice’s electronic system.

This element calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage based on at least three months of data in the electronic system. The practice must provide the numerator and denominator numbers, as well as the percentage and the dates used in the calculation.

- *Denominator* = Number of patients seen by the practice at least once during the reporting period (for factor 9, include only those who meet the age parameters).
- *Numerator* = Number of patients in the denominator for whom the specified data are entered for each data element.

**Factors 13, 14:** For each factor, NCQA reviews:

- A documented written process for staff to identify how and where patient information is captured, **and**
- Three examples documenting implementation of the process.

Element B: Clinical Data		2.00 points		
The practice uses an electronic system to record the following as structured (searchable) data.		Yes	No	NA
1.	An up-to-date problem list, including current and active diagnoses, for more than 80 percent of patients.	<input type="checkbox"/>	<input type="checkbox"/>	
2.	Allergies, including medication allergies and adverse reactions, for more than 80 percent of patients.	<input type="checkbox"/>	<input type="checkbox"/>	
3.	Blood pressure, including the date of update, for more than 80 percent of patients 3 years and older.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Height/length for more than 80 percent of patients.	<input type="checkbox"/>	<input type="checkbox"/>	
5.	Weight for more than 80 percent of patients.	<input type="checkbox"/>	<input type="checkbox"/>	
6.	BMI, which is calculated and displayed. (NA for pediatric practices).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Growth charts (length/height, weight and head circumference (less than 2 years of age)) and BMI percentile (0–20 years) (NA for adult practices).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Status of tobacco use for patients 13 years and older, for more than 80 percent of patients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	List of prescription medications, including date of updates, for more than 80 percent of patients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Family health history, for more than 20 percent of patients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	An electronic progress note that can be created, edited and signed by an eligible professional.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	The practice meets 9-11 factors	The practice meets 7-8 factors	The practice meets 5-6 factors	The practice meets 3-4 factors	The practice meets 0-2 factors

**Explanation**

The practice collects clinical information on its patients through an EHR or other electronic system, such as a practice management or billing system that can be searched for each factor and can create reports. Documentation in the medical record of “none” or “patient declined to provide information” counts toward the numerator.

**Searchable data** means that the information is entered into a field that allows the practice to conduct data searches and create reports.

**Structured data fields** have specified data types and response categories in a record or file.

Information included in a referral from primary care may be used, but the data must be included in the patient’s medical record with the specialist.

**Factor 1:** The practice records the patient's current and active problem list or diagnoses.

**Factor 2:** The practice records the patient's allergies (including medication, food or environmental allergies) and associated reactions.

**Factor 3:** The practice documents and dates all blood pressure readings for more than 80 percent of patients 3 years and older. This factor is NA for practices with no patients 3 years and older. The practice must provide a written explanation for an NA response.

**Factors 4–5:** The practice documents and dates height/length and weight for more than 80 percent of all patients.

**Factor 6:** The practice's electronic system can calculate and display BMI within the medical record. Pediatric practices may respond NA. The practice must provide a written explanation for an NA response.

**Factor 7:** The practice's electronic system can plot and display length, weight and head circumference on a growth chart for patients 0–2 years. Head circumference in children under 2 is a vital growth parameter that provides a guide to a child's health, development, nutritional status and response to treatment.

*For patients 0–20 years, BMI is calculated using height and weight and plotted on the appropriate CDC BMI-for-age growth chart to obtain a percentile ranking, and is displayed in the medical record. Percentiles are the most commonly used indicator of size and growth patterns.*

NA may be used for practices with no pediatric patients. The practice must provide a written explanation for an NA response.

**Factor 8:** The practice collects data on smoking status and tobacco use. This information is collected as a separate factor, to emphasize its importance in relation to overall health. NA may be used if the practice has no patients 13 years and older. The practice must provide a written explanation for an NA response.

**Factor 9:** The practice records current prescription medications (and updates) prescribed by clinicians seen by the patient (including those outside the practice). If a patient's medical record documents that the patient does not take prescribed medications ("None"), the patient counts toward the numerator.

This factor is NA for any eligible provider who does not prescribe medications. The practice must provide a written explanation for an NA response.

**Factor 10:** The practice records family health history for first-degree relatives—family members who share about 50 percent of their genes with a particular individual in a family. The practice may mark this field "unknown" for patients who do not know their family health history. Family health history may include history of chronic diseases or events (e.g., diabetes, cancer, mental health, substance abuse, myocardial infarction, hypertension). This factor is NA for any eligible provider who has no office visits during the reporting period. The practice must provide a written explanation for an NA response.

**Factor 11:** The practice's progress notes are text-searchable. Nonsearchable notes do not meet the factor. Following the CMS definition, the practice may determine guidelines with regard to what progress notes are necessary to communicate individual patient circumstances. The practice coordinates notes with previous documentation of patient observations, treatments or results. This factor is NA for any eligible provider who has no office visits during the reporting period. The practice must provide a written explanation for an NA response.

### Documentation

NCQA reviews the Organizational Background “Practice Information” in the ISS survey tool, to gain a better understanding of the patient population and how the practice functions. Completing this information is recommended, but is not required.

**Factors 1–5, 8–10:** NCQA reviews reports from the electronic system showing the percentage of *all* unique patients for each populated data field, not only patients who are in a disease-specific registry. The report contains each required data element, to determine how many elements are consistently entered in the practice’s electronic system.

This element calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage based on three months of data in the electronic system.

- *Denominator* = Number of patients seen by the practice at least once during the reporting period (only those meeting the age parameters are included).
- *Numerator* = Number of patients in the denominator for whom the specified data are entered for each data element.

**Factors 6, 7:** NCQA reviews screen shots demonstrating capability of the electronic system to display BMI (factor 6) and display growth charts and BMI percentile (factor 7).

**Factor 11:** NCQA reviews at least one example demonstrating use or capability to create, edit and sign an electronic progress note.



**Element C: Implement Evidence-Based Reminders for Specialty Care 3.00 points**

For patients with whom it has an ongoing relationship, the practice uses patient information, clinical data and evidence-based guidelines to proactively remind patients/families/caregivers of needed services for:

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 1. A condition-related service.        | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. A second condition-related service. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. A third condition-related service.  | <input type="checkbox"/> | <input type="checkbox"/> |

	100%	75%	50%	25%	0%
Scoring	The practice all 3 factors	The practice meets 2 factors	No scoring option	The practice meets 1 factor	The practice meets 0 factors

**Explanation** The practice produces lists of patients needing services or follow-up, and uses evidence-based guidelines to implement clinical decision-support interventions. The practice has a documented process for reminding patients about necessary services that uses mail, telephone or e-mail reminders.

NCQA encourages practices to identify and coordinate services with primary care or the referring clinician. The agreement between the specialty practice and primary care may specify which practice is responsible for tests, services and follow-up care.

**Factors 1–3**

The practice uses its patient lists to remind patients of three defined services that are appropriate to the practice’s specialty.

**Documentation**

*NCQA reviews the Organizational Background “Practice Information” in the ISS survey tool, to gain a better understanding of the patient population and how the practice functions. Completing this information is recommended, but is not required.*

The practice demonstrates that during the past year it proactively generated lists to identify and provide outreach to patients in need of defined services (as described in the documentation for each factor). The practice may provide data from one or more health plans that account for at least 75 percent of its patient population.

**Factors 1–3:** For each factor, NCQA reviews:

- Reports or lists of patients needing services generated within the past 12 months. Reports may include documentation that a specific service is being managed by primary care, **and**
- Materials showing how patients are notified of needed services (e.g., letters sent to patients, a script or description of phone reminders, screen shots of electronic notices).

<b>Element D: Implement Evidence-Based Decision Support</b>		<b>3.00 points</b>			
The practice implements clinical decision-support interventions+ (e.g., point-of-care reminders) following evidence-based guidelines for conditions appropriate to the services it provides.		Yes	No		
1.	The practice implements a clinical decision-support intervention.+	<input type="checkbox"/>	<input type="checkbox"/>		
2.	The practice implements a second clinical decision-support intervention.+	<input type="checkbox"/>	<input type="checkbox"/>		
3.	The practice implements a third clinical decision-support intervention.+	<input type="checkbox"/>	<input type="checkbox"/>		
4.	The practice implements a fourth clinical decision-support intervention.+	<input type="checkbox"/>	<input type="checkbox"/>		
5.	The practice implements a fifth clinical decision-support intervention.+	<input type="checkbox"/>	<input type="checkbox"/>		
Scoring	<b>100%</b>	<b>75%</b>	<b>50%</b>	<b>25%</b>	<b>0%</b>
	The practice meets all 5 factors	The practice meets 4 factors	The practice meets 3 factors	The practice meets 2 factors	The practice meets 0-1 factors

**Explanation** + Meaningful Use Modified Stage 2 Alignment

The services provided by the practice to patients are based on evidence-based guidelines. A key to successful implementation of guidelines is to embed them in the practice's day-to-day operations (frequently referred to as "clinical decision support"), enabling the practice to develop treatment plans and document patient status and progress.

Clinical Decision Support (CDS) is a systematic way to prompt clinicians to consider evidence based guidelines at the point of care. CMS notes that CDS is "not simply an alert, notification, or explicit care suggestion. CDS encompasses a variety of tools including, but not limited to:

- Computerized alerts and reminders for providers and patients
- Clinical guidelines
- Condition-specific order sets
- Focused patient data reports and summaries
- Documentation templates
- Diagnostic support
- Contextually relevant reference information."

While CDS may relate to clinical quality measures, measures alone do not achieve the broader goals of CDS.

Clinical data collected in PCSP 3, Element B support the practice's approach to meeting criteria in this element. When selecting conditions, the practice considers:

- Diagnoses and risk factors prevalent in patients seen by the practice.
- The availability of evidence-based clinical guidelines.
- American Board of Internal Medicine Foundation's Choosing Wisely campaign provides information about implementing evidence-based guidelines as clinical decision support ([www.choosingwisely.org](http://www.choosingwisely.org)).
- Other resources for evidence-based guidelines include:
  - Up-to-Date: [www.uptodate.com](http://www.uptodate.com)
  - National Guideline Clearinghouse: <http://www.guideline.gov/>
  - American Academy of Pediatrics: <http://goo.gl/izxWY9>

**Factors 1–5:** The practice uses evidence-based guidelines for clinical decision support related to the specialist’s scope of practice or patient population.

CMS provides additional information: The practice is expected to “implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP’s scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions” relevant to the patient population.

#### **Documentation**

*NCQA reviews the Organizational Background “Practice Information” in the ISS survey tool, to gain a better understanding of the patient population and how the practice functions. Completing this information is recommended, but is not required.*

**Factors 1–5:** NCQA reviews:

- The conditions identified for each factor.
- The source of guidelines used by the practice for each condition.
- At least one example demonstrating guideline implementation for a patient at the point of care.

**Note:** *Each selected condition may be used only once for this element.*

**PCSP 4: Plan and Manage Care****18.00 points**

The practice collaborates with the referring clinician and the patient/family/caregiver to plan and manage care and provide self-care support.

<b>Element A: Care Planning and Support Self-Care</b>	<b>8.00 points</b>	
	Yes	No
The practice provides the following care management and self-care support for practice-specific conditions.		
1. Conducts pre-visit preparations.	<input type="checkbox"/>	<input type="checkbox"/>
2. Assesses patient risk status to identify patients needing additional support and services.	<input type="checkbox"/>	<input type="checkbox"/>
3. Collaborates with the patient/family/caregiver to develop and update a specialist's plan of care that includes the patient's goals, potential barriers and self-care ability. (CRITICAL FACTOR)	<input type="checkbox"/>	<input type="checkbox"/>
4. Shares the specialist's plan of care, including recommendations for self-care support, with the PCP and the referring clinician. (CRITICAL FACTOR)	<input type="checkbox"/>	<input type="checkbox"/>
5. Gives the patient/family/caregiver the specialist's plan of care, including self-care recommendations.	<input type="checkbox"/>	<input type="checkbox"/>
6. Provides educational resources or refer patients/families/caregivers to assist in self-management.	<input type="checkbox"/>	<input type="checkbox"/>
7. Assesses and addresses potential barriers to meeting goals.	<input type="checkbox"/>	<input type="checkbox"/>
8. Uses an EHR to identify and provide patient-specific education resources to more than 10 percent of patients.+	<input type="checkbox"/>	<input type="checkbox"/>

<b>Scoring</b>	<b>100%</b>	<b>75%</b>	<b>50%</b>	<b>25%</b>	<b>0%</b>
	The practice meets 6-8 factors, including factors 3 and 4	The practice meets 4-5 factors, including factors 3 and 4	The practice meets 2-3 factors, including factors 3 and 4	No scoring option	The practice meets 0-1 factors or does not meet factors 3 and 4

**Explanation** +Meaningful Use Modified Stage 2 Alignment

This element emphasizes the importance of the coordination, communication and collaboration required to plan and manage patients referred to the specialist from primary care. Care revolves around conditions related to the practice specialty and is coordinated with the patient/family/caregiver (as appropriate for the patient) and primary care or the referring clinician. The details of care provided by the specialist vs. primary care may be specified in the primary care-specialist agreement. Practices may also refer to PCSP 2, Element C.

**Factor 1:** The practice asks (e.g., by letter, e-mail) patients to complete required paperwork before a scheduled visit, in addition to lab tests, imaging tests or referral visits. The practice reviews test results before the visit. This process may be part of the team daily huddle or a protocol, procedure or checklist.

**Factor 2:** The practice assesses patient risk status and, when appropriate, refers patients to other resources (external or internal) for additional care management support, such as disease management (DM) programs or case management programs. Practices may use motivational interviewing to assess patient readiness to

change, and assess self-management abilities through patient questionnaires and self-assessment forms. The practice may evaluate patient information to help identify high-risk patients (e.g., multiple co-morbid conditions, lack of caregiver support, inadequate living conditions, multiple hospitalizations).

Assessing self-management abilities enables the practice to adjust plans to fit patient/family/caregiver capabilities and resources. Patients/families/caregivers who feel they can manage their condition, learn needed self-care skills or adhere to treatment goals will have greater success.

The criteria for identifying complex or high-risk patients come from a profile of resource use and risk in the practice's population, and may include the following, or a combination of the following:

- High level of resource use (e.g., visits, medication, treatment or other measures of cost).
- Frequent visits for urgent or emergent care (i.e., two or more visits in the last six months).
- Frequent hospitalizations (i.e., two or more in the last year).
- Multiple co-morbidities, including mental health.
- Noncompliance with prescribed treatment/medications.
- Terminal illness.
- Psychosocial status, lack of social or financial support that impedes ability for self-care.
- Advanced age, with frailty.
- Multiple risk factors.

### **Pediatric populations**

The practice may identify children and youths with special health care needs who are defined by the U.S. Department of Health and Human Services Maternal and Child Health Bureau (MCHB) as children “who have or are at risk for chronic physical, developmental, behavioral or emotional conditions and who require health and related services of a type or amount beyond that required generally.” (Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, American Academy of Pediatrics, 3rd Edition, 2008, p. 18.)

Additional care management guidelines for children and youth with special needs are included in *Caring for Children Who Have Special Health-care Needs: A Practical Guide for the Primary Care Practitioner*. Matthew D. Sadof and Beverly L. Nazarian, *Pediatr. Rev.* 2007;28:e36-e42

<http://pedsinreview.aappublications.org/cgi/content/full/28/7/e36>

The practice may identify patients through a billing or practice management system or electronic medical record; through key staff members; or through profiling performed by a health plan, if profiles provided by the plan represent at least 75 percent of the patient population.

**Factor 3:** The practice builds on the primary care plan. If no plan is available, the practice works with patients/families/caregivers to develop a care plan. The plan references the patient's condition and includes the patient's goals and possible barriers to reaching the goals, and the patient's capacity for self-care. The care plan specifies the services and responsibilities of the specialist plan of care and those of the primary care clinician, to avoid potential overlaps or gaps in services and care.

The practice obtains patient permission to involve family members or caregivers in development of the care plan.

Research supports the importance of collaboration to develop a care plan that may be used by patients and families to understand care that will be provided by the specialist and expectations for care management at home. Thus, **factor 3** has been identified as **one of two critical factors** required for practices to receive more than 25 percent of the available points in this element.

**Factor 4:** The specialist shares the care plan with the primary care clinician and the referring clinician. This is necessary whether the referral is a request for a consultation or if patient care is being co-managed by the specialist. Research supports the importance of collaboration between specialists and primary care to develop and implement a care plan, to avoid overlaps in care or gaps. **Factor 4** is the **second critical factor** required for a practice to receive more than 25 percent of the available points in this element.

**Factor 5:** The practice gives the patient/family/caregiver a care plan tailored for the patient's use at home and to the patient's understanding as developed for factor 3. The practice documents that it provides written care plans to patients, families or caregivers.

**Factor 6:** Educational programs and resources may include information about a medical condition being managed by the specialist and may include resources related to the patient self-management.

Resources include brochures, handout materials, videos, Web site links and pamphlets, as well as community resources (e.g., programs, support groups).

Materials in languages other than English are available for patients/families, if appropriate, based on the practice's assessment of languages spoken by its patients (PCSP 3, Element A).

Patients/families/caregivers (as appropriate for the patient) may be referred to resources outside the practice, with consideration that resources may not be covered by health insurance.

In coordination with primary care, the practice provides patients with self-management support and tools beyond the counseling or guidance typically provided during an office visit. In addition, the practice provides or refers patients to self-management programs or classes (e.g., asthma education, diabetes education). Programs may be offered through community agencies, a health plan or a patient's employer.

**Factor 7:** The clinician or care team assesses or talks with the patient/family/caregiver and to the primary care clinician, to determine reasons for limited progress toward treatment goals and to help the patient/family address barriers (e.g., patient's lack of understanding or motivation or readiness for change, financial need, insurance issues, adverse effects of medication or other treatment or transportation problems). The clinician or care team changes the treatment plan or adds treatment, if appropriate.

**Factor 8:** The practice uses a certified EHR to identify patient-specific educational resources, and provides these resources to at least 10 percent of its patients, if appropriate.

CMS states, “Resources are identified through logic built into certified EHR technology which evaluates information about the patient and suggests education resources that would be of value to the patient.” Patients may be identified as candidates for patient-specific educational resources through the patient’s problem list, medication list or laboratory test results. The practice uses certified EHR technology to suggest patient-specific educational resources, but the clinician makes the final decision on the usefulness and relevance to a specific patient.

### **Documentation**

*For all factors that require a documented process, the documented process must include a date of implementation or revision and must be in place for at least three months prior to submitting the PCSP 2016 survey tool.*

#### **Factors 1–7:** NCQA reviews:

- A documented process for staff to follow in:
  - Pre-visit planning.
  - Assessing patient need for additional support and services.
  - Collaborating with patient on a specialist’s plan of care.
  - Sharing care plan with primary care.
  - Giving the patient the specialist’s written care plan.
  - Providing educational materials for self-management.
  - Assessing and addressing barriers, **and**
- Three examples demonstrating implementation of each factor.

#### **Factor 8:** NCQA reviews a report with numerator and denominator.

This factor calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage based on 3 months of data in the electronic system.

- *Denominator* = Number of patients seen by the practice during the reporting period.
- *Numerator* = Number of patients provided patient-specific education resources.

**Element B: Medication Management (MUST-PASS) 6.00 points**

The practice has a process and demonstrates that it systematically manages medications prescribed by the practice in the following ways:	Yes	No	NA
1. Reconciles medications for more than 50 percent of patients received from another care setting or at a relevant visit.+	<input type="checkbox"/>	<input type="checkbox"/>	
2. Provides information about new prescriptions from specialty practice to patients/families/caregivers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Coordinates medication management with the PCP, referring clinician (if applicable) and patient/family/caregiver.	<input type="checkbox"/>	<input type="checkbox"/>	
4. Assesses patient/family/caregiver understanding of medications from specialty practice.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Assesses patient response to medications from specialty practice and barriers to adherence.	<input type="checkbox"/>	<input type="checkbox"/>	
6. Documents nonprescription medications.	<input type="checkbox"/>	<input type="checkbox"/>	

Scoring	100%	75%	50%	25%	0%
	The practice meets 5-6 factors	The practice meets 4 factors	The practice meets 3 factors	The practice meets 2 factors	The practice meets 0-1 factors

**Explanation** **MUST-PASS** elements are considered essential to a patient-centered specialty practice. Practices must earn a score of 50% or higher. All six must-pass elements are required for recognition.

+Meaningful Use Modified Stage 2 Alignment

**Factor 1:** Maintaining a current list of a patient's medications and resolving conflicts with medications reduces the possibility of duplicate medications, medication errors or adverse drug events. A process for documenting and maintaining a current list of patient medications is essential for patient safety.

The practice reviews and documents all prescribed medications a patient is taking in the medical record, and reviews and reconciles medications during **relevant** visits to the specialist and following ER visits, hospitalizations or visits to other specialists. The practice may define "relevant visit."

Clinicians who do not prescribe medications, must have a process for documenting current medications.

**Factor 2:** The practice provides patients/families/caregivers (as appropriate for the patient) with information about new medications prescribed by the specialist, including potential side effects, drug interactions, instructions for taking the medication and the consequences of not taking it. The practice may respond NA if it does not prescribe medications. It must provide a written explanation for an NA response.

**Factor 3:** The practice coordinates medication management with primary care or the referring clinician by exchanging information about changes in medications. This expectation may be in the agreement established by the specialist and primary care. The practice involves the patient/family/caregiver in the coordination and reconciliation of medications. Practices have found greater patient engagement if staff explains the emphasis on reconciling medications and encouraging the patient/family/caregiver to give the practice a list of *current* medications.



**Factor 4:** The practice assesses the patient/family/caregiver's, understanding of medications prescribed by the specialist, including why a medication is prescribed, how and when to take it, potential side-effects and consequences of not taking the medication. The practice may respond NA if it does not prescribe medications. It must provide a written explanation for an NA response.

**Factor 5:** During the visit, the practice asks the patient about problems or difficulty taking the medication and side effects; whether the patient is taking and refilling the medication as prescribed; and, if the patient is not taking the medication, possible reasons. If the practice does not prescribe medications, it asks the patient if medication is being taken as prescribed, and contacts the prescribing clinician to address barriers or issues.

**Factor 6:** The practice reviews and documents nonprescription medications the patient is taking, such as over-the-counter (OTC) medications, herbal therapies and supplements, to prevent interference with prescribed medications and to evaluate potential side effects and interactions. Nonprescribing clinicians collect and document this information and provide it to primary care or the referring clinician.

### **Documentation**

*For all factors that require a documented process, the documented process must include a date of implementation or revision and must be in place for at least three months prior to submitting the PCSP 2016 survey tool.*

**Factor 1:** NCQA reviews a report showing that more than 50% of patients had medications reviewed and reconciled at a relevant visit.

- *Denominator* = Number of patients seen by the practice in the reporting period.
- *Numerator* = Number of patients with a completed medication review.

**Factors 2–6:** NCQA reviews:

- A documented process for staff to follow for managing the medications prescribed by the practice, **and**
- Three examples for each factor.
  - Examples may collectively demonstrate that each factor is met or show individually that each factor is met.

**Element C: Use Electronic Prescribing** **4.00 points**

The practice uses an electronic prescription system with the following capabilities:	Yes	No	NA
1. At least 75 percent of eligible prescriptions are generated using the electronic prescription system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. More than 50 percent of eligible prescriptions written by the practice are compared to drug formularies and sent to pharmacies electronically.+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. More than 60 percent of medication orders are entered into the medical record.+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Performs patient-specific checks for drug-drug and drug-allergy interactions.+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Prescription system alerts prescribers to generic alternatives.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Scoring**

100%	75%	50%	25%	0%
The practice meets 3-5 factors	The practice meets 2 factors	The practice meets 1 factor	No scoring option	The practice meets 0 factors

**Explanation**

+ Meaningful Use Modified Stage 2 Alignment

**Note:** This Element is NA for practices that do not prescribe any medications. In this case, points assigned to this element are redistributed to the other elements in PCSP 4. If the practice responds NA to this element, it must provide a written explanation.

**Factor 1:** At least 75 percent of eligible prescriptions written by the practice are generated electronically, including new prescriptions and renewals, which requires the practice to produce a denominator that encompasses the total number of prescriptions issued (by hand, by phone and electronically).

**Note:** If the organization cannot produce a report to meet the factor requirement, refer to factor 1 alternative documentation.

**Factor 2:** More than 50 percent of eligible prescriptions written by the practice are:

- Compared with drug formularies to identify covered drugs and the copayment tier, if applicable, **and**
- Sent to pharmacies electronically.
  - Sent “electronically” means conveyed from the practice electronically to the pharmacy; it *does not* mean printing a copy of the prescription and faxing it to the pharmacy.

**Exclusions.** If a practice meets the exclusion criteria for the current final rule for Meaningful Use, it may respond NA to the factor. The practice must provide a written explanation for an NA response.

The practice enters the number of prescriptions written during the reporting period in the survey tool comment box or links a document to attest to exclusion from this requirement.

**Factor 3:** The practice enters more than 60 percent of medication orders into patient medical records. The electronic prescribing system lets the practice view patient diagnoses and medications; enter new medications and make changes; and identify allergies.

If a practice meets the exclusion criteria for the current final rule for Meaningful Use, it may respond NA to the factor. The practice must provide a written explanation for an NA response.

**Factor 4:** When a new prescription request is entered, the practice's electronic prescribing system alerts the clinician to potentially harmful patient-specific interactions between drugs or to patient allergy to a drug.

If a practice meets the exclusion criteria for the current final rule for Meaningful Use, it may respond NA to the factor. The practice must provide a written explanation for an NA response.

**Factor 5:** The practice's electronic system alerts the clinician to cost-effective, generic options.

### Documentation

**Factor 1:** NCQA reviews reports from the practice's electronic system.

This element calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage based on a recent three-month period.

- *Denominator* = Eligible prescriptions written by the practice.
- *Numerator* = Eligible prescriptions generated by the practice using the practice's electronic prescribing system.

*Factor 1 alternative documentation.* If the practice cannot demonstrate that 75 percent of eligible prescriptions are entered electronically, it may use the following documentation method:

- Provide its prescribing process/policy, including how it ensures that prescriptions are not handwritten, **and**
- Provide a report with a denominator showing the total number of patients seen in a recent three-month period **and** a numerator showing the total number of eligible prescriptions generated by the practice using the practice's electronic prescribing system during the same time period, **and**
- Explain how this calculated ratio meets the factor requirement.

**Factor 2:** NCQA reviews reports from the practice's electronic system.

This element calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage based on a recent three-month period.

- *Denominator* = Eligible prescriptions written by the practice.
- *Numerator* = Eligible prescriptions generated by the practice that are compared with drug formularies **and** transmitted to pharmacies by the practice's electronic prescribing system.

**Factor 3:** NCQA reviews reports from the practice's electronic system.

This element calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage based on a recent three-month period.

- *Denominator = Patients in the practice's system with at least one medication in their medication list.*
- *Numerator = Number of patients in the denominator with at least one medication electronically recorded in the patient record.*

**Factors 4, 5:** NCQA reviews reports from the practice's electronic system or screen shots demonstrating the system's capabilities.

**PCSP 5: Track and Coordinate Care**

**16.00 points**

The practice systematically tracks tests and referrals and coordinates care with the referring clinician and facilities.

<b>Element A: Test Tracking and Follow-Up (MUST-PASS)</b>		<b>5.00 points</b>		
		<b>Yes</b>	<b>No</b>	<b>NA</b>
The practice has a documented process for and demonstrates that it:				
1.	Requests and tracks receipt of test results from the PCP and referring clinician.	<input type="checkbox"/>	<input type="checkbox"/>	
2.	Provides the PCP and referring clinician with results of relevant tests ordered by the specialist. (CRITICAL FACTOR)	<input type="checkbox"/>	<input type="checkbox"/>	
3.	Tracks lab tests until results are available, flagging and following up on overdue results.	<input type="checkbox"/>	<input type="checkbox"/>	
4.	Tracks imaging tests until results are available, flagging and following up on overdue results.	<input type="checkbox"/>	<input type="checkbox"/>	
5.	Flags abnormal lab results, bringing them to the attention of the clinician.	<input type="checkbox"/>	<input type="checkbox"/>	
6.	Flags abnormal imaging results, bringing them to the attention of the clinician.	<input type="checkbox"/>	<input type="checkbox"/>	
7.	Notifies patients/families/caregivers about normal and abnormal lab and imaging test results.	<input type="checkbox"/>	<input type="checkbox"/>	
8.	Electronically records more than 30 percent of laboratory orders in the patient record.+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Electronically records more than 30 percent of radiology orders in the patient record.+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Incorporates clinical lab test results electronically into structured fields in the medical record.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Makes scans and tests that result in an image accessible electronically.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Scoring</b>	<b>100%</b>	<b>75%</b>	<b>50%</b>	<b>25%</b>	<b>0%</b>
	The practice meets 6-11 factors, including factor 2	The practice meets 4-5 factors, including factor 2	The practice meets 3 factors, including factor 2	The practice meets 1-2 factors, including factor 2	The practice meets 0 factors or does not meet factor 2

**Explanation** **MUST-PASS** elements are considered essential to a patient-centered specialty practice. Practices must earn a score of 50% or higher. All six must-pass elements are required for recognition.

+ Meaningful Use Modified Stage 2 Alignment

Coordination of tests and test results between the primary care clinician or referring clinician and the specialist are vitally important. This coordination will help avoid duplication of or gaps in tests and to ensure collaboration in care management that includes the patient. Systematic monitoring is important to ensure that needed tests are performed and that results are acted on when they indicate a need for action. The practice is able to demonstrate that its documented process has been implemented.

Behavioral health practices request relevant lab and imaging tests received or requested from primary care or the referring clinician, along with the referral. “Relevant test results” may relate to or be affected by the mental health or substance use disorder and may include tests associated with a chronic condition.

**Factor 1:** The practice has a process to request relevant test results if they did not accompany the referral, such as screening test results or diagnostic testing that could help the specialist provide effective, non-duplicative care.

**Factor 2:** The specialist provides timely test results on relevant tests it orders to the primary care or the referring clinician, as appropriate. Failure to do so may result in less than optimal care; thus, **factor 2** has been identified as a **critical factor** and is required for practices to receive any credit for this element.

Privacy concerns may be an issue with behavioral healthcare test results. The practice asks patient permission before sending test results to primary care. Patient refusal is documented in the medical record.

The practice has a documented process for obtaining permission to share test results (e.g., results of a mental health evaluation, depression screening, HIV-AIDS lab test) with primary care.

**Factors 3, 4:** The practice tracks lab and imaging tests ordered by the specialist from the time they are ordered until results are available, and flags test results that have not been made available. The practice follows up with the lab or diagnostic center and, if necessary, with the patient, to determine why results are overdue.

Ineffective management of laboratory and imaging test results could compromise patient safety. **Flagging** is a systematic method of drawing attention to results that have not been received by the practice. The flag may be an icon that automatically appears in the electronic system or a manual tracking system with a timely surveillance process. The expected time that results are made available to the practice varies by test and is at the discretion of the practice.

**Factors 5, 6:** Abnormal results of lab or imaging tests are flagged or highlighted and brought to the attention of the clinician, to ensure timely follow-up with the patient/family/caregiver.

**Factor 7:** The practice gives normal and abnormal results to patients/families/caregivers in a timely manner (defined by the practice). Notifying the patient of results at the next office visit does not meet the intent of the factor.

If frequent lab tests are ordered, the practice is expected to have a process for providing the patient/family/caregiver, with all initial test results, normal and abnormal, and clear expectations of follow-up test results and how normal vs. abnormal results will be handled.

**Factors 8, 9:** Lab and imaging test orders are electronically recorded in the patient’s medical record.

If a practice meets the exclusion criteria for the current final rule for Meaningful Use, it may respond NA to the factor. The practice must provide a written explanation for an NA response.

**Factor 10:** The practice incorporates clinical lab test results electronically, into structured fields in medical records, rather than requiring them to be looked up in a separate system and manually entered into the electronic medical record.

If a practice does not order lab tests whose results are in a positive or negative affirmation or numeric format, it may enter an NA response. The practice must provide a written explanation for an NA response.

**Factor 11:** Imaging results that include a written report, and may include images, are electronically integrated into the medial record, rather than requiring them to be looked

up in a separate system and manually entered into the electronic medical record. A scanned PDF of images entered in the medical record, which allows the practice to retrieve and review the image, is acceptable.

If a practice orders fewer than 100 imaging tests during the reporting period or has no access to electronic imaging results, it may respond NA to the factor. The practice must provide a written explanation for an NA response.

### **Documentation**

*For all factors that require a documented process, the documented process must include a date of implementation or revision and must be in place for at least three months prior to submitting the PCSP 2016 survey tool.*

#### **Factors 1–7:** NCQA reviews:

- A documented process or procedure for staff, **and**
- A report with five days of data or three examples of the process being met for each factor.

A de-identified screen shot demonstrating that the process was implemented is also acceptable.

#### **Factor 8:** NCQA reviews reports from the electronic system.

This element calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage based on 3 months of data in the electronic system.

- *Denominator* = Number of lab tests ordered during the reporting period.
- *Numerator* = Number of lab tests ordered that are electronically recorded in the patient record.

**Factor 9:** NCQA reviews reports from the electronic system. This element calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage based on a recent three-month period.

- *Denominator* = Number of radiology tests ordered during the reporting period.
- *Numerator* = Number of radiology tests ordered that are electronically recorded in the patient record.

**Factors 10, 11:** NCQA reviews a screen shot demonstrating capability.

**Element B: Referral Tracking and Follow-Up** **6.00 points**

The practice coordinates referrals to other (secondary) specialists by:	Yes	No	NA
1. Consulting with the PCP and referring clinician and patient/family/caregiver regarding secondary referrals.	<input type="checkbox"/>	<input type="checkbox"/>	
2. Giving the specialist the clinical reason for the referral and pertinent clinical information. (CRITICAL FACTOR)	<input type="checkbox"/>	<input type="checkbox"/>	
3. Tracking the status of the referral, including required timing for receiving a specialist's report.	<input type="checkbox"/>	<input type="checkbox"/>	
4. Following up to obtain the specialist's report.	<input type="checkbox"/>	<input type="checkbox"/>	
5. Establishing and documenting arrangements with specialists in the medical record, if co-management is needed.	<input type="checkbox"/>	<input type="checkbox"/>	
6. Asking patients/families/caregivers about self-referrals and requesting reports from clinicians.	<input type="checkbox"/>	<input type="checkbox"/>	
7. Ensuring that the PCP and the original referring clinician are notified of the secondary referral results.	<input type="checkbox"/>	<input type="checkbox"/>	
8. Demonstrating its capability to provide an electronic summary-of-care record to another provider following a referral.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Electronically transmitting a summary-of-care record to another care provider, for more than 10 percent of care referrals.+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Demonstrating its capability for electronic exchange of information with a recipient that uses different EHR technology.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Scoring**

100%	75%	50%	25%	0%
The practice meets 8-10 factors, including factor 2	The practice meets 6-7 factors, including factor 2	The practice meets 4-5 factors, including factor 2	The practice meets 1-3 factors, including factor 2	The practice meets 0 factors

**Explanation**

+ Meaningful Use Modified Stage 2 Alignment

The specialty practice tracks referrals to secondary specialists using a reporting log or electronic reporting system that includes when the referral is discussed with primary care. This includes referrals to medical specialists, mental health and substance abuse specialists and other services.

**Factor 1:** The specialist discusses secondary referrals with the primary care clinician and the patient/family/caregiver before sending a referral to another specialist. Exceptions to this collaboration between primary care or referring clinician and the specialty practice must be explained. A practice that routinely refers patients to a team of secondary specialists (e.g., an oncologist who works with a breast cancer team [radiation oncologist, surgeon]) includes information about the team in the referral agreement. This helps avoid the need to communicate with the referring clinician at the time of the referral.

The practice informs patients/families/caregivers in collaboration with primary care about additional referrals, and provides enough information for them to make an informed decision.



**Factor 2:** The specialty practice provides the secondary specialist or consulting clinician with the information needed to successfully perform the consultation, including:

- The clinical reason for the referral (i.e., the question to be answered by the referral) and the urgency of the referral.
- Relevant patient demographics and clinical information (i.e., patient's family and social history, clinical findings and current treatment).

Providing the secondary specialist with the clinical reason for the referral, in addition to pertinent clinical information about the patient, is deemed vital for implementing a successful and efficiently managed referral. Thus, **factor 2** has been identified as a **critical factor** and is required for practices to receive any credit for this element.

**Factor 3:** The referral tracking system includes the date when the referral was initiated **and** the required timing for receiving the report.

Documentation requires a paper or electronic tracking sheet or system showing referral tracking and follow-up of multiple patients (blinded). Screen shots of a patient record do not meet the requirement.

**Factor 4:** If the practice does not receive a report from the secondary specialist, it contacts the specialist's office about the report's status and the expected date for receiving the report, **and** documents the effort to retrieve the report in a log or electronic system.

**Factor 5:** For patients who are regularly treated by a secondary specialist, the referring specialist enters into an agreement for co-management of care and includes timely sharing of changes in patient status and treatment plan. For co-managed patients, the referring **and** secondary specialists exchange information within a period agreed to by both parties. This information is documented in the medical record.

**Factor 6:** Patients may see other specialists without a referral from or knowledge of the medical home or the specialty practice. The practice routinely asks patients if they are receiving care from a specialist and, if so, requests a report from the specialist and documents the information in the medical record.

**Factor 7:** The practice has a process for notifying primary care or the referring clinician, as appropriate, of the results of secondary referrals. The practice defines "timely."

**Factor 8:** The practice provides a summary-of-care record to the referred specialists. The summary-of-care record includes, at a minimum:

- The current problem or a list of problems.
- Current medications the patient is taking.
- Medications to which the patient is allergic.

A practice that refers a patient to another provider fewer than 100 times during the reporting period may respond NA to this factor. The practice must provide a written explanation of the NA response.

**Factor 9:** The practice electronically transmits a summary of care record to the referred specialist for more than 10 percent of referrals.

#### **Note**

- *If the practice provides documentation that it meets the Meaningful Use Modified Stage 2 Requirement Objective 5 (Health Information Exchange), measures 1 and 2, such as with the requisite Meaningful Use report, it may be given credit for PCSP 1, Element D, factor 8; PCSP 5, Element B, factors 8 and 9; and Element C, factors 4 and 5.*

- *Although this factor may appear to duplicate PCSP 1, Element D, factor 8 and PCSP 5, Element C, factor 5, it underscores the importance of the specialist providing a summary of care to a secondary specialist.*

The CMS requirements include transitions of care and referrals in one measure. CMS provides the following additional information: “The referring party must provide the summary of care record to the receiving party. The clinician can send an *electronic or paper copy of the summary of care record* directly to the next provider or can provide it to the patient to deliver to the next provider, if the patient can reasonably be expected to do so. If the provider to whom the referral is made has access to the medical record maintained by the referring provider, the summary of care record would not need to be provided and that patient should not be included in the denominator for transitions of care.”

**Care plan** is defined by CMS as “The structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome).”

CMS provides the following additional information: “To count in the numerator, the summary-of-care record must be received by the provider to whom the sending provider is referring or transferring the patient.”

If a practice meets the exclusion criteria for the current final rule for Meaningful Use, it may respond NA to the factor. The practice must provide a written explanation of the NA response.

**Factor 10:** The practice has conducted one or more successful electronic exchanges of a summary-of-care document, as identified in factor 9, with a recipient whose EHR technology is different from the practice’s. The practice:

- Shows at least one successful electronic exchange of a summary-of-care document with another provider using a different EHR technology, **or**
- Conducts one or more successful tests with the CMS-designated test EHR during the reporting period.

A practice that refers a patient to another provider fewer than 100 times during the reporting period may respond NA to this factor. The practice must provide a written explanation of the NA response.

### **Documentation**

*NCQA reviews the Organizational Background “Practice Information” in the ISS survey tool, to gain a better understanding of the patient population and how the practice functions. Completing this information is recommended, but is not required.*

*For all factors that require a documented process, the documented process must include a date of implementation or revision and must be in place for at least three months prior to submitting the PCSP 2016 survey tool.*

### **Factors 1–4 and 7:**

NCQA reviews:

- A documented process for staff to use in coordinating referrals with secondary specialists, **and**
- Reports or logs demonstrating that data collected in the tracking system is used for each factor. A paper log or screenshot showing electronic capabilities is acceptable. The report may be system generated or may be based on at least one week of referrals, with de-identified patient data.

**Factors 5, 6:** NCQA reviews at least three examples.

**Factor 8:** NCQA reviews at least one example.

**Factor 9:** NCQA reviews a report with a numerator, denominator and percentage from at least three months of transitions and referrals.

This element calls for calculation of a percentage that requires a numerator and a denominator. The practice provides reports from the electronic system. The practice may use the following methodology to calculate the percentage based on three months of data in the electronic system.

- *Denominator* = Number of referrals to another provider during the EHR reporting period.
- *Numerator* = Number of referrals in the denominator where a summary-of-care record was electronically transmitted.

**Factor 10:** NCQA reviews a screenshot or other documentation showing a test of the EHR's capability to exchange a summary-of-care document with a different EHR technology.

**Element C: Coordinate Care Transitions****5.00 points**

The practice supports patients who have an ongoing relationship with a specialist during acute care transitions. For these patients, the practice systematically:

	Yes	No	NA
1. Demonstrates its process for identifying patients with a hospital admission and patients with an emergency department visit.	<input type="checkbox"/>	<input type="checkbox"/>	
2. Demonstrates its process for sharing clinical information with admitting hospitals or emergency departments.	<input type="checkbox"/>	<input type="checkbox"/>	
3. Demonstrates its process for consistently obtaining patient discharge summaries from the hospital and other facilities.	<input type="checkbox"/>	<input type="checkbox"/>	
4. Demonstrates its capability to provide an electronic summary of care record to another facility following a transition of care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Electronically transmits a summary of care record to another care setting for more than 10 percent of care transitions.+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Scoring**

100%	75%	50%	25%	0%
The practice meets 4-5 factors	The practice meets 3 factors	The practice meets 2 factors	The practice meets 1 factor	The practice meets 0 factors

**Explanation**

+Meaningful Use Modified Stage 2 Alignment

Effective transitions of care—between specialist providers, between facilities, between physicians and institutional settings—ensure that patient needs and preferences for health services and sharing information across people, functions and sites are met over time. Enhancing care transitions across providers can improve coordination of care and its effect on quality and efficiency (Greiner/ABIM Fdn 2007).

**Factor 1:** The practice has a written process for working with local hospitals, ERs and health plans to identify patients with conditions being managed by the specialist and who were hospitalized or had ER visits. Behavioral health specialists may have patients who are hospitalized (including at a mental health hospital) or go to the ER for conditions being managed by the specialist.

**Factor 2:** The practice has a documented process for providing facilities with appropriate and timely information about patients.

**Factor 3:** The practice or external organization has a process for obtaining patient discharge summaries from hospitals including mental health hospitals and ERs.

**Factor 4:** The practice provides a summary-of-care record to other facilities following a care transition. The summary-of-care record includes, at a minimum:

- The current problem or a list of problems.
- Current medications the patient is taking.
- Medications to which the patient is allergic.

A practice that refers a patient to another provider fewer than 100 times during the reporting period may respond NA to this factor. The practice must provide a written explanation of the NA response.

**Factor 5:** The practice electronically transmits a summary-of-care record for more than 10 percent of referrals to another care facility.

**Note**

- If the practice provides documentation that it meets the Meaningful Use Modified Stage 2 Requirement Objective 5 (Health Information Exchange), measures 1 and 2, such as with the requisite Meaningful Use report, it may be given credit for PCSP 1, Element D, factor 8; PCSP 5, Element B, factors 8 and 9; and Element C, factors 4 and 5.
- Although this factor may appear to duplicate PCSP 1, Element D, factor 8 and PCSP 5, Element B, factor 9, it underscores the importance of the specialist providing a summary of care to a secondary specialist.

The CMS requirements include transitions of care and referrals in one measure. According to CMS: “The clinician can send an electronic or paper copy of the summary-of-care record directly to the next [facility] or can provide it to the patient to deliver to the next provider, if the patient can reasonably be expected to do so. If the provider to whom the referral is made has access to the medical record maintained by the referring provider, the summary-of-care record would not need to be provided and that patient should not be included in the denominator for transitions of care.”

**Care plan** is defined by CMS as “The structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome).”

CMS provides the following additional information: “To count in the numerator, the summary-of-care record must be received by the provider to whom the sending provider is referring or transferring the patient.”

If a practice meets the exclusion criteria for the current final rule for Meaningful Use, it may respond NA to the factor.

**Documentation**

NCQA reviews the Organizational Background “Practice Information” in the ISS survey tool, to gain a better understanding of the patient population and how the practice functions. Completing this information is recommended, but is not required.

For all factors that require a documented process, the documented process must include a date of implementation or revision and must be in place for at least three months prior to submitting the PCSP 2016 survey tool.

**Factor 1:** NCQA reviews:

- A documented process showing that the practice identifies patients who have been hospitalized or have had an ER visit, **and**
- At least three examples.

**Factor 2:** NCQA reviews:

- A documented process of how the practice provides hospitals and ERs with clinical information, **and**
- At least three examples of patient information sent to the hospital or ER.

**Factor 3:** NCQA reviews:

- A documented process for consistently obtaining hospital discharge summaries, **and**
- At least three examples of a discharge summary.

**Factor 4:** NCQA reviews at least one example.

**Factor 5:** NCQA reviews a report with a numerator, denominator and percentage from at least 3 months of transitions and referrals.

- *Denominator* = Number of transitions of care to another facility during the EHR reporting period.
- *Numerator* = Number of transitions of care the denominator where a summary of care record was electronically transmitted.

**PCSP 6: Measure and Improve Performance****16.00 points**

The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience.

<b>Element A: Measure Performance</b>	<b>4.00 points</b>
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The practice measures or receives data on:	Yes	No
1. At least three clinical measures related to the practice specialty.	<input type="checkbox"/>	<input type="checkbox"/>
2. Coordination of care results.	<input type="checkbox"/>	<input type="checkbox"/>
3. At least two utilization measures affecting health care costs.	<input type="checkbox"/>	<input type="checkbox"/>
4. Performance data, stratified for vulnerable populations (to assess disparities in care).	<input type="checkbox"/>	<input type="checkbox"/>
5. Timely access to appointments based on established criteria.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	The practice meets 4-5 factors	The practice meets 3 factors	The practice meets 1-2 factors	No Scoring Option	The practice meets 0 factors

**Explanation**

The practice reviews its performance on measures related to its specialty, to better understand its strengths and discover opportunities for improvement. Data may be from internal or external sources. If an external source (such as a health plan) provides the data, the information must represent 75 percent of the practice's eligible population. Although some measures may fit into multiple categories, each measure may be used only once for this element.

When it selects measures of performance, the practice must document the:

- Period of measurement.
- Number of patients represented by the data.
- Patient selection process.

**Factor 1:** The practice provides a written explanation of how a measure applies to the specialty of the clinicians included in the application. Measures selected for reporting are related to and actionable on the part of the specialty. The practice may meet this requirement through successful participation in other specialty-specific performance measurement and quality improvement programs, such as:

- American Board of Internal Medicine (ABIM) Maintenance of Certification (MOC) and Performance Improvement Modules (PIM).
- American Society of Clinical Oncology (ASCO) Quality Oncology Practice Initiative (QOPI®).
- American Academy of Pediatrics EQUIPP, an online learning program that includes improvement principles and concepts and clinical content <http://eqipp.aap.org/>
- The American Society of Clinical Oncology (ASCO) and Oncology Nurses Society (ONS) chemotherapy administration standards <https://www.ons.org/practice-resources/standards-reports/chemotherapy>
- The National Cardiovascular Data Registry (NCDR®) Cardiology registries for hospitals and practices: <http://cvquality.acc.org/NCDR-Home.aspx>

- American Congress of Obstetricians and Gynecologists (ACOG) program on quality and safety: <http://www.acog.org/About-ACOG/ACOG-Districts/District-II/Patient-Safety>
- Measures listed in the Meaningful Use Requirements (<https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/clinicalqualitymeasures.html>), NQF and PQRS—specialty specific—practice level.

Practices must provide details or reports of their results on performance measures to NCQA regarding participation in other quality programs.

When 75 percent or more of the clinicians in the practice have earned recognition in the NCQA Heart/Stroke Recognition Program (HSRP) or NCQA Diabetes Recognition Program (DRP) the practice may receive credit for performance data for recognitions. The recognitions must be current at the time the practice submits its PCSP survey tool. The practice must include a statement about the recognized clinicians, the name of the recognition program and the number or percentage of recognized clinicians in the practice in the Organizational Background section of the PCSP ISS survey tool.

**Factor 2:** The practice examines data tracked and collected as specified in PCSP 1, Element D, which may include:

- Confirming receipt of the referral request from the referring clinician, along with the date and time of the patient's appointment.
- Requesting patient test results from primary care.
- Providing timely patient test results to primary care.
- Providing timely referral responses.
- Identifying patients who may not require the services of a specialist.

The practice may conduct a feedback survey with primary care or referring clinicians regarding the effectiveness of care coordination efforts. Feedback may be used to satisfy Element 6A, factor 2 requirements.

If appropriate for the specialty, the practice is encouraged to coordinate this requirement with ABIM's Care Coordination Performance Improvement Module: <https://www.abim.org/maintenance-of-certification/earning-points/practice-assessment.aspx>.

**Factor 3:** The practice uses resources judiciously. The types of measures monitored for this factor are intended to help practices understand how efficiently they provide care, and may include:

- Expedient transitioning of patients back to the primary care practice.
- ER visits.
- Potentially avoidable hospitalizations and hospital readmissions.
- Use of episode groups to assess clinical episodes of illness, services associated in diagnosis, management and treatment.
- Redundant imaging or lab tests.
- Prescribing generic medications vs. brand name medications.
- Number of secondary specialist referrals.

Practices may use data from one or more payers that cover at least 75 percent of patients, or may collect the data over time.

**Factor 4:** Data collected by the practice for one or more measures from factors 1–3 are stratified by race and ethnicity, or by other indicators of vulnerable groups that reflect the practice's population demographics, such as age, gender, language needs, education, income, type of insurance (i.e., Medicare, Medicaid, commercial), disability or health status.



Vulnerable populations are “those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability” (AHRQ) and include people with multiple co-morbid conditions or who are at high risk for frequent hospitalization or ER visits.

**Factor 5:** Practice staff use the criteria established for PCSP 2, Element A: Access and the information tracked for timely access to appointments.

The practice has a process (i.e., schedule monitoring, patient survey) for determining timeliness of appointments. Timely appointment access may be defined by the practice, in accordance with the specialty and the needs of patients seen by or referred to the practice.

#### **Documentation**

**Factors 1–5:** NCQA reviews the following for each measure selected:

- The measurement period.
- The number of patients represented by the data (i.e., numerator and denominator).
- The rate (percent).

NCQA reviews reports or recognition results showing performance measures. The practice provides a brief explanation or identifies the nationally-recognized source for each selected measure.

<b>Element B: Measure Patient/Family Experience</b>		<b>4.00 points</b>	
The practice obtains feedback from patients/families/caregivers on their experiences with the practice and their care.	Yes	No	
1. The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories: Access, Communication, Coordination, Self-Management Support.	<input type="checkbox"/>	<input type="checkbox"/>	
2. The practice uses CAHPS Clinician and Group (CG) survey tool.	<input type="checkbox"/>	<input type="checkbox"/>	
3. The practice obtains feedback on experiences of vulnerable patient groups.	<input type="checkbox"/>	<input type="checkbox"/>	
4. The practice obtains feedback from patients/families/caregivers through qualitative means.	<input type="checkbox"/>	<input type="checkbox"/>	

Scoring	100%	75%	50%	25%	0%
		The practice meets 3-4 factors	No scoring option	The practice meets 2 factors	The practice meets 1 factor

**Explanation**

The practice uses a patient survey to gather feedback on a regular basis, and uses feedback to inform quality improvement activities. To meet the intent of the element, practices should survey patients at least annually.

The practice also defines the survey time period and number of patients included in the survey. The patient survey must represent the practice population and include all relevant subpopulations, and may not be limited to patients of only one of several clinicians or data from one payer, if there are multiple payers.

**Factor 1:** The practice or practice designee surveys patients// family/caregivers to assess experience. The survey must include questions related to at least three of the following categories:

- **Access**, which may include routine, urgent and after-hours care.
- **Communication** with the practice, clinicians and staff may include feeling respected, listened to and able to get answers to questions.
- **Coordination of care** may include being informed and up-to-date on referrals from primary care to specialists and the associated exchange of information and coordination of care, changes in medications and lab or imaging results.
- **Self-management support** may include support provided to the patient/family/caregiver for self-management. The emphasis is on self-care associated with the condition and may include mental health and urgent care; advice, assistance and support for managing the condition; coordination with primary care and related health habits; and health care decisions.

**Factor 2:** The practice uses the standardized CG-CAHPS (Consumer Assessment of Healthcare Providers and Systems Clinician and Group) Survey to collect patient experience data.

The practice may use another standardized survey administered through measurement initiatives that provides benchmark analysis external to the practice organization. The survey may not be a proprietary (vendor-created) instrument. To receive credit for this factor, the practice must administer the entire approved standardized survey, not only sections of the survey.

**Factor 3:** The practice uses survey data or other means to assess quality of care for its vulnerable subgroups. Patient self-identification in the survey may define a subgroup.

Vulnerable populations are “those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability” (AHRQ) and include people with multiple co-morbid conditions or who are at high risk for frequent hospitalization or ER visits.

**Factor 4:** Qualitative feedback methods, which may include focus groups, individual interviews, patient-experience shadowing and suggestion boxes, may be used. Practices may use a feedback methodology conducive to their population of patients/families/caregivers (as is appropriate), such as “virtual” participation (e.g., phone or video conference).

Open-ended questions or requesting comments from patients added at the end of a quantitative survey do not meet the intent of this factor.

#### **Documentation**

**Factors 1–4:** NCQA reviews reports with summarized results of patient feedback. A blank survey tool does not meet the intent of this element.

The practice identifies the survey tool it uses to collect feedback, the survey dates, the number of patients and the survey method (e.g., mail, phone, in-person, kiosk).

<b>Element C: Implement and Demonstrate Continuous Quality Improvement (MUST-PASS)</b>	<b>4.00 points</b>
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	Yes	No
The practice demonstrates ongoing monitoring of the effectiveness of its quality improvement process by:		
1. Setting goals and acting to improve on at least three clinical quality or utilization measures.	<input type="checkbox"/>	<input type="checkbox"/>
2. Setting goals and acting to improve coordination with primary care.	<input type="checkbox"/>	<input type="checkbox"/>
3. Setting goals and acting to improve quality on at least one patient experience measure.	<input type="checkbox"/>	<input type="checkbox"/>
4. Setting goals and acting to improve timeliness of patient access.	<input type="checkbox"/>	<input type="checkbox"/>
5. Setting goals and addressing at least one identified disparity in care/ service for vulnerable populations.	<input type="checkbox"/>	<input type="checkbox"/>
6. Tracking results over time.	<input type="checkbox"/>	<input type="checkbox"/>
7. Assessing the effect of its actions.	<input type="checkbox"/>	<input type="checkbox"/>
8. Achieving improved performance on one measure.	<input type="checkbox"/>	<input type="checkbox"/>
9. Achieving improved performance on a second measure.	<input type="checkbox"/>	<input type="checkbox"/>

	100%	75%	50%	25%	0%
<b>Scoring</b>	The practice meets 7-9 factors	The practice meets 5-6 factors	The practice meets 3-4 factors	The practice meets 2 factors	The practice meets 0-1 factors

<b>Explanation</b>	<p><b>MUST-PASS</b> elements are considered essential to a patient-centered specialty practice. Practices must earn a score of 50% or higher. All six must-pass elements are required for recognition.</p> <p>Quality improvement is a continual process that requires an ongoing effort of assessing, improving and reassessing.</p> <p>The practice has a defined, ongoing quality improvement strategy and process that includes regular review of performance data and evaluation of performance against goals or benchmarks. Review and evaluation offer the practice an opportunity to identify and prioritize areas for improvement, to analyze potential barriers to meeting goals and to plan methods for addressing the barriers.</p> <p>The practice sets goals and establishes a plan to improve performance on clinical quality and resource measures used in Element A and patient experience measures used in Element B.</p> <p>The practice may participate in or implement a rapid-cycle improvement process, such as Plan-Do-Study-Act (PDSA), that represents a commitment to ongoing quality improvement and goes beyond setting goals and taking action.</p> <p><b>Resource:</b> One resource for the PDSA cycle is the Institute for Healthcare Improvement (IHI):  <a href="http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/">http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/</a></p> <p><b>Resource:</b> Solberg, L.I., G. Mosser, S. McDonald. 1997. The Three Faces of Performance Measurement: Improvement, Accountability and Research. <i>Journal on Quality Improvement</i>. 23(3);135-47.</p>

**Factors 1, 3:** The practice sets goals and acts to improve performance, based on clinical measures and utilization (Element A, factors 1 and 3) measures and patient experience measures (Element B). The goal is for the practice to reach a desired level of achievement based on its self-identified standard of care.

Practices may use the process and data from NCQA's Heart/Stroke Recognition Program (HSRP) or NCQA Diabetes Recognition Program (DRP) to establish comparative data for factor 1, if 75 percent of its clinicians have achieved NCQA Recognition. Recognitions must be current at the time the practice submits its PCSP survey tool.

**Factor 2:** The practice sets goals and acts to improve performance using data collected for Element A, factor 2, related to coordination of care with primary care or referring clinicians.

**Factor 4:** The practice sets goals and acts to improve performance results on measures collected for Element A, factor 5, related to timely access to appointments.

**Factor 5:** The practice identifies areas of disparity in care or service for vulnerable populations, sets goals and acts to improve performance in these areas. Vulnerable groups reflect the practice's population demographics (e.g., age, gender, race, ethnicity, language needs, education, income, type of insurance [Medicare, Medicaid, commercial], disability or health status).

Vulnerable populations are "those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability" (AHRQ) and include people with multiple co-morbid conditions or who are at high risk for frequent hospitalization or ER visits.

**Factor 6:** The practice demonstrates that it collects clinical or resource (Element A) performance data or patient experience (Element B) performance data, and assesses the results over time. The practice establishes the number and frequency data collection (e.g., monthly, quarterly, biannually, yearly).

The practice may use the process and data from NCQA Clinical Recognition programs to establish comparative clinical quality measures data, if 75 percent of its clinicians have achieved NCQA Recognition. Practices must show a comparison of at least two sets of DRP or HSRP data or scores.

**Factor 7:** The practice identifies the steps it has taken and evaluates these steps to improve performance. The practice is not required to demonstrate improvement in this factor.

**Factors 8,9:** The practice demonstrates improved performance over time, based on its assessment.

#### **Documentation**

**Factors 1–9:** NCQA reviews reports *or* a completed PCSP Quality Measurement and Improvement Worksheet.

The PCSP Quality Measurement and Improvement Worksheet is an optional reporting method; however, practices are encouraged to consult the worksheet for reporting guidelines for this element and examples.

For each follow-up measure in factors 6–9, the practice documents:

- The measurement period.
- The number of patients represented by the data (i.e., numerator and denominator).
- The rate (percent).

**Element D: Report Performance** **2.00 points**

The practice shares performance data from Element A and Element B:	Yes	No
1. Within the practice, by individual clinician.	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the practice, across the practice.	<input type="checkbox"/>	<input type="checkbox"/>
3. Outside the practice, to patients or publicly, across the practice or by clinician.	<input type="checkbox"/>	<input type="checkbox"/>

**Scoring**

100%	75%	50%	25%	0%
The practice meets 3 factors	The practice meets 2 factors	The practice meets 1 factor	No scoring option	The practice meets 0 factors

**Explanation**

The practice may use data that it produces or may use data provided by affiliated organizations, such as a larger medical group, individual practice association or health plan. Performance results must reflect care provided to all patients (relevant to the measure), not only patients covered by a specific payer.

Data are:

- Reported to individual clinicians and practice staff (e.g., via memos, staff meeting agendas, minutes).
- Made available to patients or reported publicly; for example, by a health plan.

When 75 percent or more of the clinicians in the practice earned recognition in the NCQA Heart/Stroke Recognition Program (HSRP) or NCQA Diabetes Recognition Program (DRP) the practice may receive credit for performance data for recognitions. The recognitions must be current at the time the practice submits its PCSP survey tool.

**Factor 1:** Some data from Element A **and** Element B must be reported by clinician **and** shared with clinicians **and** practice staff to score factor 1 as “yes.” Reports reflect the care provided by the care team.

**Factor 2:** Some data from Element A **and** Element B must be reported at the practice level **and** shared with clinicians **and** practice staff to score factor 2 as “yes.”

**Factor 3:** Some data from Element A **and** Element B must be reported or made available to practice staff and patients or made public by a health plan or other entity. Reporting to patients may include posting in the practice’s waiting room, through a letter or e-mail, on the practice’s Web site or through a mass mailing to patients.

**Documentation**

**Factors 1, 2:** NCQA reviews blinded reports. Reports could be distributed as blinded results across the practice **and** to practice staff, showing individual clinician (factor 1) and/or summary of practice (factor 2) performance, **and** explaining how the practice provides results.

**Factor 3:** NCQA reviews examples of reporting (by clinician or across the practice) to patients or to the public.

**Element E: Use Certified EHR Technology 2.00 points**

The practice uses a certified EHR system.	Yes	No	NA
1. The practice uses an EHR system (or modules) that has been certified and issued a CMS Certification ID.++ (CRITICAL FACTOR)	<input type="checkbox"/>	<input type="checkbox"/>	
2. The practice attests to conducting a security risk analysis of its EHR system (or modules) and implementing security updates as necessary and correcting identified security deficiencies.+	<input type="checkbox"/>	<input type="checkbox"/>	
3. The practice demonstrates the capability to submit electronic syndromic surveillance data to public health agencies electronically.+	<input type="checkbox"/>	<input type="checkbox"/>	
4. The practice demonstrates the capability to identify and report cancer cases to a public health central cancer registry electronically.+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The practice demonstrates the capability to identify and report specific cases to a specialized registry electronically (other than a cancer registry).+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. The practice reports clinical quality measures to Medicare or to a state Medicaid agency, as required for Meaningful Use.++	<input type="checkbox"/>	<input type="checkbox"/>	
7. The practice demonstrates the capability to submit electronic data to immunization registries or immunization information systems.+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	The practice meets factor 1	No scoring option	No scoring option	No scoring option	The practice does not meet factor 1

**Explanation** + Meaningful Use Modified Stage 2 Alignment

++ CMS Meaningful Use Alignment

**Only factor 1 is eligible for credit; factors 2–7 are not scored.** The intent is to give credit to practices who use certified EHR technology.

**Note:** The CMS EHR certification ID: [http://www.healthit.gov/policy-researchers-implementers/certified-health-it-product-list-chpl#cms\\_ehr\\_certification\\_id](http://www.healthit.gov/policy-researchers-implementers/certified-health-it-product-list-chpl#cms_ehr_certification_id).

The practice protects the privacy and security of the electronic health information within its certified EHR system (or modules).

The following links provide additional information:

- U.S. Department of Health & Human Services, Health Information Privacy Web site: <http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/index.html>
- Modified Stage 2 Meaningful Use Requirement Information: [https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage3Overview2015\\_2017.pdf](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage3Overview2015_2017.pdf)

**Factor 1:** The practice attests to using a certified EHR system and provides the CMS Certification ID number of **all** software systems (or modules) it uses. CMS provides information on obtaining a Certification ID on their Web site at [http://www.healthit.gov/policy-researchers-implementers/certified-health-it-product-list-chpl#cms\\_ehr\\_certification\\_id](http://www.healthit.gov/policy-researchers-implementers/certified-health-it-product-list-chpl#cms_ehr_certification_id). A list of Certified Health IT Products can be found at <https://chpl.healthit.gov/#/search>.

**Factor 2:** The practice attests to conducting the required security risk analysis of its certified EHR system (or modules), implementing security updates as necessary and correcting identified security deficiencies.

**Factor 3:** The practice attests that it performs “successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period.”

**Factor 4:** The practice attests that it has “successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period.

**Factor 5:** The practice attests that it has “successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period.”

**Factor 6:** The practice reports clinical quality measures to Medicare or a state (Medicaid program).

**Factor 7:** The practice attests that it has “performed at least one test of certified EHR technology’s capacity to submit electronic data to immunization registries and follow up submission if the test is successful.”

Factor 7 is NA for practices that “[administer] no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.”

### **Documentation**

**Factor 1:** By entering a “yes” response in the PCSP survey tool, the practice attests to its using a Certified Electronic Health Record and has been issued a CMS certification ID to perform the designated *CMS Meaningful Use* requirements.

**Factor 2:** By entering a “yes” response in the PCSP survey tool, the practice attests to: conducting the required security risk analysis of its certified EHR system (or modules) and implementing security updates as necessary and correcting identified security deficiencies.

**Factor 3:** By entering a “yes” response in the PCSP survey tool, the practice attests to its: “capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.”

**Factor 4:** By entering a “yes” response in the PCSP survey tool, the practice attests to its: “capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice.

**Factor 5:** By entering a “yes” response in the PCSP survey tool, the practice attests to its “capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.”

**Factor 6:** By entering a “yes” response in the PCSP survey tool, the practice attests it reports clinical quality measures to Medicare or Medicaid as required for Meaningful Use and provides a copy of a report from the agency.  
<http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/ClinicalQualityMeasures.html>.

**Factor 7:** By entering a “yes” response in the PCSP survey tool, the practice attests to “its capability to submit electronic data to immunization registries or immunization information systems.”