The "Medical Neighborhood"
Advanced Alternative Payment Model (AAPM) Proposal

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I. Abstract

The Medical Neighborhood Model (MNM) is a five-year, multi-payer pilot that seeks to improve coordination between specialty practices and primary care practices who refer patients to them and provide advanced support to their patients. The model addresses two key problems:

- **A dearth of specialty Advanced Alternative Payment Models (APMs)**. The MNM can apply to a broad range of specialties with a sufficient number of high value electronically specified clinical quality measures.
- **Poor primary care practice and specialist referral coordination,** which is a significant contributor to poor quality care, inefficient resource allocation, and unnecessary costs. The MNM holds clinicians accountable for outcomes, patient experience and efficient resource utilization. It builds on the Patient-Centered Specialty Practice (PCSP) concept, which is promoted by the Medicare Access & CHIP Reauthorization Act (MACRA) statute and accompanying regulations with full automatic credit in the Merit-Based Incentive Payment System's (MIPS) Improvement Activities Category. PCSPs meet rigorous criteria that promote high-quality coordination with referring primary care practices guided by Care Coordination Agreements. PCSP standards emphasize enhanced access to timely, patient-focused care, shared decision making, continuous improvement, and use of Certified Electronic Health Record Technology (CEHRT). All of these features improve primary care and specialty coordination, close gaps in care, and lead to better outcomes.

Quality: The MNM features a core set of cross-cutting measures and a menu of high-value specialty-specific electronic clinical quality measures. It uses electronic reporting exclusively to minimize burden and leverage the rich clinical data in electronic health records, specialty-specific registries, and other electronic sources. Measures focus on high-priority domains such as utilization, behavioral health, patient-reported outcomes, patient experience, and care coordination (where applicable). The model also features two claims-based readmission measures and a subset of CAHPS®[1] patient experience survey questions (see Appendix 1).

Payment: All MNM practices receive a monthly per beneficiary per month (PBPM) care coordination fee to support enhanced care coordination and care delivery innovations. All model participants are also subject to a retrospective positive or negative payment adjustment based on how actual spending compares with a financial benchmark (adjusted for performance on quality and utilization metrics). The MNM would feature two distinct tracks. Track 1 practices would bill traditional Medicare as usual, while Track 2 practices would receive reduced Medicare payments in exchange for prospective quarterly payments based on projected spending.

Scalability: The MNM pilot will compare referrals from Comprehensive Primary Care Plus and Primary Care First primary care practices to specialists in MACRA-approved PCSPs verses non-PCSPs. It has the capacity to include any specialty that has enough high-value electronic clinical quality measures and ideally, a dedicated Qualified Clinical Data Registry (QCDR). Currently Cardiology, Neurology, and Infectious Disease meet these qualifications and we have provided sample quality measures for these specialties. If the pilot is successful, the model can be expanded to include referrals from patient-centered medical homes (PCMHs),[2] additional specialties, and additional payers.

[1]CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[2] MACRA provides the same Practice Improvement automatic credit to PCMHs as it does to PCSPs.

II. The Medical Neighborhood Model

The American College of Physicians (ACP) and National Committee for Quality Assurance (NCQA) propose the Medical Neighborhood Model (MNM). Our initial goal is a 5-year, multi-payer pilot connecting primary care practices in Comprehensive Primary Care Plus and Primary Care First to specialty practices that meet rigorous clinical transformation and care coordination criteria for Medicare Access & CHIP Reauthorization Act (MACRA)-recognized Patient Centered Specialty Practices (PCSPs).

This model can improve quality, costs and patients' experience of care by closing care coordination gaps, enhancing access, and providing patient-centered care. The model builds on the strong foundations of Comprehensive Primary Care Plus, Patient Centered Medical Homes (PCMHs), and PCSPs based on medical neighborhood white papers by ACP and the Agency for Healthcare Research and Quality.[3,4] NCQA's MACRA-approved PCSP program is based on these white papers and complements MACRA-approved PCMHs, which overlap in many ways with Comprehensive Primary Care Plus.

1. Background

The problem: Over the course of a year, a primary care practice can coordinate with 229 physicians in 117 practices.[5] Medicare beneficiaries see an average of seven physicians.[6] Specialty visits constitute over half of all outpatient visits,[7] yet up to 50% of referring physicians have no idea if patients ever actually see the specialist.[8] Primary care physicians report sending referral information nearly 70% of the time, but specialists report receiving it only 35% of the time. Specialists report sending reports back more than 80% of the time, but primary care physicians report getting them only 62% of the time.[9] Poor coordination contributes to care gaps, inappropriate care and errors that increase spending and can harm patients.[10] The National Quality Forum has said "care coordination is essential to reducing medical errors, wasteful spending, and unnecessary pain and procedures for patients."[11] Peer-reviewed literature suggests that emphasis on enhanced access, team-based care management, care coordination, and comprehensive care geared toward treating the "whole person" both improves quality of care and reduces costs.

The solution: The MNM addresses these issues with a multipronged approach to evaluating and rewarding high-quality, efficient care. Practices must meet consensus-based standards to improve care coordination and advanced care delivery and incorporate a pre-screening process for all visits to ensure that patient visits are maximized. The model also requires practices to use certified electronic health record technology (CEHRT) and electronically report quality, cost and outcomes data. This minimizes a practice's burden while maximizing its ability to collect and

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[3] The Patient-Centered Medical Home Neighbor, American College of Physicians, 2010.
[4] Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanism, AHRQ, 2011.
[5] Primary Care Physicians' Links to Other Physicians Through Medicare Patients: The Scope of Care Coordination, Pham et al, AIM, 2009
[6] Chronic Conditions: Making the Case for Ongoing Care Partnership for Solutions, Partnership for Solutions, 2002.
[7] Expenses for Office-Based Physician Visits by Specialty, 2004, Machlin et al, AHRQ, 2007
[8] Dropping the Baton: Specialty Referrals in the United States, Mehrotra et al, Milbank Quarterly, 2011.
[9] Referral & Consultation Communication Between Primary Care & Specialist Physicians, O'Malley et al, AIM, 2011.
[10] Frandsen et al, Care Fragmentation, Quality, and Costs Among Chronically Ill Patients, AMJC, May 2015.
[11] NQF Endorses Care Coordination Measures, Aug. 10, 2012.

leverage data to promote accountability and drive performance improvement. Combined, these features improve specialty-primary care coordination, close gaps, and improve health outcomes.

2. Quality

To participate in the MNM, specialty practices must meet MACRA-approved PCSP standards to ensure they are delivering advanced clinical care and actively coordinating with patients' other health care clinicians. To date, NCQA's PCSP recognition program is the only one that is MACRA-approved[12] and includes standards on:

- Establishing and maintaining agreements with referring primary care practices on how they will share information and coordinate care before, during, and after referrals;
- Providing expanded access to timely care, including providing same-day appointments when patients need them and electronic access to patients' information;
- Providing culturally and linguistically appropriate services;
- Using a team-based approach to optimize patient care;
- Identifying and coordinating patient populations, using electronic systems to monitor clinical data and implementing evidence-based reminders and decision supports;
- Planning and managing care that includes medication management, support for patients' self-care, and electronic prescribing;
- Tracking and coordinating care across settings;
- Measuring, improving, and reporting on performance, including patients' experience of care; and
- Use of CEHRT.

As part of ongoing participation in the MNM, practices are assessed on a set of quality and utilization measures that include: 1) two administrative claims-based readmissions measures; 2) a set of patient-experience CAHPS survey questions; 3) two core electronic clinical quality measures that capture the existence of a care plan and all-cause unplanned admissions for patients with multiple chronic conditions; and 4) a minimum of three specialty- or condition-specific electronic clinical quality measures that align with Medicare's Quality Payment Program (QPP). See Appendix 1 for the full measures set. The model uses administrative claims or eCQMs to help minimize reporting burden and leverage timely data to actively monitor and improve performance.

Also important, the MNM aligns with the proposed impending transition to the new "Value Pathway" for the Merit-Based Incentive Payment System (MIPS), which would feature limited measure sets centered on a given specialty or condition as an on-ramp to Advanced Alternative Payment Models (APMs). The specialty-focused MNM and its set of menu measures are a logical next step to specialty-specific MIPs Value Pathway bundles.

[12] A full set of NCQA's PCSP standards is included in Appendix II.

3. Payment and Incentives

As in the Comprehensive Primary Care Plus Model, participants receive a small monthly care-coordination fee (CCF) per attributed patient to support advanced clinical supports, plus a potential performance-based payment adjustment based on spending relative to a financial benchmark, which is adjusted for performance on quality and utilization metrics.

The MNM features two tracks. Track 1 practices continue to be reimbursed for claims on a fee-for-service basis. Track 2 practices agree to reduced fee-for-service payments of 75% in exchange for quarterly prospective payments based on projected spending equivalent to 25% of Physician Fee Schedule spending. Both are calculated at 110% of Physician Fee Schedule rates (e.g., with a 10% bonus) to support enhanced comprehensiveness of care delivered, similar to Track 2 in CPC+.

We expect regulatory waivers provided to other risk-bearing APMs would apply, including:

- A telehealth waiver from Medicare site-of-service and geographic limitations;
- A skilled nursing facility (SNF) 3-day rule waiver exempting participants from the requirement that patients have at least a three-day hospital inpatient stay to be eligible for SNF coverage;
- A waiver exempting participants from appropriate-use and prior-authorization criteria;
- A patient incentives waiver to let practices cover copays or reimburse for services such as transportation or other services that contribute to better outcomes;
- A shared savings payments waiver to allow sharing of savings based on performance;
- A waiver from Stark and Anti-Kickback fraud and abuse restrictions; and
- A pre-participation waiver that offers practices protection when they are actively building an Advanced APM but have not established a formal contract and are therefore not yet covered under the Stark and Anti-Kickback waivers.

Qualifying as an Advanced APM Under the QPP: All MNM practices will be financially at risk for their retrospective performance-based payment adjustment, which can be positive or negative, based on their performance against a financial benchmark (adjusted for performance on utilization and quality measures). Therefore, both tracks are expected to meet the financial risk criterion, along with the other criteria expected of Advanced APMs (use of CEHRT and reporting quality measures comparable to MIPS), and is expected to qualify as an Advanced APM.

4. From the Patient's Perspective

The patient and primary care practice must first agree that a specialty referral is appropriate. The primary care practice refers the patient to either a PSP participating in the MNM or a non-PCSP outside the MNM.

The MNM specialty practice will pre-screen the referral request and accompanying documentation to ensure it has all the information it needs and that scheduling a specialty visit is the most appropriate next step for the patient. If the MNM practice believes referral back to the primary care practice, another specialist, or another course of action is more appropriate, it will schedule an electronic consultation with the referring primary care practice. Otherwise, the

MNM practice would schedule an appointment. During the patient visit, the practice would establish a care plan with the patient and referring primary care practice and enter into a Care Coordination Agreement. Based on the needs of the patient and in consultation with the referring clinician, if the specialist will remain actively involved in care, they are designated either as the patient's principal co-manager (along with the referring primary care practice) or as primary manager of the patient's care for the referred condition.

This designation along with the completed office visit would trigger an "active phase" of attribution under the model, which would commence model payments including the monthly CCFs. During the active phase, the specialist shares relevant information with the primary care practice (e.g., potential issues, subsequent care the patient may need) and other considerations based on the established patient care plan.

Ongoing "active" participation in the model is demonstrated through: 1) an ongoing care agreement that lists the specialist as a continuing principal co-manager or primary manager of care for the relevant condition; and 2) frequently billed specialty services relevant to the condition (at least one qualifying service every quarter). If the patient does not have a relevant in-person or non-face-to-face service billed within that time, or the specialist is downgraded in the Care Coordination Agreement to a less active role, the patient is unattributed and CCFs and other model payments would cease, though they may be restarted at any time if the patient is re-attributed to the model. This emulates Primary Care First's quarterly attribution timeline and helps to ensure that the specialist is both actively engaged in the patient's care and actively communicating with the primary care practice. A set of qualifying services will be defined for each specialty with input from specialty stakeholders and CMS. Payments do not occur if the specialist remains in a limited supporting role and the referring primary care practice is primarily responsible for the patient's care.

All Comprehensive Primary Care Plus and Primary Care First referred patients would receive a targeted CAHPS patient-experience survey from the referring primary care practice regardless of whether they are referred to a MNM aligned or non-MNM aligned specialty practice to assess their experience of the transfer of care, as well as overall care provided by the specialty practice. This will allow for survey results comparing participating PCSPs with non-participating PCSPs to be considered for program evaluation purposes along with cost and quality metrics.

5. From the Physician's Perspective

Specialists participating in the MNM are required to meet a set of robust clinical transformation standards for MACRA-approved PCSPs. Key expectations include pre-screening incoming patient referrals, closing referral loops and better communication with referring primary care practices throughout the patient's treatment. Participating specialists would use prospective care coordination fees and optional comprehensive specialty care payments to invest in care-coordination staff or technology or deploy practice improvements to meet these advanced criteria—which are further incentivized by the prospect of performance-based payment adjustments. (*Refer to Payment Methodology* below.)

Primary care practices who refer patients to participating PCSPs benefit from better coordination with specialists, which results in improved patient experience and outcomes, which in turn boosts performance for the primary care practice. Referring practices can also benefit from reimbursements for e-consultation services that are incorporated into the MNM.

III. Response to Criteria

1. Scope (High-Priority Criterion)

Relevance to Clinicians

The MNM is easily scalable and can significantly expand the Advanced APM portfolio for specialties that currently have limited options for participation. It builds on MACRA's recognition of PCMHs/PCSPs as the gold standard for advanced clinical practice transformation. MACRA and CMS regulations provide full credit to clinicians in recognized PCMH/PCSPs in the MIPS Improvement Activities category. The MNM builds on Comprehensive Primary Care Plus and Primary Care First investments by extending them to the specialty setting to establish medical neighborhoods with resources to improve care coordination across settings and enhance patient access to a comprehensive set of primary and specialty services that we expect to yield better outcomes, improve efficiency, and lower costs.

We suggest initially piloting the model in a subset of Comprehensive Primary Care Plus and/or Primary Care First regions with specialties that have a sufficient number of high value electronic clinical quality measures and ideally, an accompanying QCDR (though this is not necessary). Currently, Cardiology, Infectious Disease, and Neurology have been identified as having a sufficiently robust set of quality measures that have been rated as valid by ACP's Performance Measurement Committee.[13] Comprehensive Primary Care Plus currently operates in 18 geographic regions with dozens of aligned payers. We currently have tentative interest from at least one Comprehensive Primary Care Plus state and a large health system in another Comprehensive Primary Care Plus state.

Eventually, the model can be expanded to any specialty that has enough high-value electronic Clinical Quality Measures and/or referrals from CPC+, Primary Care First MACRA-approved PCMHs. Several specialties have expressed interest in participating should this model move forward.

PCSPs have support from public and private payers through technical assistance, coaching, or in-kind support. There are 3,027 clinicians at 532 sites in NCQA's PCSP program—to date, the only MACRA-approved PSP program. If the MNM is piloted, we expect it to drive substantial growth in PCSP recognition among practices seeking Advanced APM opportunities, which could greatly expand the pilot scope. The model also aligns with CMS' plan to transition to the MIPS Value Pathway, which will feature more targeted sets of specialty- or condition-specific measures and provide more-frequent performance feedback with the goal of helping the MIPS practices transition to Advanced APMs. A specialty focused MNM will be a logical next step for many MIPS Value Pathway reporting practices.

In CPC+, participation is based on the physical practice site (the physical location where patients are seen), with engagement from the entire team, including clinical and nonclinical staff. To guarantee a statistically valid sample size, at least 100 patients must be attributed and trigger monthly CCFs over the course of a year. Because attribution will be based on services billed under the practice's Tax Identification Number, it will make no difference if a clinician is employed by the practice or is independently contracted. It may be necessary to allow newly established patient-centered specialty practices into the pilot in order to obtain enough numbers for

[13] https://www.acponline.org/clinical-information/performance-measures

evaluation. If so, it is important to note that the process for earning PCSP recognition can take 12 months or more and it typically takes several months after earning recognition for practices to achieve their best performance.

The majority of current PCSP practices are small, with an average of 5.6 clinicians per practice site, so we do not expect this model to deter participation by small practices.

There are modest costs for PCSP Recognition and the Genesis Registry, but we do not expect these to be barriers for small practice participation given the upside potential of MNM incentives. For illustration purposes, the 2020 PCSP initial recognition fee for a 5-clinician practice would be $3,025 or an average of $605 per clinician. Fees to sustain recognition would be $155/clinician ($755) per year thereafter. The cost per clinician decreases significantly for both initial and annual recognition for groups with 13 or more clinicians.[14] Electronic Clinical Quality Measure reporting via registry costs vary by vendor but are modest. ACP's Genesis Registry is $299 - $699 per clinician per year. To promote robust participation, both NCQA and ACP will discount these fees 30% for pilot participants.

Relevance to Patients

The MNM was designed to deliver individualized, accessible, comprehensive, and effective patient care. To qualify for NCQA PCSP recognition, practices and their clinicians must meet advanced transformation criteria for enhanced patient access, provision of additional services, and delivery of patient-centered, coordinated care. Patients receive expanded access via electronic communications and after-hours and same-day appointments, when appropriate. All referrals are pre-screened to ensure that the specialty visit is appropriate for the patient and that all necessary documentation is in order to reduce duplicate tests, reduce the need for unnecessary follow-up appointments and maximize the utility of each visit. A benefit of these processes is better access and availability of short-notice appointments for high-risk, high-complexity patients. MNM practices will also be expected to develop personalized care plans, regularly report back to the primary care practice, identify care gaps or barriers, and connect patients with nonmedical community support services, when appropriate.

The model emphasizes coordination with primary care practices to co-manage patients and ensure timely exchange of information. This includes tracking referrals and follow-up, sharing summaries of care, tracking and sharing lab results—and entering this information electronically in the patient's medical record. Participants must have specified and systematic methods for identifying patients who have experienced acute incidents, exchanging clinical information with admitting hospitals, obtaining discharge summaries and sending 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 quality and outcomes, experience of care and costs.

2. Quality and Cost (High-Priority Criterion)

The MNM targets primary-specialty care coordination gaps that harm quality and increase costs by contributing to avoidable complications, emergency and hospital utilization, and duplicate tests.

[14] https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-specialty-practice-recognition-pcsp/pricing-pcsp-2020-pricing/

Quality

The model addresses quality assessment and improvement from several angles to ensure patient protections and maximize incentives for maintaining and improving quality of care.

Clinical practice transformation criteria. Acceptance into the MNM is contingent on certification of proven clinical practice transformations geared toward improving overall quality, such as NCQA's rigorous PCSP Recognition or other MACRA-approved PCSP programs. Under PCSP criteria, participants must demonstrate that they:

- Maintain referral agreements and care plans for timely sharing of information with primary care practices who make referrals to them;
- Provide superior access to care when patients need it, including electronically and via same-day appointments when necessary;
- Identify and coordinate patient populations;
- Plan and manage care, including medication management;
- Use systems to track patients over time and across clinical encounters, including tracking and follow-up on specialist-to-specialist referrals, with a focus on chronic conditions;
- Provide patient-centered, culturally and linguistically appropriate care that includes the patient (and family or caregiver, if appropriate) in care planning and goal setting; and
- Implement and demonstrate continuous quality improvement efforts.

Pre-consultations. Another feature of the model is a required pre-consultation when a referral from a Comprehensive Primary Care Plus or Primary Care First practice is first received. Before a patient is seen by the specialist, the referral explanation and supporting documentation are reviewed to ensure that: 1) the specialty practice has all the necessary supporting documentation from the referring practice, including test results; and 2) the specialty practice is confident that scheduling an appointment is the most appropriate step in a patient's treatment plan.

If the specialist agrees that a visit is appropriate, a visit is scheduled. If the specialist feels a visit is not appropriate or that a referral to a different specialty or subspecialty would be more appropriate, they triage the referral with the primary care practice to agree on a course of action. The screening process can take many forms, depending on the technological capabilities available to each practice including notes exchanged over CEHRT, telephone conversations, secure messaging, video messaging services, etc. The purpose of the required pre-screening step is to help reduce unnecessary testing and appointments, freeing the practices to see urgent patients more quickly, and thus ensuring timely treatment, which leads to improved patient outcomes.

Quality and utilization metrics. MNM practices will be assessed on a set of quality and utilization measures that include: 1) two readmissions measures based on administrative claims data; 2) a set of CAHPS patient experience survey questions; 3) two core Electronic Clinical Quality Measures that are reported by all participants, regardless of specialty; and 4) specialty- or condition-specific Electronic Clinical Quality Measures (participants select and report three). Refer to Appendix 1 for a complete list of proposed quality and utilization measures. All

measures are approved by ACP's Performance Measurement Committee for meeting rigorous statistical and clinical validity standards.

Using administrative claims-based and Electronic Clinical Quality Measures helps minimize the burden of reporting and facilitate aggregation of data and timely performance feedback. Electronic Clinical Quality Measures can be supported through QCDRs, including ACP's Genesis registry, and CEHRT. We would also encourage CMS to facilitate higher participation in the model by expanding the Comprehensive Primary Care Plus Web Interface to accommodate relevant subspecialty measures and provide an additional cost-effective option for practices to report data and receive performance feedback.

Unless otherwise noted, the MNM will adopt the MIPS measure specifications, including case minimums, for each measure. All measures must meet a minimum average reliability of 0.75 to ensure they meet rigorous independent standards for reliability to help ensure they measure true differences in performance generated by practice actions as opposed to random variation.[15,16,17] Measures that do not meet this minimum will not be scored or count toward the quality or utilization component score, although the practice will continue to receive performance feedback. Measures will be risk-adjusted based on the Hierarchical Condition Categories (HCC) risk scoring methodology. We recommend that measures are independently evaluated for statistical validity and reliability and that they meet rigorous, independent criteria such as ACP's measure review criteria[18] to ensure an accurate reflection of performance.

Regarding how quality will impact payment, participants must first meet minimum quality standards to share in any performance-based payment adjustments (PBPAs). They will then receive an increasing proportion relevant to their score on quality and utilization metrics. To ensure transparent, predictable performance thresholds and align with MIPS, utilization and quality metrics will be based on national averages from benchmarks based on electronic submission of quality measures for the most recent performance year for which data are available (most likely two years before the relevant performance year).

The floor for all utilization and cost measures will be set at the national average (the 50th percentile). For every percentile increase of quality and utilization performance above this, practices will retain an additional 1%, up to 100%. Utilization and quality will be weighted equally; for example, a practice that scores in the 80th percentile on utilization and the 60th percentile on quality will earn 70% of its PBPA. All utilization and quality measures will be weighted equally within the utilization and quality components of the score. Accordingly, the two hospital readmission measures will each be worth half the utilization component while the two core measures, three specialty specific measures and CAHPS measure will each compose one sixth of the quality component. See Appendix I for a visual representation of how quality performance will impact a practice's PBPA.

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[15] Average reliability indicates how much variation is due to the variable in question, as opposed to random variation. 0.75 is the minimum recommended by statisticians for a measure to be considered an accurate indicator of performance and is consistent with ACP policy for all performance measures.

[16] Koo, Terry K., and Mae Y. Li. "A Guideline of Selecting and Reporting Intraclass Correlation Coefficients for Reliability Research." Journal of Chiropractic Medicine15, no. 2 (June 2016): 155-63.doi:10.1016/j.jcm.2016.02.012

[17] https://www.acponline.org/acp_policy/letters/acp_letter_to_cms_development_mips_outcome_measure_hospital_admission_rates_2019.pdf

[18] https://www.nejm.org/doi/full/10.1056/NEJMp1802595?_ga=2.34127457.1903606744.1570565646-948199801.1537215350

Regular performance feedback is critical so participants can monitor performance and track the progress of care interventions. Relying on administrative claims-based data and Electronic Clinical Quality Measures allows data to be collected more quickly, resulting in more timely performance feedback. At a minimum, CMS will provide quarterly performance feedback reports, no later than one quarter after the last claim was processed. For example, performance feedback for January 1–March 31 claims will be provided no later than June 30. Subsequent performance reports will include both performance metrics from that quarter, as well as a cumulative report for the performance year. Reports will provide meaningful comparison information, including national averages and performance for other MNM practices, in addition to information about a practice's own performance. Ideally, CMS will provide access to a real-time claims data feed with consistently updated data. Practices are also likely to get feedback from the QCDR or other vendor they use to report clinical quality measures. QCDRs help track performance against national benchmarks and peer data and include dashboards with performance scores and trend lines.

Cost

Spending will be retrospectively reconciled using a benchmark that is based half on the practice's historic spending and half on regional spending. This will reward performance improvement, as well as consistent low spenders. Cost performance information, including whether practices are on target to hit financial benchmark targets, will be reflected in quarterly performance reports and ideally a real-time claims data feed from participating payers.

Assessments of PCSPs on cost and quality are ongoing; NCQA will share results when they are available. One recently published study documented that NCQA PCSP recognition improved access for new and follow-up patients, increased care coordination with referral loop closure from 92.6% to 100%, and improved patient-experience survey scores over four years.[19] This suggests potential savings from decreased delays in accessing needed care, fewer duplicated tests and gaps in care, and better patient adherence to treatment protocols. PCMH studies document positive cost and quality results when paired with financial or other incentives for improvement. The Urban Institute estimated that efforts to improve care coordination for the chronically ill or disabled could save $331 billion over a decade, with 75% of that accruing to the federal government.[20] As is typical with system-wide quality improvement initiatives, it took most PCMHs at least three years to begin to realize cost savings. CMS should consider this when evaluating the program.

3. Payment Methodology (High-Priority Criterion)

Patient Attribution to the Model

Step 1: Pre-screen all referrals. Specialty referrals play a critical role in patient care. Without adequate infrastructure, the referral process between primary care and specialty care can contribute to unnecessary costs and poor outcomes. Patients arrive at their appointment only to find out they do not need a specialist, the specialist lacks necessary information or test results, or the condition could be more appropriately treated with another type of intervention, such as

[19] Huang et al, *Transforming Specialty Practice in Pursuit of Value-Based Care: Results from an Integrated Cardiology Practice*, March 21, 2019, NEJM.

[20] The Potential Savings from Enhanced Chronic Care Management Policies, 2011 Holahan et al. http://research.urban.org/uploadedpdf/412453-The-Potential-Savings-from-Enhanced-Chronic-Care-Management-Policies-Summary.pdf

self-monitoring. Specialist visits that could be appropriately resolved elsewhere wastes time and money for all parties—the specialty practice, the primary care practice, and most importantly, the patient. Poor communication leads to frustration and dissatisfaction for clinicians, but the patients ultimately pay the largest price, with worse outcomes, lost time, and wasted money.

In the MNM, all referral requests are pre-screened to ensure that the necessary information is received from the primary care practice. All requests indicate whether the specialist will provide principal care, active co-management, or a more supportive role deferring to the primary care clinician for the referred condition. Specialty practice staff will use this information to determine if a specialty visit is the appropriate next course of action and whether the patient gets attributed to the practice under the MNM (which requires either principle care or active co-management).

Case Study I

An endocrinology practice in Colorado led by an ACP member and consultant deployed appropriate referral criteria through a CCA. As a result, receipt of a clinical question increased from 0% to 75% and receipt of adequate supporting data increased from 30% to 60% within six months and continued to improve. The percentage of patients with insufficient information at their referral appointment declined from 70% to less than 5%, allowing the practice to essentially eliminate duplicate testing and the associated follow-up appointments, which saved costs. By receiving more complete referral information and utilizing pre-consultation review, the practice reduced inappropriate referrals from 20% to nearly 0%, saving patients time and money and allowing the practice to reduce wait times by more than two months and see urgent cases sooner. These changes encourage improved patient outcomes and saving downstream system costs by avoiding unnecessary emergency room visits.[21]

Case Study II

A 2001 study of an e-consultation intervention in a rheumatology practice found that at least 4 in 10 patients did not actually require a rheumatology consultation for appropriate care. According to the study, some issues were “rapidly resolved” without consultation by the specialist. In certain cases, other specialty consultation or continuing prior care were more appropriate and did not compromise patient outcomes. Appropriate referrals improved practice access and efficiency and profitability was maintained because the proper patients could be scheduled and seen sooner. The study concluded that new patient pre-appointment management should be a “key strategy” for reducing health care costs, addressing personnel shortages and improving access to and coordination of rheumatic disease care. Participants were also held financially accountable for quality and cost outcomes.[22]

Step 2: E-consultation (*optional*). If specialty staff are not convinced that a specialty visit is appropriate, the specialist has an e-consult with the referring primary care clinician. This can occur over secure messaging, CEHRT, telephone, videoconference or other permitted forms

[21] Society of General Internal Medicine. Afternoon poster session. Practice Innovations. https://www.sgim.org/File%20Library/SGIM/Meetings/Regional%20Meetings/Mountain%20West/MWST19Agenda-FINAL.pdf

[22] Pre-Appointment Management of New Patient Referrals in Rheumatology: A Key Strategy for Improving Health Care Delivery J. TIMOTHY HARRINGTON AND MICHAEL B. WALSH ARTHRITIS CARE & RESEARCH 45:295–300, 2001 © 2001, American College of Rheumatology Published by Wiley-Liss, Inc

under current CPT guidelines. The specialist and primary care physician will agree whether a specialty visit should be scheduled or if the patient should be returned to the primary care practice for further monitoring, referral to another specialist, etc. If the patient is not scheduled for a specialist visit, the specialty practice bills for the e-consult, but the patient is not attributed and does not trigger CCF payments under the model.

Step 3: Specialty visit. Only qualifying patients referred by Comprehensive Primary Care Plus or Primary Care First participating primary care clinicians that: 1) passed screening criteria in the referral pre-screening step; 2) have the specialist listed as a principal co-manager or primary care manager for the referred condition; and 3) have an office visit billed through the participating MNM specialist will be attributed and qualify for payment. Beneficiary attribution occurs monthly.

Payment Structure

- Care Coordination Fee (CCF). All participating practices receive a risk- and geographically-adjusted non-visit-based per beneficiary per month CCF on all attributed patients.[17] The fee would vary based on risk tier (detailed below) and would be based on an average of $37. It is intended to cover the costs of providing advanced clinical services and enhanced coordination required by the model, such as obtaining and reviewing data or relevant information, outlining suggestions for long-term handling of the problem, and completing literature review in response to issues raised during communication. This fee is calculated and paid on a quarterly basis. It is not subject to financial risk and is free of patient-cost sharing, as is the case with CPC+. The amount is risk-adjusted at the population level for each practice to account for the intensity of care management services required for the practice's specific patient population while taking emphasis off coding for individual patients.

  To ensure program integrity, patients may not trigger monthly payments under the MNM until the following two conditions are met: 1) at least one office visit is billed by the specialty practice; and 2) the specialist is designated in the Care Coordination Agreement as a principal co-manager or primary care manager for the referred condition. The patient is automatically unattributed based on which of the following occurs *first:* 1) the specialist and primary care practice document in the Care Coordination Agreement that the primary care practice resumes primary responsibility for the patient; or 2) the specialist did not bill a claim for the patient in the preceding quarter (claims can be for relevant in-person or non-face-to-face services). The latter emulates the Primary Care First quarterly attribution timeline and helps to ensure that the specialist is actively engaged in the patient's care and actively coordinating with the primary care practice.

- Performance-Based Payment Adjustments (PBPA). The MNM practice and its eligible clinicians bear risk through PBPAs, which can be positive or negative based on financial performance relative to a benchmark that is based half on a practice's own historical spending (two calendar years before the performance year) and half on regional spending during the relevant performance year. This gives an incentive for participants to both improve and consistently deliver high-quality, low-cost care.

  Benchmarks are recalibrated annually. Participating practices share half the savings or losses they generate beyond a minimum savings rate or minimum loss rate up to a cutoff for windfall savings or catastrophic losses. Practices choose their own symmetrical savings/loss rate, which ranges from 0% to 2% from the benchmark in 0.5% increments. Savings or losses are

capped at 10% of the benchmark in order to protect practices from catastrophic losses and the Medicare trust funds from massive payouts in the event of windfall savings.

PBPAs are assessed annually following a 30-day claims runoff period, then divided evenly across second, third, and fourth quarter payments for the subsequent performance year.

To share in earned savings, practices must meet minimum standards for all quality and utilization performance measures. Unlike other Medicare models, the amount of PBPA that a practice retains is continuously adjusted based on how well they perform on utilization and quality metrics, up to 100%. This is to encourage ongoing positive performance above minimum quality and utilization thresholds. (Refer to *Quality* for a more detailed explanation.)

- Comprehensive Specialty Care Payment (CSCP) *(optional; for Track 2 only).* Track 2 practices would receive prospective quarterly payments based on 25% of the anticipated Physician Fee Schedule spending for the quarter, then fee-for-service payments are reduced to 75% when services are rendered and billed. Services receive a 10% boost to account for providing more-comprehensive clinical support services. Anticipated costs are based on historical costs from the calendar year two years before the performance year (as used for the financial benchmark) and are divided into four equal payments. This type of calculation helps smooth large fluctuations. Like CCFs, CSCPs do *not* vary based on performance. However, CSCPs are reconciled retroactively against actual spending and paid out similarly to PBPAs, evenly divided three ways among the final three quarters of the subsequent performance year.

Note: *This payment is only for practices that opt into Track 2; Track 1 practices would bill traditional Medicare and have all claims paid on a fee-for-service basis as usual.*

Table 1: Summary of Payments Under the Medical Neighborhood Model

Track	Care Coordination Fee (CCF) $37	Performance-Based Payment Adjustment (PBPA)	Medicare Physician Fee Schedule	Comprehensive Specialty Care Payment (CSCP)
1	Risk-adjusted per beneficiary per month fee to support enhanced care coordination supports	Annually retroactively assessed based on performance against financial benchmark and quality and utilization targets; paid/ owed quarterly in the final three quarters of the subsequent performance year.	Regular fee-for-service	none
2	Risk-adjusted per beneficiary per month fee to support enhanced care coordination supports	Annually retroactively assessed based on performance against financial benchmark and quality and utilization targets; paid/owed on a quarterly basis in the final three quarters of the subsequent performance year.	Paid at reduced rate of 75% based on 110% of Physician Fee Schedule rates.	Quarterly prospective lump sum payments based on 25% of anticipated fee-for-service revenue at 110% of Physician Fee Schedule rates. Payments are retroactively reconciled and paid out quarterly in the final three quarters of the subsequent year along with PBPAs.

Table 2: Breakdown of Medical Neighborhood Model Quarterly Payments

CCF payment for 3 months of patients.	One-third of PBPA assessed from previous year (if 2nd–4th quarter).	**Track 2 Only:** Quarterly prospective CSCP payment.	**Track 2 Only:** One-third of CSCP reconciliation from previous year (if 2nd-4th quarter).

Risk Adjustment. Adequate risk adjustment is essential to protect against cherry picking, inappropriate underutilization, and undue risk for a naturally aging population. As in Primary Care First, CCF risk adjustment occurs at the population level based on risk quintiles and is updated on a rolling basis as claims are billed. Risk adjustment is based on HCC scoring while adjusting for additional factors that influence outcomes, such as social determinants of health.[23]

4. Value Over Volume

The MNM promotes value over volume in many ways, including the following.

- Pre-screening referrals reduce inappropriate referrals, wasteful visits, and potential harms from overuse and allows the practice to see higher-acuity patients sooner.
- Referral ranking and tracking ensures that the most urgent conditions are prioritized and that referral loops are closed.
- Better primary and specialty care coordination through the Care Coordination Agreement clearly defines the primary care and specialty roles and reduces gaps in care that increase avoidable and costly complications and improve patients' overall experience of care.
- MNM practices are evaluated on key utilization and quality metrics and against financial benchmarks to ensure they deliver high value care in an efficient, cost-effective way.

5. Flexibility

Accommodation Across Clinical Specialties and Patient Subgroups

A defining characteristic of the MNM is that it can be easily scaled to a variety of geographic locations, specialties, and payers. It can accommodate virtually all patient-facing specialty types and patients who need referrals to these specialties. The flexible design allows expansion to a range of subspecialties.

We 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 consultations to ongoing collaboration with primary care practices and cases (cancer, for example) where 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, the MNM has the flexibility to accommodate a wide

[23] Social Determinants of Health, NEJM Catalyst, December 2017.

range of specialties while maintaining consistency and not imposing undue complexity or burden on participants. Its flexibility separates it from other proposed specialty models.

Building the Infrastructure

The MNM will not require infrastructure changes to succeed besides those required to meet MACRA-qualified PCSP criteria, which both Congress and Medicare have endorsed in legislation and regulation. Prospective payments empower MNM practices to invest in the necessary infrastructure. For this reason, we expect that uptake will be relatively straightforward and quick. CPC+ has already added 2,881 primary care practice participants since the creation of its predecessor program, Comprehensive Primary Care, in 2012.

Adapting to Changing Technologies

Participating practices will be well-positioned to incorporate appropriate upgrades as health IT and other technologies evolve, thanks to their prospective PBPM payments. Because participating practices have an incentive to provide high-quality, efficient care, they will employ new technologies that facilitate cost-effective standards of care. Use of Health IT is a cornerstone of the MNM and its focus on care coordination across settings. As an anticipated Advanced APM, it would require CEHRT.

As the program expands to incorporate new specialties, the QCDRs and qualified registries connected with it can also expand. Additionally, the existing Comprehensive Primary Care Plus online platform and CMS Web Interface offers another promising way to connect data from multiple systems and vendors, MNM practices, PCSPs, patients and payers.

Addressing Operational Burdens and Reporting Requirements

The MNM reduces burden in multiple ways, including the following.

- As an intended multi-payer model, it will align performance measurement across payers, streamlining the number of individual metrics that participants are required to report.
- By leveraging digital and automatic methods for reporting quality, cost, and utilization data, it minimizes reporting burden on participants while facilitating frequent, timely feedback.
- It will encourage the use of data intermediaries to automatically extract measure data from electronic health records, health information exchanges, and other digital sources.
- We anticipate that participants will be eligible for Medicare payment and fraud and abuse waivers that can lift burdensome billing and administrative hurdles, as has been the case for other risk-bearing Alternative Payment Models.

The model has 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, rather than engaging in separate data reporting merely to satisfy “check the box” requirements.
- **More accurate results.** Automated systems are equipped to pull comprehensive, relevant data and understand how it interacts. This greatly reduces the chance of underreporting performance and helps to enhance the accuracy of risk adjustment.

- **More meaningful measures.** Data in electronic systems is much richer than claims data. Most important, these systems include outcomes data that is considered the gold standard for assessing quality.[24]
- **More rapid feedback.** Electronic data reporting allows for more rapid and meaningful performance feedback to clinicians. Under Medicare's MIPS Program, clinicians deliver care in one year, report on that care the next and see their performance scores the year after that. Data aggregators should be able to provide feedback in (nearly) real-time so clinicians can identify gaps and make needed improvements more quickly.

6. Ability to Evaluate

As with other Medicare pilots, the MNM model would undergo a robust evaluation from an independent third party. The evaluator would identify cohorts of patients who received a referral to an MNM specialist for follow-up care and compare them to a control group of patients who received care from non-MNM specialty practices. Using Medicare claims data, reported Electronic Clinical Quality Measures, and responses from the CAHPS survey that would be distributed to all patients (both MNM and non-MNM) by the referring Comprehensive Primary Care Plus or Primary Care First practice, the evaluator would assess whether and how participation affects patient experience, health outcomes, resource utilization, and total cost of care. The evaluation would compare total spending and rates of hospital admissions and emergency department visits following the referral using matched pairs of referrals—one to an MNM-aligned practice, one to a non-MNM specialty practice. These comparisons should occur quarterly for providing timely feedback to participants, annually for determining PBPAs and over the course of the pilot for full evaluation of the MNM and its total effects. We propose a pilot period of five years to allow for downstream care outcomes and savings to be fully realized and to align with Comprehensive Primary Care Plus and Primary Care First.

Introduction of the model could change the mix of patients referred to specialty care, primarily as a result of the required pre-screening step. As proposed, the pilot is intended to enhance provision of care through improved coordination. We expect to observe flat or increased average acuity of patients, conditional on referral to specialty care among practices participating in the model. To monitor potential for gaming, we propose a difference-in-differences design that compares MNM-aligned specialty practices and non-MNM practices, before and after introduction of the pilot using Medicare claims data. Estimates from these models could offer evidence of whether the pilot induced changes to the patient mix and whether severity increased or decreased.

The evaluation should document how the MNM changed the structure and processes surrounding delivery of specialty care. We propose using a mixed methods approach that would rely on practice application data and interviews with practices to document how provision of care changed among MNM participants and how practices modified their approach to coordinating with primary care practices. The evaluation process also should track changes in key features of practices that choose to participate in the MNM, including practice size (number of clinicians, patients), affiliations with hospital systems, or single specialty versus multispecialty status.

[24] The benefit of using both claims data and electronic medical record data in health care analysis, Optum, 2012.

Program evaluation also would assess the program's impact on increasing specialty practice adoption of PCSP Recognition. The MACRA statute promotes PCSP recognition as a policy goal by providing full, automatic credit for patient-centered specialty practice clinicians in the MIPS Improvement Activities Category. An important potential additional benefit of the MNM is that it could promote increased PCSP adoption. To document these changes, we propose comparing rates of adoption in the pre- and post-MNM pilot implementation.

7. Integration and Care Coordination

As discussed, participating practices must meet rigorous standards for coordinating and improving care. (Refer to Appendix 2 for detailed PCSP requirements.) We do not expect technology boundaries to inhibit e-consultations, which can be performed through CEHRT, practice management systems, telecommunication technologies with video or audio capabilities or over the phone. E-consultations are performed when there is inadequate information in the patient record to effectively treat the patient without performing tests again or scheduling a visit to gather information and then another appointment—so we expect that instilling the pre-consultation step, followed by a possible e-consultation, will result in net savings. Non-physician medical and administrative staff can assist with the pre-screening process.

8. Patient Choice

The MNM will not affect patients' freedom to choose. Patients can see a non-MNM specialist even if the primary care practice referral is to an MNM specialist. However, we think that patients will see the advantages of a coordinated team of clinicians working to improve their care and will generally prefer to see model-aligned practices. If CMS creates a waiver to allow MNM practices to create beneficiary incentive programs, participants can also offer patients positive incentives to receive care that includes reduced copays for certain high-value services and supplementary services not reimbursed by traditional Medicare.

The MNM prioritizes voluntary alignment, which facilitates accurate attribution, promotes proactive patient choice and helps ensure that patients are fully aware of their participation. Beneficiaries will attest (on MyMedicare.gov) to the health care clinician and practice that provides their care. Voluntary attribution is supplemented with claims-based attribution triggered by a relevant specialty visit.

PCSP recognition is another mechanism to ensure that all referrals receive equal priority in participating practices. In addition to committing to providing high-quality, coordinated care for their entire patient panel, recognized patient-centered specialty practices commit to ensuring equal access to all patients, regardless of payment or referral source. Furthermore, as a result of pre-consultation, participating specialists divert inappropriate referrals back to the primary care practice or another specialist, increasing their capacity to see patients that need their services more quickly. Priority ranking and maintaining a certain amount of appointments for urgent cases helps to ensure that patients who could benefit the most from urgent care are seen first, avoiding unnecessary complications and hospitalizations. We are confident that better coordination between primary care practices and participating practices will highlight the benefits of care that is organized and assessed based on the same core principles for patient-centered care, coordination, data sharing, and seamless care transitions.

9. Patient Safety

PCSP standards, quality metrics, and program oversight actively reinforce patient safety. The NCQA terms of PCSP recognition stipulate that NCQA may periodically review PCSPs. The review may include an audit or discretionary survey to target and address issues where a practice may not continue to meet patient-centered specialty practice standards. NCQA may also revoke PCSP recognition if it identifies a significant threat to patient safety or care.

The MNM features a multi-pronged approach to data collection on patient experience, quality of care and health outcomes. Survey questions about patient experience and utilization and a series of quality and utilization measures help to monitor that all patients in the model receive recommended (or higher) levels of care. Measures are risk adjusted to avoid adverse patient selection issues, another important patient-safety concern.

The model would also incorporate elements of direct patient-safety monitoring, as seen in other Medicare models (e.g., Comprehensive Primary Care Plus), through a combination of different methods including annual submission of program-integrity data, quarterly attestations to care-delivery achievements, quarterly "flag reports," annual review of cost, utilization, patient experience and quality data, and ad hoc audits as necessary. These mechanisms will not only protect patient safety but ensure that the highest possible standards of care quality are met.

10. Health IT

Data collection and transparency and tracking care across settings are a central focus of the MNM design. The model would require use of CEHRT, which facilitates pre-screening, storing, and sharing data across care settings, and sharing aggregate data with public health agencies and registries. It supports data reporting and communication across settings through QCDRs and qualified registries such as ACP's Genesis Registry. Ideally, CMS will modify the existing online Comprehensive Primary Care Plus platform and CMS Web Interface portal to further support reporting and cross communication. NCQA's PCSP recognition further requires primary care practices who refer to patient-centered specialty practices to have written agreements on how they will exchange information before, during and after a referral.

The variety of reporting options—particularly an online platform available from CMS at no cost—ensures a range of technology options. Reporting and data sharing through the existing Comprehensive Primary Care Plus online portal or through the CMS Web Interface would allow maximum data transparency for model participants, CMS and the public at large. Real-time claims data feeds drive quality improvement, and we encourage CMS to make these data available to the extent possible.

Importantly, proposed CMS and Office of the National Coordinator for Health Information Technology (ONC) rules on interoperability and data sharing—based on 21st Century Cures Act requirements—address concerns about data blocking and lack of interoperability that impede data sharing. The proposed rules would require adoption of uniform electronic data exchange standards among physicians and patients, and prohibit data blocking by clinicians or vendors, or any action that could interfere with users' ability to access or use certified electronic health record technology capabilities. Together, patient-centered specialty practice requirements and impending CMS/ONC policies can eliminate barriers to data exchange in the MNM.

11. Caveats

Population Size

We appreciate that as with any model, having a sufficient patient population over which to spread risk and model participation to justify the costs of implementing and maintaining a pilot are both critical elements. That is why we have expanded referrals from Comprehensive Primary Care Plus as well as the impending Primary Care First model to hopefully double the number of qualifying referrals. As noted earlier, while we envision a limited scale pilot in one or a limited number of specialties, this model could eventually be expanded to suit a variety of different specialties for which there are adequate quality metrics and financial data for benchmarking—we feel this is one of the strongest reasons for piloting it. Similarly, the model could be expanded across several payers, which will only expand its reach and the number of patients it covers. To protect against variation for individual MNM practices as well as payers, we have instituted a minimum of 100 relevant referrals.

Patient Safety

With any risk-bearing payment model, ensuring all patients continue to receive the highest quality of care is paramount. During initial PCSP recognition, participants document that they have met rigorous clinical transformation standards for at least 90 days. During annual renewal, participants document that they continue to meet program standards. All MNM practices are expected to comply with afore-mentioned integrity and evaluation tactics to ensure that they satisfy program requirements and complete an independent evaluation of their success. In addition, CMS will review all revenue and expense data, along with cost, utilization, quality outcomes, and patient experience data, to monitor for threats to patient safety or other concerning trends related to cost-cutting tactics (e.g., unusually low utilization rates), particularly for vulnerable segments of the patient population.

Program Integrity and Evaluation

As detailed in *Payment Structure,* monthly CCFs are not triggered until the following conditions are met: 1.) at least one office visit is billed by the PCSP; and 2) the specialist is designated in the Care Coordination Agreement as either managing or co-managing a patient's condition with the primary care practice. The patient will be automatically unattributed from the model based on which of the following occurs *first:* 1) the specialist and primary care practice document in the Care Coordination Agreement that the primary care practice is resuming primary responsibility for the patient; or 2) the specialist did not bill a relevant claim for the patient in the preceding quarter. The latter emulates Primary Care First's quarterly attribution timeline and helps ensure that the specialist is actively engaged in the patient's care and actively coordinating with the primary care practice.

Participation is voluntary; practices may withdraw at any point, provided they notify CMS at least 90 calendar days in advance. Monthly payments cease at the end of the quarter in which the practice announces its intent to terminate and practices would be expected to repay a proportional amount of their PBIP, and, if applicable, CSCP. This incentivizes practices to remain in the program to improve their financial performance and reduce losses while maintaining the flexibility to terminate on a quarterly basis.

Practices that do not meet participation terms may be terminated at any point by CMS. Grounds for termination may include, but are not limited to, failure to meet reporting deadlines, not meeting advanced clinical practice criteria, not complying with enforcement activities, etc.

Spillover Effect

Like Comprehensive Primary Care Plus and Primary Care First, the MNM is intended to be a multi-payer model with aligned criteria and payment incentives across all participating payers. As with Comprehensive Primary Care Plus, we expect positive spillover to patients covered by non-participating payers, because care coordination payments are likely to facilitate practice-wide transformation that can extend to patients covered by non-participating insurers. Researchers have documented similar spillover effects with Medicare Advantage managed care plans. One study found that greater penetration was associated with lower hospital costs for all seniors and for commercially insured younger populations.[25] Another found that a 10% increase in Medicare Advantage market penetration was associated with decreases of 7.3% in hospital days and 9.1% in nonsurgical hospital days, and with increases of 5.5% in outpatient visits and 8.9% in outpatient surgical visits.[26] However, we consider these spillover effects to be positive because they indicate practice wide transformation that improves care for more patients.

[25] Baicker et al, *The Spillover Effects of Medicare Managed Care: Medicare Advantage and Hospital Utilization,* NBER Working Paper, May 2013.
[26] Baicker et al, *Medicare Payments and System-Level Health-Care Use: The Spillover Effects of Medicare Managed Care,* AJHC 2015.

APPENDIX 1: QUALITY MEASURES

Scoring Example:

Quality Component (50%)						**Utilization Component (50%)**	
REVISED Care Plan Measure	REVISED All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions Measure	CAHPS Patient Experience Survey Measure	Menu Measure 1	Menu Measure 2	Menu Measure 3	Hospital Wide All-Cause Readmission Rate Measure	SNF 30-day All-Cause Readmission Measure
95%	75%	80%	85%	90%	85%	70%	80%
85%						75%	
Final Score: 80%							

This MNM practice would retain 80% of its PBA.

Utilization Measures

- Hospital Wide All-cause Readmission Rate Measure (NQF ID #1789)
- SNF 30-day All-Cause Readmission Measure (NQF ID #2510)

Patient Experience Measures

The Medical Neighborhood Model will repurpose the following Comprehensive Primary Care Plus CAHPS survey questions:

- Q6. Patient always got appointment as soon as needed when contacting provider's office to get an appointment for care needed right away.
- Q8. Patient always got appointment as soon as needed when making an appointment for check-up or routine care.
- Q10. When patient contacted provider's office during regular office hours with a medical question, patient always received an answer that same day.
- Q11. Providers always explained things to patient in a way that was easy to understand.
- Q12. Provider always listened carefully to patient.
- Q13. Provider knew important information about patient’s medical history.
- Q14. Provider always showed respect for what patient had to say.
- Q15. Provider always spent enough time with patient.

- Q17. Someone from provider's office followed up with patient to give results of blood test, x-ray, or other tests.
- PCMH3. Provider always seemed informed and up to date about the care patient received from primary care providers and other specialists.
- Q.20. Someone from provider's office talked with patient about all prescription medications being taken.
- PCMH4. Someone in provider's office discussed specific health goals with patient.
- PCMH5. Someone in provider's office asked whether there were things that made it hard for patient to take care of health.
- Q18. Patient rating of provider as best provider possible (0–10 out of 10).

Electronic Clinical Quality Measures

Core measures (2)

- **REVISED** Care Plan Measure (MIPS 047) (must address ACP recommendations to limit the denominator to established patient visits and to consider extending the frequency of reporting to biannually to minimize administrative burden on clinicians).
- **REVISED** All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions Measure (must address ACP concerns by combining all chronic diseases under a single definition and defining what constitutes a validated admission and acceptable admission prevention methods).

Menu Measures (*must select three from relevant specialty measure set)*

Measure Name	Applicable Specialty	Measure Type	Valid per ACP Review
Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy (QID 326; NQF 1525)	Cardiology	Process	Yes
Cardiac Rehabilitation: Patient Referral from an Outpatient Setting (QID 243; NQF 0643)	Cardiology	Process	Yes
Chronic Stable Coronary Artery Disease: Antiplatelet Therapy (QID 006; NQF 0067)	Cardiology	Process	Yes
Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%) (QID 007; NQF 0070)	Cardiology	Process	Yes
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (QID 438, Not NQF-endorsed)	Cardiology	Process	Yes
Persistence of Beta-Blocker Treatment after a Heart Attack (QID 442; NQF 0071)	Cardiology	Process	Yes
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet (QID 204; NQF 0068)	Cardiology	Process	Yes
Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB)	Cardiology	Process	Yes

Measure Name	Applicable Specialty	Measure Type	Valid per ACP Review
Therapy for Left Ventricular Systolic Dysfunction (LVSD) (QID 005; NQF 0081)			
Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) (QID 008; NQF 0083)	Cardiology	Process	Yes
Use of Imaging for Low Back Pain (QID 312; NQF 0052)	Neurology	Overuse	Yes
Documentation of Signed Opioid Treatment Agreement (QID 412; Not NQF-endorsed)	Neurology	Process Cross-cutting	Yes
Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy (QID 032; Not NQF-endorsed)	Neurology	Process	Yes
Overuse of Neuroimaging for Patients with Primary Headache and a Normal Neurological Evaluation (QID 419; Not NQF-endorsed)	Neurology	Overuse	Yes
Measures Included in NCQA List			
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (QID 107; NQF 0104)	Cardiology Neurology	Process Cross-cutting	Yes
Evaluation or Interview for Risk of Opioid Misuse (QID 414; Not NQF-endorsed)	Neurology	Process Cross-cutting	Yes
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (NQF 0058; QID 116; NQF 0058)	Infectious Disease	Process	Yes
Annual HCV Screening for Patients who Are Active Injections Users (QID 387; not NQF-endorsed)	Infectious Disease	Process Cross-cutting	Yes
One-Time Screening for HCV for Patients at Risk (QID 400, NQF 3059)	Infectious Disease	Process Cross-cutting	Yes
HIV: Viral Load Suppression (QID 338, NQF 2082)	Infectious Disease	Process	Yes
HIV/AIDS: CD4 Cell Count or Percentage Performed (NQF 0404)	Infectious Disease	Process	Yes
HIV/AIDS Pneumocystis Jiroveci Pneumonia Prophylaxis (NQF 0405)	Infectious Disease	Process	Yes
Annual Cervical Cancer Screening or Follow-up in High-Risk Women (NQF 0579)	Infectious Disease	Process	Yes
National Healthcare Safety Network Facility-Wide Inpatient Hospital Onset MRSA Bacteremia Outcome (NQF 1716)	Infectious Disease	Outcome	Yes
National Healthcare Safety Network CLABSI Outcome Measure	Infectious Disease	Outcome	Yes
Adult Sinusitis: CT for Acute Sinusitis (QPP 333)	Infectious Disease	Overuse	Yes

APPENDIX 2: CLINICAL PRACTICE TRANSFORMATION CRITERIA
NCQA Medicare Access & CHIP Reauthorization Act-Approved PCSP standards.

(Attached)

APPENDIX 3: CLINICIAN NARRATIVE

The Medical Neighborhood Model from the Physician Perspective

Clinical interactions between the primary care practice and the participating practice can take the following forms.

Non-Model Triggers

- Referral triage (intended to expedite/prioritize care) can:
  - Determine if a different type of specialty should handle the patient.
  - Determine if the referral request is not medically necessary (no further intervention indicated).
  - Answer a clinical question without needing an in-person specialty visit by the patient (e-consultation or virtual clinician-to-clinician consultation and advise) (“curbside consultation”). The interprofessional consultation code is billed by the specialist and the patient is not entered into the model.
  - Prepare the patient for a specialty care appointment by ensuring receipt of pertinent supporting information (as specified in referral guidelines or by specialty care clinician review) by the scheduled appointment. [This category includes the establishment of general referral guidelines to help expedite timeliness and appropriateness of referrals] and can help determine/prioritize the urgency for scheduling the appointment. Several national specialty/subspecialty societies have already developed referral guidelines, and these should be utilized to inform this process.
- Formal consultation (to deal with a discrete question/procedure) is limited to one (or a few) visits that focus on answering a discrete question and may include a particular service request by a primary care practicefor a patient. Fee-for-service coding may apply.
- A detailed report and discussion of management recommendations provided to the Comprehensive Primary Care Plus or Primary Care First practice. The participating practice would not manage the problem on an ongoing basis.

Model Triggers

- Principal care co-management for the disease (a disorder or set of disorders)—both the Comprehensive Primary Care Plus practice and Medical Neighborhood Model practice are concurrently active in the patient’s treatment, but the participating practice’s responsibilities are limited to a discrete group or set of problems and the practice provides care and first contact for the disease. The primary care practicepractice maintains responsibility for all other aspects of patient care and remains the first contact for the patient.
- Principal care co-management of the patient for a consuming illness for a limited period. The participating practice is temporarily the first contact for care because of the significant nature and impact of the disease. Although the patient is triggered into the model, the Comprehensive Primary Care Plus practice receives ongoing treatment information, retains input on secondary referrals and may provide certain defined care.

- Transfer of patient to the Medical Neighborhood Model practice for the entirety of care. The participating practice assumes the role of the primary point of contact after consultation with the primary care practiceand approval by the patient.

Examples

- A patient with **colon cancer** is seen by a participating oncologist in the hospital postoperatively. It is determined that the patient will need six months of adjuvant chemotherapy. The oncologist provides the adjuvant chemotherapy and all care related to delivery of chemotherapy drugs/monitoring toxicities and prioritizes the importance of care for other health issues. The patient is triggered into the Medical Neighborhood Model and payment is made under the model.

  The oncologist guides the patient to the primary care practicefor other issues (ongoing hypertension and hyperlipidemia management), but over the course of active therapy, is the first contact for all issues.

  After completing the active adjuvant care, the patient continues to follow up with oncology. After a determined period, the patient exits the model and payments stop.

- A patient with poorly controlled **Type 2 Diabetes Mellitus** (T2DM) is seen by a participating endocrinologist for principal care management, triggering patient entry into the model. The endocrinologist works with the patient to find a treatment regimen that is both acceptable to the patient and achieves glycemic targets—this takes a number of adjustments to medications and lifestyle.

  Over time, the patient's glycemic control improves and remains stable with no untoward adverse effects. Management of the condition is transitioned back to primary care. The patient exits the model and payments stop.

- A patient with **Crohn's disease** and **Type 1 Diabetes Mellitus** (T1DM) and who is on insulin pump therapy sees a participating gastroenterologist and endocrinologist for principal care co-management of the conditions.

  The Crohn's disease flares, requiring the gastroenterologist to assume principal care co-management of the patient for a consuming illness.

  The endocrinologist continues to provide principal care co-management for the T1DM, adjusting pump therapy as needed throughout the flare episode and thereafter.

  The primary care practicecontinues to provide medical home and other care needs and is connected via information sharing and communication.

  Once the Crohn's disease flare is resolved, the patient returns to principal co-management of the disorder for the Crohn's and continues in same for the T1DM.

- A cardiology practice satisfies CAHPS for the Merit-Based Incentive Payment System survey requirements and submits two core measures and three additional menu measures from the cardiology measure set. The practice scores in the 85th percentile for the CAHPS for the Merit-Based Incentive Payment System survey. On the menu measures, the practice scores in the 90th percentile on the first measure; in the 70th percentile on the second; and in the 75th percentile on the third.

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PCSP PUBLICATION SYMBOL LEGEND		
Symbol	**Meaning**	**Description**
	**Site-Specific**	For organizations with multiple sites, criteria require evidence be demonstrated for each site.
	**Specialty-Specific**	For organizations with multiple specialties, criteria require evidence be demonstrated for each specialty. ***For organizations with two specialties at one site:*** Evidence must be provided for both specialties. ***For organizations with three or more specialties at one site:*** Evidence must be provided for three specialties: 1. Largest specialty across the organization, represented by number of patient visits across the organization. 2. Behavioral health, if included as a specialty, **OR** the largest specialty at the site, if behavioral health is not applicable. 3. A third specialty selected by the organization.
	**Cross-Program Shared Credit Option**	For organizations seeking PCSP Recognition with 1.) existing Recognition status (e.g., PCMH) or 2.) concurrently seeking Recognition with other Recognition programs, criteria may be shared between programs. Specific shared credit alignment is noted next to the symbol. ***Note:*** *If an organization shares criteria within or between programs, it is attesting that all practices pursuing or holding Recognition status follow the same policies and procedures and use the same systems.*

Team-Based Care and Practice Organization (TC)

The practice provides continuity of care; communicates its role and responsibilities to patients/families/caregivers; and organizes and trains staff to work to the top of their license, to provide patient-centered care as part of the medical neighborhood.

Competency A: Practice Organization. The practice commits to transforming into a sustainable patient-centered practice. Care team members have the knowledge and training necessary to perform their roles, which are defined by the practice's organizational structure.

TC 01 (Core) Transformation Leads: Designates a clinician lead and a staff person to manage the transformation and ongoing patient-centered care.	
GUIDANCE	**EVIDENCE**
The practice identifies the clinician lead and the transformation manager (the person leading the PCSP transformation). This may be the same person. Identification of the lead/manager includes: • Name. • Credentials. • Roles/responsibilities. Practice transformation is successful when there is support from a clinician lead. The lead's support sets the tone for how the practice functions as a patient-centered practice. The intent is to ensure that the practice has clinical and operational support and resources to implement the medical neighborhood model.	• **Details about the clinician lead** ***AND*** • **Details about the transformation manager**
TC 02 (Core) Structure and Staff Responsibilities: Defines the practice's organizational structure and staff responsibilities/skills to support key practice functions.	
GUIDANCE	**EVIDENCE**
The practice provides an overview of practice staff roles and an outline of duties staff will execute as part of the medical neighborhood model, and explains how it will support and train staff to complete these duties. Structured tasks and clearly stated staff responsibilities enable the practice to ensure that staff provide efficient medical care and are trained in the skills necessary to support the functions of the medical neighborhood model.	• **Staff structure overview** ***AND*** • **Description of staff roles, skills and responsibilities**

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TC 03 (1 Credit) Collaboration With the Medical Neighborhood: The practice is involved in external medical neighborhood collaborative activities.	
GUIDANCE	**EVIDENCE**
The practice demonstrates that it is involved in at least one state or federal initiative (e.g., CMMI initiatives such as the Comprehensive ESRD Care Model or the AMI Model, state-led care management learning collaborative) or population-based care learning collaborative. Participating in an ACO or clinically integrated network would not meet this requirement. Participating in ongoing collaboration with other practices or entities allows the practice's staff to learn and share best practices with their peers.	• **Description of involvement in external collaborative activity**
TC 04 (2 Credits) Patient/Family/Caregiver Involvement in Governance: Patients/families/caregivers are involved in the practice's governance structure or on stakeholder committees.	
GUIDANCE	**EVIDENCE**
The practice either: • Creates a role for patients/families/caregivers in the practice's governance structure or on its board of directors, ***or*** • Organizes a Patient and Family Advisory Council (PFAC) (stakeholder committee). The practice specifies: • How patients/families/caregivers are selected for participation; • The patient/family/caregiver's role; • Frequency of meetings. Patients are more than consumers in their care, they are partners. Involving patients/families/caregivers in practice governance can provide additional input for improving patient services and engaging patients in the care they receive from the practice.	• **Documented process** ***AND*** • **Evidence of implementation**
TC 05 (2 Credits) Certified EHR System: The practice uses a certified electronic health record technology (CEHRT) system.	
GUIDANCE	**EVIDENCE**
The practice enters the name of the electronic systems implemented and actively used in the practice. Only systems the practice is actively using should be entered. Use of a certified EHR can increase productivity, reduce paperwork and enable the practice to provide patient care more efficiently. https://chpl.healthit.gov/#/search	• **CEHRT name**  *PCMH TC 05*

Competency B: Team Communication. The practice facilitates communication among staff to ensure that patient care is coordinated, safe and effective.

TC 06 (Core) Individual Patient Care Meetings/Communication: Has regular patient care team meetings or a structured communication process focused on individual patient care.	
GUIDANCE	**EVIDENCE**
The practice has a structured communication process or holds regular care team meetings (such as huddles) for sharing patient information, care needs, concerns for the day and other information that encourages efficient patient care and practice workflow. A structured communication process is focused on individual patients and may include entering tasks or messages in the medical record, regular email exchanges or notes on the schedule about specific patients and the roles of the clinician or care team leader and others in the process. Consistent care team meetings allow staff to anticipate the needs of all patients and provide a forum for staff to communicate about daily patient care needs.	• **Documented process** ***AND*** • **Evidence of implementation**  *Evidence of implementation only* 
TC 07 (Core) Staff Involvement in Quality Improvement: Involves care team staff in the practice's performance evaluation and quality improvement activities.	
GUIDANCE	**EVIDENCE**
The practice describes staff roles and involvement in performance evaluation and improvement activities. Improving quality outcomes involves all members of the practice staff and care team. Engaging the team in review and evaluation of the practice's performance is important for identifying opportunities for improvement and developing meaningful improvement activities.	• **Documented process** ***AND*** • **Evidence of implementation** 

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Competency C: Practice Responsibilities. The practice defines and communicates its role and the patient's role in the medical neighborhood model of care.

TC 08 (Core) Specialty Practice Information: Has a process for informing patients/families/caregivers about its role and responsibilities and provides materials that contain the information.	
GUIDANCE	**EVIDENCE**
The practice has a process for informing and providing patients/families/caregivers with information about its role and responsibilities at the start of care and throughout the care trajectory. Reminding patients periodically ensures that they have ready access to essential information and available resources. The practice is encouraged to provide the information in multiple formats, to accommodate patient preference and language needs. At a minimum, materials include: • Names and phone numbers of practice points of contact. • Instructions for reaching the practice after office hours. • A list of services offered by the practice. • How the practice uses evidence-based care. • A list of resources for patient education and self-management support. The practice explains to patients the importance of maintaining comprehensive information about their health care. It describes how and where (e.g., specialty practice, primary care office, ED) patients should access the care they need.	• **Documented process** ***AND*** • **Evidence of implementation**

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Initial Referral Management (RM)

The practice sets expectations for referrals and care transitions from primary care and other referring clinicians to deliver high-quality, coordinated care.

Competency A: Care Coordination With Primary Care and Other Referring Clinicians. The practice coordinates with primary care and referring clinicians to ensure timely exchange of information.

RM 01 (Core) Setting Expectations With Referring Clinicians: Works with frequently referring clinicians to set expectations for information sharing and patient care.	
GUIDANCE	**EVIDENCE**
The practice promotes effective communication and care coordination by establishing ongoing, collaborative relationships with primary care and other clinicians. Relationships between primary care clinicians and specialists support a coordinated, safe, high-quality care experience for patients. The practice shares information that includes, but is not limited to: • How it interacts and communicates with referring clinicians. • How it shares and exchanges information about patient care. The practice has relationships 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 clinical interactions (consultative, referral and treatment, co-management, temporary or long-term principal care).	• **Evidence of implementation** ***OR*** • **RM 02**
RM 02 (1 Credit) Agreements With Referring Clinicians: Has agreements with a subset of primary care or other referring clinicians.	
GUIDANCE	**EVIDENCE**
The practice has jointly agreed upon procedures (referral/care coordination agreements and care compacts) and provides two examples. Agreements or care compacts define the general referral guidelines and exchange of information to expedite timeliness and appropriateness of referrals, gather information about the patient's environment and improve coordination of patient care, as agreed on by the primary care or other referring clinician and the specialty practice. Agreements between specialist and primary care define communication processes for secondary referrals. Agreements may be formal or informal and do not need to be legally binding. The practice determines the number of agreements it needs with referring clinicians but should consider creating agreements with clinicians with whom it commonly works.	• **Agreements**

RM 03 (Core) Communicating Referral Requests: Actively communicates receipt and status of referral requests, including all of the following: A. Receipt and acceptance of the referral. B. Date and time of patient appointments. C. Information the referring clinician can expect in the referral response.	
GUIDANCE	**EVIDENCE**
The practice has a process for managing initial referrals from primary care and other clinicians, and from self-referred patients. There is a workflow for managing the referral activities and identifying staff responsible for sharing information with primary care and other referring clinicians, patients and families or caregivers. The practice: A. Notifies the primary care or referring clinician that it has received and accepted the referral. B. Includes the date and time of the patient's appointment in the notification. C. Specifies when the primary care or referring clinician can expect to receive a referral summary, and the type of information that will be included in the summary. A tracking process establishes effective communication and collaboration, and gives specific details about the appointment, in case follow-up is needed. **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, and have a documented process for managing referrals that describes how communication and coordination of care take place. Processes addressing self-referred patients include coordinating follow-up care with the patient's primary care clinician (RM 09) or connecting patients with a primary care practice if they do not have a primary care clinician (RM 10).	• **Documented process** ***AND*** • **Evidence of implementation**

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RM 04 (Core) Verifies Receipt of Information: Verifies that it has received the necessary information from referring clinicians to determine how to proceed with the referral, and:

A. Tracks receipt of the clinical question to be answered, the referral type and the urgency.

B. Assesses if the clinical question is within the scope of the practice.

C. Tracks receipt of pertinent demographic and clinical data, including test results and the current care plan.

D. Determines the clinician responsible for communicating with the patient/family/caregiver.

GUIDANCE	EVIDENCE
The practice works to ensure that the initial referral contains complete information. The specialist confirms that the referring clinician has provided the necessary information about referred patients and tracks the information it receives. A. The referring clinician provides a concise reason for the referral ("the clinical question") to be answered by the specialist, the referral type (consultation, co-management, transfer) and the urgency of the referral. This information helps the specialist prioritize and schedule patients. B. Specialists use information in the referral to determine whether the care requested is appropriate to their scope of services and expertise. C. Complete background information about the patient informs the specialist about treatment, tests and other care options, and for answering the clinical question. D. The referral states who will be responsible for communicating with the patient/family/caregiver. This may include information about the level of patient/family/caregiver understanding of the reason for referral, diagnosis and possible treatment options. Tracking information enables the specialist to identify missing information and provide an appropriate and complete response to referring clinicians.	• **Documented process** ***AND*** • **Evidence of implementation**

RM 05 (Core) Gathering Information Not Initially Received: Requests and tracks receipt of pertinent demographic and clinical data not initially received from the primary care or referring clinician.

GUIDANCE	EVIDENCE
If pertinent information is missing from the initial referral, the practice has a process for requesting and tracking additional information about referred patients from primary care or referring clinician. The practice requests the necessary patient information from primary care or the referring clinician, including the clinical question to be answered by the specialist, the relevant patient history and test results.	• **Documented process** ***AND*** • **Evidence of implementation**

Competency B: Practice Response to Initial Referrals. The practice facilitates comprehensive care coordination by providing timely, complete and relevant responses to primary care providers and referring clinicians.

RM 06 (Core) Follow-Up After Missed Appointments and Cancellations: Has a process for handling missed appointments and cancellations, including appropriate communication with the referring provider for follow-up with the patient after a missed appointment.	
GUIDANCE	**EVIDENCE**
The practice has a process for contacting patients to reschedule a missed or cancelled initial appointment. The process details how the referring provider is notified of a missed or cancelled initial appointment with the specialist, and the new appointment date, if applicable. The practice notes the reason (e.g., lack of transportation, health issue resolved) for the missed appointment or cancellation, if one is given. Closing the referral loop after a patient misses or cancels an appointment can prevent delays in diagnosis and treatment.	• **Documented process** ***AND*** • **Evidence of implementation *or*** • **Report**
RM 07 (Core) Response to Primary Care and Referring Clinicians: Monitors that the outgoing response to primary care and referring clinicians includes (must meet all): **A. Answers to clinical questions in the referral.** **B. The diagnosis.** **C. Procedures, test results and recent hospitalizations.** **D. The specialist's recommended plan of care, including updates to the medication list.** **E. Follow-up needed.** **F. Timeliness of the referral response.**	
GUIDANCE	**EVIDENCE**
The practice provides complete information to the referring clinician when it sends the referral response. The practice monitors completeness and timeliness in order to identify any opportunities for improvement. A. The practice responds to the clinical question in the referral. B. The response includes the diagnosis determined or confirmed by the specialist. C. The response includes the results of procedures or tests performed as part of patient evaluation and treatment, and any hospitalizations that occurred while the patient was under the specialist's care.	• **Documented process** ***AND*** • **Report**

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RM 07 (Core) Response to Primary Care and Referring Clinicians *continued*	
D. The response shares the plan of care, including medications prescribed by the specialist. The specialist's plan of care may also include care management, patient education and secondary referrals. E. The response details any necessary follow-up with the referring clinician and/or specialist. This may include coordination with the specialist or recommendations for co-management or transition of co-managed patients back to primary care. Actions to be taken by the patient are clearly stated. F. The response to the referring clinician is timely. The practice tracks and monitors the timeliness of the response against its time frame. Complete and accurate information about the patient visit demonstrates the specialist's ability to act as a care partner in the medical neighborhood. Although behavioral healthcare practices may need to obtain a patient release before sharing care information with primary care and the referring clinician, the practice must demonstrate that they have a process for sharing pertinent clinical information with the patient's clinicians.	

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Competency C: Connecting Patients With Primary Care. The practice works with primary care clinicians to share information and connect patients with primary care clinicians if they do not have a usual source of primary care.

RM 08 (Core) Documenting Primary Care Clinician: Identifies and documents the primary care clinician in the medical record.	
GUIDANCE	**EVIDENCE**
The practice has a process for identifying the primary care clinician and documents the following information in patient files: • The primary care clinician's name and contact information. • Whether the patient declined 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.	• **Documented process** ***AND*** • **Evidence of implementation *or*** • **Report**
RM 09 (1 Credit) Communicates the Importance of Follow-Up With Primary Care: Communicates to patients the importance of following up with their primary care clinician.	
GUIDANCE	**EVIDENCE**
The specialist informs patients about the importance of follow-up with their primary care clinician. Reinforcing the importance of primary care helps clarify the roles of the specialist and primary care clinician in patient care. Primary care is central to coordinating patient care across care settings.	• **Documented process** ***AND*** • **Evidence of implementation**
RM 10 (1 Credit) Connecting Patients With Primary Care: Provides information on available primary care clinicians to patients without a primary care clinician.	
GUIDANCE	**EVIDENCE**
The specialist gives information about primary care clinicians to patients without a primary care clinician, and documents patient receipt of the information. The information may be in a brochure, on a printed list or online, and: • Lists available clinicians in patient communities. • Encourages patients to contact their insurance provider to verify coverage before choosing a primary care clinician.	• **Documented process** ***AND*** • **Evidence of implementation**

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RM 11 (Core) Contacting the Primary Care Clinician Prior to Treatment: Determines if the primary care clinician needs to be contacted prior to treatment.	
GUIDANCE	**EVIDENCE**
The practice has a process for determining if the scope of patient care requires consultation with the primary care clinician prior to treatment. This type of coordination can reduce duplicate tests and provide insight into the patient's care needs and history, which can improve the effectiveness and efficiency of the specialist's care.	• **Documented process** ***AND*** • **Evidence of implementation**

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Knowing and Managing Your Patients (KM)

The practice captures and analyzes information about its patients and the community it serves, and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.

Competency A: Collecting Patient Information. The practice routinely collects comprehensive patient data and uses the data to understand patients' backgrounds and health risks.

KM 01 (Core) Patient-Specialist Relationship: Identifies and documents the type of patient-specialist relationship in the medical record, including co-management relationships.	
GUIDANCE	**EVIDENCE**
The practice defines and documents the patient-specialist relationship based on care and services provided to the patient. The practice may use any method or terms to characterize the patient-specialist relationship, including the CMS operational list of physician-patient relationship categories or by indicating the relationship status most closely characterized by one of the following: • Consultation with primary care. • Evaluation and treatment. • Formal co-management. • Transfer of the patient to specialty (specialist as principal manager of care). For information about different types of referrals and patient relationships, refer to *The Patient-Centered Medical Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/ Subspecialty Practices* (American College of Physicians white paper, 2010, pp. 6–7). https://www.acponline.org/advocacy/wherewestand/policy/pcmhneighbors.pdf Defining the relationship the specialist has with their patient clarifies roles the specialist and other members of the care team play in caring for all the patient's medical conditions (e.g., oncology is the principal co-manager, but cardiology will manage the heart failure, endocrinology will manage diabetes).	• **Documented process** ***AND*** • **Evidence of implementation *or*** • **Report**

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KM 02 (Core) Medical History and Problem List Documentation: Documents the medical history of each patient and family in the medical record and keeps an up-to-date problem list for each patient, with current and active diagnoses.	
GUIDANCE	**EVIDENCE**
The practice collects medical history (e.g., history of chronic disease or event [e.g., diabetes, cancer, surgery, hypertension]) for patients and "first-degree" relatives (who share about 50% of their genes with a specific family member) and maintains an up-to-date problem list that includes acute and chronic conditions, behavioral health diagnoses and past diagnoses relevant to the patient's current care. **Up-to-date** means that the most recent diagnoses—ascertained from previous records, transfer of information from other providers, diagnosis by the clinician or by querying the patient—are added to the problem list. If the practice provides a report, it shows a percentage of patients with a problem list that has been updated at least annually.	• **Documented process** ***AND*** • **Evidence of implementation *or*** • **Report**
KM 03 (1 Credit) Predominant Conditions and Concerns: Identifies the predominant conditions and health concerns of the patient population.	
GUIDANCE	**EVIDENCE**
The practice analyzes diagnosis codes or problem lists to identify its patients' most prevalent and important conditions and concerns. Each specialty has a unique population that influences how the practice organizes work and resources. Knowing its population's top concerns helps the practice adopt guidelines, focus decision support and outreach efforts, establish referral relationships with other commonly used specialties and determine what special services to offer (e.g., group sessions, education, counseling) that align with population needs.	• **List of top priority conditions and concerns**

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KM 04 (1 Credit) Specialist Comprehensive Health Assessment: Comprehensive health assessment includes (at least four of the following):

A. Family/social/cultural characteristics.
B. Mental health/substance use history of patient and family.
C. Communication needs.
D. Behaviors affecting health.
E. Pain assessment/functional assessment.
F. Patient preferences and personal health goals.
G. Advance care planning.

GUIDANCE	EVIDENCE
A comprehensive patient assessment includes an examination of the patient's social and behavioral influences, in addition to a physical health assessment. The practice uses evidence-based guidelines to determine how frequently it performs and updates health assessments. Comprehensive, current patient data provides a foundation for supporting population needs. As part of the comprehensive health assessment, the practice: A. **Family/social/cultural characteristics.** Evaluates social and cultural needs, preferences, strengths and limitations (e.g. family/household structure, support systems, patient/family concerns). Considers a variety of characteristics (e.g., education level, marital status, unemployment, social support, assigned responsibilities). B. **Patient and family mental health/substance use history of patient and family.** Collects patient and family behavioral health history (e.g., schizophrenia, stress, alcohol, prescription drug abuse, illegal drug use, maternal depression). C. **Communication needs.** Identifies whether a patient has specific communication requirements due to hearing, vision or cognition issues. *Note: This does not address language; refer to KM 07 for language needs.* D. **Behaviors affecting health.** Assesses risky and unhealthy behaviors that go beyond physical activity, alcohol consumption and smoking status and may include nutrition, oral health, dental care, risky sexual behavior and secondhand smoke exposure.	• **Documented process** ***AND*** • **Evidence of implementation**

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KM 04 (1 Credit) Specialist Comprehensive Health Assessment: *continued*	
GUIDANCE	**EVIDENCE**
E. **Pain assessment/functional assessment.** Assesses and documents patient pain or function. The practice may use a standard pain scale (0–10 scale) or another method to meaningfully assess pain (e.g., use of a simple pain assessment that evaluates the level of pain: no pain, pain present but in control to the patient's satisfaction, pain present and needs to be addressed). Pain assessment may include location, intensity, frequency (constant versus intermittent), quality (e.g., ache, deep, dull, numb, sharp, tingling), causes (e.g., specific movement, changes in weather, activity level), and sources of relief (e.g., pain-free positions, OTC medication). The practice may also assess functional health status using a standardized tool (e.g., Seattle Angina Questionnaire, MD Anderson Symptom Inventory, SF-12®/VR-12® functional health status assessment). F. **Patient Preferences and Personal Health Goals.** Assessing patients' personal health goals and preferences helps a care team plan and provide effective, patient-centered care and address barriers to treatment. Patient preferences are inclinations toward lifestyle, living situation and how care is provided. The patient's personal health goals can relate to their ability to continue hobbies or work, maintain activity levels or participate in other activities that contribute to quality of life. Goals are the foundation of person-centered care planning and address a desired outcome. G. **Advance care planning.** Documents patient/family preferences for advance care planning (i.e., care at the end of life or for patients who are unable to speak for themselves). This may include discussing and documenting a plan of care, with treatment options and preferences. Patients with an advance directive on file meet the requirement.	• **Documented process** ***AND*** • **Evidence of implementation**

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KM 05 (1 Credit) Behavioral Health Screenings: Conducts behavioral health screenings and/or assessments using a standardized tool to ensure accurate diagnosis, treatment and follow-up (implement one or more):

A. Depression.
B. Anxiety.
C. Alcohol use disorder.
D. Substance use disorder.
E. Pediatric behavioral health screening.
F. Post-traumatic stress disorder.
G. Attention deficit/hyperactivity disorder.
H. Postpartum depression
I. Cognitive impairment.
J. Distress.

GUIDANCE	EVIDENCE
Practice staff are trained to use standardized tools when administering behavioral health screenings and assessments. A **standardized tool** collects information using a current, evidence-based approach that was developed, field-tested and endorsed by a national or regional organization. The practice considers the patient population when selecting conditions to screen or assess. If the screen is positive, the practice appropriately refers the patient or diagnoses, treats and follows up. Screening in specialty practices can detect behavioral health disorders that may otherwise go undiagnosed and untreated. **Screening/assessment resources** • SAMHSA-HRSA Center for Integrated Health Solutions: https://www.integration.samhsa.gov/clinical-practice/screening-tools • American College of Obstetricians and Gynecologists: https://www.acog.org/Womens-Health/Depression-and-Postpartum-Depression • American Academy of Pediatrics: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/Primary-Care-Tools.aspx • American Cancer Society: https://www.cancer.org/treatment/treatments-and-side-effects/emotional-side-effects/distress/tools-to-measure-distress.html • Alzheimer's Association: https://www.alz.org/health-care-professionals/cognitive-tests-patient-assessment.asp	• **Documented process** ***AND*** • **Evidence of implementation**

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Competency B: Patient Diversity. The practice uses information about the characteristics of its patient population to provide culturally and linguistically appropriate services.

KM 06 (Core) Diversity: Assesses the diversity (race, ethnicity and one other aspect of diversity) of its population.	
GUIDANCE	**EVIDENCE**
The practice collects information on how patients identify in at least three areas that include: 1. Race. 2. Ethnicity. 3. One other aspect of diversity, which may include, but is not limited to, gender identity, sexual orientation, religion, occupation, geographic residence. Assessing the diversity of its population can help a practice identify subpopulations with specialized needs or that are subject to systemic barriers, leading to disparities in health outcomes. The practice may collect data directly from patients or may use data about the community (e.g., zip code analysis, community level census data) it serves.	• **Report**

KM 07 (Core) Language: Assesses the language needs of its population.	
GUIDANCE	**EVIDENCE**
The practice identifies the prevalent language needs of its population. It may collect data directly from all patients or may obtain it from community-level statistics for the community it serves. If the practice collects data directly, all responses (e.g., patient declined to provide language information, primary language is English, patient does not need language services) must be recorded; a blank field does not mean the patient's preferred language is English. Documenting patients' preferred spoken and written language helps the practice identify the language resources required to serve the population effectively (e.g., materials in prevalent languages, translation services, bilingual staff).	• **Report**

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KM 08 (2 Credits) Staff Cultural Competence and Health Literacy Skills: Educates staff about cultural competence and health literacy, and applies those skills when communicating with patients.	
GUIDANCE	**EVIDENCE**
The practice works to become a health-literate and culturally competent organization by providing staff with the education and resources to communicate effectively with patients and the community (e.g., applies universal precautions, provides health literacy training for staff, redesigns systems to serve patients at different health literacy levels, teaches about cultural health beliefs and practices). Culturally competent organizations educate staff on interacting effectively with patients of different cultures, respecting and responding to their health beliefs and cultural and linguistic needs, and recognizing providers' biases. Health-literate organizations understand that a lack of health literacy leads to poorer health outcomes and compromises patient safety. The practice establishes processes that address health literacy to improve patient outcomes. Giving practice staff the training to understand the diverse cultural and health literacy needs of patients can minimize barriers to effective treatment. Organizations such as the Agency for Healthcare Research and Quality and the Alliance for Health Reform offer health literacy toolkits.	• **Evidence of implementation**

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Competency C: Medication Management. The practice addresses medication safety and adherence by documenting and reconciliating medications, educating patients about new prescriptions and coordinating with primary care and other referring clinicians.

KM 09 (Core) Document and Reconcile Medications: Documents and reconciles prescription and nonprescription medications for more than 80 percent of patients.	
GUIDANCE	**EVIDENCE**
The practice maintains an accurate, dated list of all medications a patient is taking and addresses potential conflicts (e.g. incorrect name, dosage, frequency and drug-drug interactions). The list includes prescription and nonprescription medications (i.e., over-the-counter medications and herbal and vitamin/mineral/dietary [nutritional] supplements). Medication data is not required to be documented in structured or searchable fields, but fields should be used, when available, to encourage standardized and systematic documentation of comprehensive health information. The clinical staff identifies and addresses conflicts or potential discrepancies. If conflicts or discrepancies are outside the scope of the practice and cannot be resolved, the issue is reported to the prescribing provider. The list of medications is reviewed at every patient encounter and reconciled as necessary for care coordination or at least annually. Maintaining an accurate list of a patient's medications reduces the possibility of duplicate medications, medication errors and adverse drug events. Medication reconciliation is an important safety net for patients. Reviewing patient medications identifies medications adherence concerns and signals to providers that additional patient education on the prescription may be needed.	• **Report**

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KM 10 (1 Credit) New Prescription Education: Assesses understanding and provides education, as needed, on new prescriptions for more than 50 percent of patients/families/caregivers.	
GUIDANCE	**EVIDENCE**
The practice uses patient-centered methods, such as open-ended questions (teach-back collaborative method), to assess patient understanding of new medications prescribed by the specialist. Educational materials are designed with regard to patient need (e.g., reading level). Medication is not taken as prescribed 50 percent of the time. (Source: CDC) Barriers to adherence, such as not understanding directions and confusion amongst multiple medication regimens, lead to poorer health outcomes and compromise patient safety.	• **Report** ***AND*** • **Evidence of implementation**
KM 11 (Core) Managing Medication With the Care Team: Coordinates medication management with primary care, the referring clinician and the patient/family/caregiver.	
GUIDANCE	**EVIDENCE**
The practice coordinates the exchange of information with the primary care clinician and other referring clinicians about changes in medications. These clinicians share responsibility for managing medication needs and coordinating medication information throughout the patient's treatment. Expectations about information exchange may be established in the expectations set between providers in RM 01 or in an agreement in RM 02. Providers are not prescribing in isolation, so it is critical to patient safety and care coordination to collaboratively manage the medications the patient is taking with the entire care team. The practice involves the patients/families/ caregivers in the coordination and reconciliation of medication. Practices find greater patient engagement if staff reconcile medications with the patient/family/caregiver and the patient's medication list.	• **Documented process** ***AND*** • **Evidence of implementation**

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KM 12 (1 Credit) Medication Responses and Barriers: Assesses and addresses patient response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment.	
GUIDANCE	**EVIDENCE**
The practice asks patients if they are having difficulty taking a medication, are experiencing side effects and are taking the medication as prescribed. If a patient is not taking a medication as prescribed, the practice determines why. If the patient has not experienced a clinical response, the practice determines why. Patients cannot get the full benefits of their medications if they do not take them as prescribed.	• **Report** ***AND*** • **Evidence of implementation**

KM 13 (1 Credit) Controlled Substance Database Review: Reviews a controlled substance database when prescribing relevant medications.	
GUIDANCE	**EVIDENCE**
The practice consults a state controlled-substance database—also known as a Prescription Drug Monitoring Program (PDMP) or Prescription Monitoring Program (PMP)—before dispensing Schedule II, III, IV and V controlled substances. The practice follows established guidelines or state requirements to determine frequency of review. This can prevent overdoses and misuse, and can support referrals for pain management and substance use disorders. For a list of PDMPs by state: http://www.pdmpassist.org/content/state-pdmp-websites	• **Evidence of implementation** *PCMH KM 18*

KM 14 (2 Credits) Prescription Claims Data: Systematically obtains prescription claims data to assess and address medication adherence.	
GUIDANCE	**EVIDENCE**
The practice systematically obtains prescription claims data or other medication transaction history. This may include systems such as SureScripts e-prescribing network, regional health information exchanges, insurers or prescription benefit management companies. The practice uses prescription claims data to determine whether a patient is adhering to the medication treatment plan.	• **Evidence of implementation** *PCMH KM 19*

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Competency D: Evidence-Based Care. The practice ensures that it provides effective and efficient care by incorporating evidence-based clinical decision support relevant to patient conditions and the population served.

KM 15 (Core) Proactive Reminder: Identifies and proactively reminds patients of one condition-related service.	
GUIDANCE	**EVIDENCE**
The practice uses lists or reports to manage the care needs of specific patient populations. Using collected data on patients and evidence-based guidelines, the practice addresses a variety of health care needs (including missing recommended follow-up visits). The practice implements this process at least annually to proactively identify and remind patients, or their families/caregivers, before they are overdue for services. NCQA encourages practices to identify and coordinate services with primary care or the referring clinician.	• **Report** ***AND*** • **Evidence of implementation** 
KM 16 (1 Credit) Additional Proactive Reminders: Identifies and proactively reminds patients of a second condition-related service.	
GUIDANCE	**EVIDENCE**
The practice expands patient outreach by implementing at least one additional care reminder to patients. Using collected data on patients and evidence-based guidelines, the practice addresses a variety of health care needs (including missing recommended follow-up visits). The practice implements this process at least annually to proactively identify and remind patients, or their families/caregivers, before they are overdue for services. NCQA encourages practices to identify and coordinate services with primary care or the referring clinician.	• **Report** ***AND*** • **Evidence of implementation** 

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KM 17 (Core) Clinical Decision Support: Adopts at least one diagnostic or therapeutic clinical decision support at the point of care relevant to the population served.	
GUIDANCE	**EVIDENCE**
The practice uses systems in day-to-day operations that integrate evidence-based guidelines, protocols or clinical pathways (frequently referred to as clinical decision support [CDS]) addressing common conditions of its patient population. **CDS** is a systematic method of prompting clinicians to consider evidence-based guidelines, protocols or clinical pathways at the point of care. CDS encompasses a variety of tools, including, but not limited to: • Computerized alerts and reminders for providers and patients. • Condition-specific order sets. • Focused patient data reports and summaries. • Documentation templates. • Diagnostic support. • Contextually relevant reference information. Although CDS may relate to clinical quality measures, measures alone do not achieve the broader goals of CDS.	• **Identifies conditions, source of guidelines *and*** • **Evidence of implementation** ***OR*** • **KM 18**

KM 18 (1 Credit) Additional Clinical Decision Supports: Adopts diagnostic or therapeutic clinical decision supports relevant to the population served by: (choose either) **A. Implementing clinical decision supports for at least four topics or conditions.** **B. Implementing clinical decision supports for at least two topics or conditions covering the majority of patients seen at the practice.**	
GUIDANCE	**EVIDENCE**
The practice expands its use of clinical decision supports (CDS) by (choose either): A. Implementing CDS that cover at least four topics addressing common conditions of the patient population. B. Implementing CDS that cover at least two topics that address the care needs of the predominant conditions and health concerns population (may be identified in KM 03). The CDS implemented covers the majority of patients at the practice. This expanded scope is intended to go beyond smaller patient population groups or patients with a specific condition. Although CDS may relate to clinical quality measures, measures alone do not achieve the broader goals of CDS.	• **Identifies conditions, source of guidelines** ***AND*** • **Evidence of implementation**

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KM 19 (1 Credit) Pathways for Symptom Management: Adopts clinical pathways for symptom management that are relevant to the population served.	
GUIDANCE	**EVIDENCE**
The practice has a process for identifying and implementing pathways for symptom management that address common symptoms or medication side effects experienced by its patient population. Using pathways to triage symptoms ensures that they are addressed and managed appropriately to prevent unnecessary ED and hospital utilization. When patients call the practice, the telephone triage team uses standardized symptom management protocols to provide a response based on described symptoms. During business hours, staff are available to answer and triage patient calls appropriately. After business hours, an on-call clinician is available to address patient concerns in a timely manner.	• **Identifies conditions, source of guidelines** ***AND*** • **Evidence of implementation** 
KM 20 (2 Credits) Excellence in Performance: Demonstrates excellence in a benchmarked/ performance-based Recognition program assessed using evidence-based care guidelines.	
GUIDANCE	**EVIDENCE**
At least 75 percent of eligible clinicians have earned NCQA HSRP or DRP Recognition. Alternatively, the practice demonstrates that it participates in a program that uses a standardized set of measures to benchmark participant results, has a process to validate measure integrity and publicly reports results. The practice shows (through reports) that clinical performance is above national or regional averages. Examples of programs may include MN Community Measures, ASCO's QOPI® certification, IHA or other performance-based Recognition program.	• **Report** ***OR*** • **HSRP or DRP Recognition for at least 75% of eligible clinicians**  

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KM 21 (1 Credit) Shared Decision-Making Aids: Adopts shared decision-making aids for preference-sensitive conditions.	
GUIDANCE	**EVIDENCE**
The care team has, and demonstrates use of, at least three shared decision-making aids that provide detailed information without universally advising patients to choose one option over another. The care team collaborates with patients to help them make informed decisions that align with their preferences and values. Helping patients understand their health condition and engaging them in shared decision-making helps build a trusting relationship. **Shared decision-making resources** International Patient Decision Aid Standards Collaboration (IPDASC) http://ipdas.ohri.ca/index.html AHRQ's SHARE Approach https://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html	• **Evidence of implementation** 

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Patient-Centered Access and Continuity (AC)

The medical neighborhood expects continuity of care. Patients/families/caregivers have access to clinical advice and appropriate care facilitated by their designated clinician/care team and supported by access to their medical record. The practice considers the needs and preferences of the patient population when establishing and updating standards for access.

Competency A: Patient Access to the Practice. The practice enhances patient access by providing appointments and clinical advice based on patients' needs.

AC 01 (Core) Access for Urgent Needs: Ensures access and appropriate level of care for urgent patient needs.

GUIDANCE	EVIDENCE
The practice evaluates patient access from collected data (i.e., survey, patient interviews, comment box) to determine if existing access methods are sufficient for its population. The practice has a process for determining patient need and degree of urgency indicated by the referring clinician or the patient. For some practices, meeting the needs of the patient population may include offering same-day appointments. Other methods for access may include evening/weekend hours, types of alternative appointments or telephone advice. Evidence of implementation may include, but is not limited to, a report or schedule showing use of appointment types or access provided through triage. Receiving timely access to specialists can be challenging for patients. By ensuring that the access provided meets the needs of patients, the practice can prevent delays in care and exacerbations of conditions.	• **Documented process** ***AND*** • **Evidence of implementation** *Evidence of implementation Only*

AC 02 (Core) Timely Clinical Advice by Telephone: Provides timely clinical advice by telephone.

GUIDANCE	EVIDENCE
Patients can telephone the practice any time of the day or night and receive interactive (i.e., from a person, rather than a recorded message) clinical advice. **Clinical advice** is response to an inquiry regarding symptoms, health status or an acute/chronic condition. Providing advice outside of appointments helps reduce unnecessary ED visits and other utilization. A recorded message referring patients to 911 when the office is closed is not sufficient. Clinicians return calls in a time frame determined by the practice. Clinical advice must be provided by qualified clinical staff, but may be communicated by any member of the care team, as permitted under state licensing laws. NCQA reviews a report summarizing the practice's expected response times and how it monitors its performance against standards for timely response. The practice must present data on at least 7 days of such calls.	• **Documented process** ***AND*** • **Report** *PCMH AC 04* *Documented process only*

AC 03 (1 Credit) Patient Portal: Has a secure electronic system where patients can (must show at least three): A. Request appointments. B. Request prescription refills. C. View referrals. D. View test results. E. Receive timely clinical advice through two-way communication.	
GUIDANCE	**EVIDENCE**
The practice has a secure, interactive electronic system (e.g., website, patient portal, secure email system) that allows two-way communication between the practice and patients/families/ caregivers and lets patients request appointments, prescription refills, referrals, test results and/or clinical advice. For clinical advice, NCQA reviews a report summarizing the practice's defined response times and how it monitors performance against standards for timely response. The practice must present data on at least 7 days of such inquiries. The report may be system generated.	**Evidence:** • **A–D: Evidence of implementation** • **E: Documented process** ***AND*** • **E: Report**

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Competency B: Communication With the Practice. The practice improves continuity of care by providing systematic access to clinical advice, patient records and consultation to referring clinicians.

AC 04 (Core) Clinical Advice Documentation: Documents clinical advice in patient records and confirms that clinical advice and care provided after-hours do not conflict with the medical record.	
GUIDANCE	**EVIDENCE**
The practice documents all clinical advice in the patient record during office hours and when the office is closed, whether the clinical advice is provided by phone or by secure electronic message. Evidence includes at least two examples of documenting clinical advice (one during office hours, one after normal business hours). If a practice uses a documentation system outside the medical record for after-hours clinical advice, or provides for after-hours care without access to the patient's record, it reconciles this information with the medical record on the next business day. The reconciliation evaluates if clinical advice or care provided after hours conflicts with advice and care previously documented in the medical record, and addresses any identified conflicts.	• **Documented process** ***AND*** • **Evidence of implementation**  *PCMH AC 05* *Documented process only*
AC 05 (2 Credits) Continuity of Medical Record Information: Provides continuity of medical record information for care and advice when the office is closed.	
GUIDANCE	**EVIDENCE**
The practice makes patient clinical information available to on-call staff, external facilities and clinicians outside the practice, as appropriate, when the office is closed. Access to medical records may include direct access to a paper or electronic record or arranging a telephone consultation with a clinician who has access to the medical record.	• **Documented process**  *PCMH AC 12*
AC 06 (1 Credit) Communicate and Consult With Treating Clinicians: Maintains availability for timely communication and nonvisit consultations with other treating clinicians.	
GUIDANCE	**EVIDENCE**
The practice has a process for communicating with treating clinicians (referred or otherwise) for care coordination. Informal consultations are an opportunity for the specialist and the primary care clinician or referring clinician to consult about management of a shared patient. Consultations can also determine if a patient should be seen by a specialist. Providing quick consultations or additional information in a timely manner (not merely an exchange of records) to the patient's care team can prevent unnecessary referrals or ED visits.	• **Documented process** ***AND*** • **Evidence of implementation** 

Plan and Manage Care (PM)

The practice collaborates with the patient's treatment team, including the primary care clinician, referring clinician, patient/family/caregiver and other providers in the medical neighborhood, to provide the necessary care and treatment support.

Competency A: Planning Care and Supporting Treatment Needs. The practice assesses patient risk and considers the needs of its patient population when preparing for appointments, creating treatment plans and counseling on second opinions.

PM 01 (Core) Risk Status Identification: Assesses patient risk status to identify patients who need a higher level of care and support.

GUIDANCE	EVIDENCE
The practice has a process for identifying high-risk patients (e.g., multiple co-morbid conditions, lack of caregiver support, inadequate living conditions, multiple hospitalizations) who may benefit from an enhanced level of care and support. This enhanced support may include care, case or disease management or other resources internal or external to the practice. Practices may use motivational interviewing to assess patient readiness to change and assess self-management abilities through patient questionnaires and self-assessment forms. Assessing self-management abilities enables the practice to adjust plans to fit patient/family/caregiver capabilities and resources. Patients/families/caregivers will have greater success if they feel they can manage the condition, learn needed self-care skills or adhere to treatment goals. The practice may identify patients through a billing or practice management system or electronic medical records; through key staff members; or through profiling performed by a health plan, if profiles represent at least 75 percent of the patient population. **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.)	• **Documented process *and*** • **Evidence of implementation** ***OR*** • **Report** ***OR*** • **PM 02**

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PM 01 (Core) Risk Status Identification *continued*	
GUIDANCE	**EVIDENCE**
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	
PM 02 (2 Credits) Comprehensive Risk-Stratification: Applies a comprehensive risk-stratification process for the entire patient population in order to identify and direct resources appropriately.	
GUIDANCE	**EVIDENCE**
The practice demonstrates that it can identify patients who are at high risk, or likely to be at high risk, and prioritize their care management to prevent poor outcomes. The practice identifies and directs resources appropriately based on need. **Risk-stratification resources** American Academy of Family Physicians' Risk Stratified Care Management Rubric.	• **Report**
PM 03 (Core) Written Treatment Plan: Collaborates with the patient/family/caregiver to develop and update a specialist's treatment plan and provides them access to the treatment plan.	
GUIDANCE	**EVIDENCE**
The practice has a process for involving the patient/family/caregiver in development of the treatment plan, and gives the patient/family/caregiver access to the plan. The **treatment plan** is a written action plan based on assessment data that identifies a patient's clinical needs, the strategy for providing services to meet those needs, the treatment goals and the objectives. The treatment plan specifies the services and responsibilities of the specialist and those of the primary care clinician and other treating providers, to avoid potential overlap or gaps in services and care. The volume of information given during appointments can be overwhelming for patients, but giving them access to their treatment plan helps them recall details and share the plan with others after they have left the office.	• **Evidence of implementation** ***OR*** • **Report**

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PM 04 (Core) Transition to Primary Care: Identifies patients transitioning back to primary care and communicates with the patient/family/caregiver about the care transition.	
GUIDANCE	**EVIDENCE**
The practice has a process for identifying patients who are ready to transition to a primary care clinician for principal care management. This includes all patient/provider relationships, especially those no longer requiring co-managed care. Specialists may determine if the patient is ready to transition back to primary care at the conclusion of treatment, after meeting care goals or upon reaching other milestones.	• **Documented process** ***AND*** • **Evidence of implementation**

PM 05 (1 Credit) Discusses Barriers to Treatment With the Primary Care Clinician: Uses the primary care clinician as a resource to gather information about barriers to treatment or adherence.	
GUIDANCE	**EVIDENCE**
The practice uses the patient's primary care clinician to give the specialist insight into the patient's environment and available services. Primary care clinicians often have a deeper understanding of factors affecting patients' care because they live and work in the same neighborhoods as their patients. The primary care clinician may have solutions for alleviating barriers to care and can be a resource for insights into the best course of treatment, especially for treatments that have equivalent safety and efficacy. For example, if distance or transportation to the specialist's office is a barrier to care, the specialist and the primary care clinician may decide that the primary care clinician should administer medications or lab and imaging tests at the primary care office.	• **Evidence of implementation**

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PM 06 (Core) Communication Plan for Co-Managed Patients: Establishes a plan to communicate with the primary care clinician about routine updates or changes in the status of co-managed patients.	
GUIDANCE	**EVIDENCE**
The practice has a strategy for coordinating co-management with the primary care clinician. This specifies the care responsibilities of the primary care provider and the specialist. The specialist has a plan for providing the primary care clinician interim updates about the patient's care, which could include: • Changes in the patient's status. • Plans for transition to hospice or other care transitions. • Missed appointments, for established patients. • Changes to a course of treatment. • Progress notes on continued care. • Other updates as established by the specialist and primary care clinician in the referral/care agreement or care compact. Establishing a co-management plan ensures that both providers understand their responsibilities.	• **Documented process** ***AND*** • **Evidence of implementation**

PM 07 (1 Credit) Shared Decision-Making Process: Informs patients about treatment options and makes evidence available to them, to ensure collaborative and patient-centric treatment decisions.	
GUIDANCE	**EVIDENCE**
With continued advancements in care, patients often have multiple treatment options. The practice has a process for informing patients about the evidence supporting treatment options, to encourage collaborative and informed decision making. It considers patient preferences and personal health goals when determining the best treatment option for the patient. The practice may provide educational resources that explain available evidence or implementing shared decision-making tools identified in KM 21. Tools and resources consider patient literacy, communication needs and health literacy. The specialist works with patients to help them understand the information and available options.	• **Documented process** ***AND*** • **Evidence of implementation**

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PM 08 (2 Credits) Management of Second Opinions: Counsels patients about obtaining a second opinion, makes and tracks appropriate referrals and discusses follow-up options.	
GUIDANCE	**EVIDENCE**
The practice guides patients through the second opinion process by: • Describing how, and where, patients can find clinicians who treat their condition or injury (e.g., personal recommendation, direct patients to local specialty society). • Sending the patient's medical records to the clinician before the appointment. • Following up with the patient after the consultation. If the patient receives conflicting information about the course of treatment, the clinician helps the patient understand their options and make a decision. Second opinions help patients make more informed decisions about their care. When practices do not initiate the conversation, patients may seek second opinions without notifying the practice, which can result in missed opportunities for follow-up and increase cost for the patient's care.	• **Documented process** ***AND*** • **Evidence of implementation**

PM 09 (1 Credit) Self-Management Support: Provides resources or refers patients/families/ caregivers for assistance with self-management.	
GUIDANCE	**EVIDENCE**
The practice helps patients self-manage conditions under care of the specialist by providing or referring patients to self-management programs or classes (e.g., asthma education, diabetes education) or by providing educational resources such as brochures, handout materials, videos, website links and pamphlets, as well as community resources (e.g., programs, support groups). The practice provides patients with self-management support and tools beyond the counseling or guidance typically provided during an office visit. The practice coordinates with primary care to ensure that the support is not duplicative or conflicting. Patients/families/caregivers (as appropriate for the patient) may be referred to resources outside the practice (e.g., programs offered through community agencies, a health plan, a patient's employer), with consideration that resources may not be covered by health insurance. Giving patients/families/caregivers these tools empowers them to manage their chronic conditions.	• **Documented process** ***AND*** • **Evidence of implementation**

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PM 10 (1 Credit) Preventive Care for Co-Managed Patients: Coordinates with the primary care clinician to ensure that co-managed patients receive timely preventive care.	
GUIDANCE	**EVIDENCE**
The practice works with primary care to ensure that co-managed patients receive needed preventive care. In some cases, a preventive care service may be provided by the specialist and not by the primary care clinician. When a patient has complex medical needs and multiple clinicians, needed preventive care is sometimes missed. The specialty practice coordinates with primary care to ensure that patients receive timely preventive services and do not experience unnecessary or duplicate care.	• **Documented process** ***AND*** • **Evidence of implementation**

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Competency B: Care Management and Support. For patients with complex needs, the practice develops and shares care plans that address barriers and incorporate patient preferences and personal health goals.

PM 11 (Core) Specialist's Care Plan: For patients identified as needing a higher level of care, the practice collaborates with the patient/family/caregiver to develop and update a specialist's care plan that includes patient's goals, potential barriers and self-care ability.	
GUIDANCE	**EVIDENCE**
The practice builds on the care plan established by the primary care clinician or, if there is no care plan, works with patients/families/ caregivers to develop one. The patient 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. The practice has a process for consistent development of care plans for patients identified for care management in PM 01 or PM 02. To ensure that a care plan is meaningful, realistic and actionable, the practice involves the patient in the plan's development, which includes discussions about goals (e.g., patient function/personal health goals, goal feasibility and barriers) and considers patient preferences. The care plan incorporates a problem list, expected outcome/prognosis, treatment goals, medication management and a schedule to review and revise the plan, as needed. The care plan may also address community and/or social services. The practice updates the care plan at relevant visits. A **relevant visit** addresses an aspect of care that could affect progress toward meeting existing goals or require modification of an existing goal. The care plan specifies the services and responsibilities of the specialist and those of the primary care clinician and other treating providers, to avoid potential overlap or gaps in services and care.	• **Documented process *and*** • **Evidence of implementation** ***OR*** • **Report** ***OR*** • **Record Review Workbook *and*** • **Patient examples**

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PM 12 (Core) Written Care Plan: Provides access to a written care plan to the patient/family/caregiver for patients identified for care management.	
GUIDANCE	**EVIDENCE**
The practice provides access to the written care plan to the patient/family/caregiver. The practice may tailor the written care plan to accommodate the patient's health literacy and language preferences (the patient version may use words or formats different from the version used by the practice team). The care plan given to the patient/family/caregiver includes the items in PM 11 (patient goals, barrier to reaching those goals, self-care.) The elements of the care plan and treatment plan may be incorporated into a single document that is printed or made available electronically to the patient.	• **Documented process *and*** • **Evidence of implementation** ***OR*** • **Report** ***OR*** • **Record Review Workbook *and*** • **Patient examples**

PM 13 (1 Credit) Plan for Managing Complex Medications: For patients with complex medication protocols, helps the patient/family/caregiver establish a plan for managing and administering medications at home.	
GUIDANCE	**EVIDENCE**
Patients with complex or comorbid medical conditions often take medications throughout the day and night. The practice works with patients/families/ caregivers at high risk for medication-related problems to establish a plan for administering medications at home. The plan considers the patient's demographic information, other health conditions, goals of therapy, past adherence, caregiver support and other factors. The practice may refer patients to a pharmacist for medication therapy management to address and identify medication-related issues before they adversely affect patient care.	• **Documented process** ***AND*** • **Evidence of implementation**

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PM 14 (1 Credit) Opioid Treatment Agreement: Incorporates opioid treatment agreement for patients prescribed Schedule II opioid prescriptions into the patient medical record.	
GUIDANCE	**EVIDENCE**
For patients on long-term chronic opioid therapy, a treatment agreement is established between the clinician and patient to support safe prescribing of opioids. Patients prescribed a Schedule II opioid require a treatment agreement signed by both parties that at a minimum: • Outlines joint expectations and responsibilities of both clinician and patient. • Includes the patient's pain management plan, to prevent development of an opioid dependency. • Is included in the patient's medical record. Patients with a signed opioid treatment agreement have shown improved guideline adherence and reduced addiction risk. This criterion aligns with Quality Payment Program final policies for CY 2019 (published in November 2018) to address efforts to improve treatment of opioid use disorders. **Opioid Agreement Resources:** • Federation of State Medical Board Chronic Use of Opioid Analgesics Guidelines https://www.fsmb.org/globalassets/advocacy/policies/opioid_guidelines_as_adopted_april-2017_final.pdf. • Washington State Department of Labor & Industries: http://www.lni.wa.gov/ClaimsIns/Files/OMD/agreement.pdf • Hegmann KT, et al., eds. "Opioids Guideline." Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers. Reed Group, 2017 http://www.acoem.org/uploadedFiles/Public_Affairs/Policies_And_Position_Statements/Guidelines/Library_and_Reference_Material/OPIOID%20TREATMENT%20-%20Reed%20Group%20Guidelines.pdf • Rhode Island Department of Health: http://health.ri.gov/publications/bytopic.php?parm=Addiction%20and%20Overdose#Healthcare%20Providers	• **Evidence of implementation**

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Competency C: Coordinating Patient-Centered Support During Treatment. The practice ensures appropriate support for patients by working with specialists, consultants, community partners and other members of the treatment team.

PM 15 (1 Credit) The Patient's Treatment Team: Establishes relationships and communication processes with providers outside the practice on the patient's treatment team.	
GUIDANCE	**EVIDENCE**
In addition to communicating information to the initial referring clinician and the primary care clinician, the practice establishes relationships with specialists and other providers caring for the patient throughout the patient's treatment, to ensure optimal care coordination. The patient's treatment team extends beyond the specialist's office to medical or surgical specialists (e.g., surgical subspecialties, palliative care, behavioral health), rehabilitation facilities, home health care and other supportive services involved in the patient's ongoing care.	• **Evidence of implementation** 

PM 16 (1 Credit) Connects to Services in the Community: Arranges or facilitates connection with relevant ancillary and community services.	
GUIDANCE	**EVIDENCE**
The practice uses information about its patient population to identify pertinent resources and community partners, and takes an active role in arranging or facilitating connections with resources. Examples include, but are not limited to, connections with: • Support groups. • Transportation to medical appointments. • Smoking cessation. • Weight management. • Exercise/physical activity. • Nutrition. • Falls prevention. • Meal support. • Hospice. • Palliative care. • Respite care. • Child care. Practices may establish a specific role (e.g., lay navigator) to fulfill this community care coordination function, or may include it among the responsibilities of a care team member.	• **Evidence of implementation**

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PM 17 (2 Credits) Connects to Financial Resources: Engages with patients regarding cost implications of treatment options, provides information about current coverage and makes connections to financial resources as needed.	
GUIDANCE	**EVIDENCE**
Cost and coverage can play a major role in a patient's drug and treatment adherence. Going without necessary medical care can result in severe consequences, particularly in patients with chronic diseases. Staff are educated in engaging patients/families/caregivers in discussion about financial need. The practice: • Discusses cost of recommended treatment options with patients and tells patients which services are critical and should not be skipped. If appropriate, the practice recommends less-expensive options. • Assesses current patient financial resources (e.g., adds a financial question to the clinical intake screening [do you have trouble affording the care or prescriptions prescribed? Y/N], the clinician asks about prescription drug coverage. • Provides information about potential sources of coverage to uninsured patients (e.g., connects patients with state Medicaid, CHIP [Children's Health Insurance Program], healthcare.gov or other patient insurance assistance programs). • Maintains an updated list of available financial assistance resources and connects patients to appropriate services. (e.g., directs patients to resources such as copay, deductible and prescription assistance programs).	• **Documented process** **AND** • **Evidence of implementation** *Evidence of implementation only*

PM 18 (2 Credits) Obtaining Financial Assistance: Helps patients complete documents required to obtain financial assistance.	
GUIDANCE	**EVIDENCE**
The practice provides financial counseling to patients through information about financial assistance options, and helps patients complete required paperwork or applications. The practice has a process for financial counseling that specifies how it identifies patients who may need counseling, the timing for provision of financial assistance options/resources and how the assistance is provided from designated staff. Staff (e.g., a financial counselor) discovers the level of patient's financial need, and helps patients apply for financial assistance resources, such as copay or deductible assistance, noncommercial health insurance options, obtaining prescription medications and applying to compassionate care programs or other foundations.	• **Documented process** ***AND*** • **Evidence of implementation** *Evidence of implementation only*

Care Coordination and Care Transitions (CC)

The practice systematically tracks tests, secondary referrals and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with primary care and other providers in the medical neighborhood.

Competency A: Secondary Referral Tracking and Follow-Up. The practice tracks and coordinates referrals to secondary specialists.

CC 01 (Core) Informing When Referring: Informs the primary care clinician and referring clinician about referrals to secondary specialists.	
GUIDANCE	**EVIDENCE**
When making a referral, the specialist informs the primary care clinician and the referring clinician about all secondary referrals. 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. When the referring clinician and specialist establish expectations in the agreement, they may jointly agree to communicate less or more frequently than at every secondary referral.	• **Documented process** ***AND*** • **Evidence of implementation**
CC 02 (1 Credit) Consultation When Referring: Discusses unanticipated referrals to secondary specialists with the primary care clinician, referring clinician and patient/family/caregiver.	
GUIDANCE	**EVIDENCE**
The practice consults the primary care clinician, referring clinician, patients/families/caregivers when the specialist makes a secondary referral that was unanticipated based on the information provided in the initial referral request. Discussing a referral with the primary care clinician, patient/family/caregiver and other referring clinicians before making the referral can help identify additional information that is useful for the secondary specialist to treat the patient. This communication can reduce duplicate tests, provide additional information about the patient's medical status and enhance collaboration.	• **Documented process** ***AND*** • **Evidence of implementation**

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CC 03 (Core) Secondary Referral Management: Systematically manages secondary referrals by:

A. Giving the consultant or specialist the reason for the referral, the required timing and the type of referral.

B. Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan.

C. Tracking referrals until the consultant or specialist report is available, flagging and following up on overdue reports.

GUIDANCE	EVIDENCE
It is important that the practice track secondary patient referrals and communicate patient information to specialists. Tracking and following up on referrals is a way to support patients who obtain services outside the practice. Poor referral communication and lack of follow-up (e.g., to see if a patient kept an appointment with a specialist, to learn about recommendations or test results) can lead to uncoordinated and fragmented care, which is unsafe for the patient and can cause duplication of care and services, as well as frustration for providers. A. The referring clinician provides a reason for the referral, which may be stated as the clinical question to be answered by the specialist. The referring clinician indicates the type of referral, which may be a consultation or single visit; a request for shared- or co-management of the patient for an indefinite or a limited time, such as for treatment of a specific condition, or a request for temporary or long-term principal care (a transfer). The referring clinician clarifies the urgency of the referral and specifies the reasons for an urgent appointment. B. Referrals include relevant clinical information such as: • Current medications. • Diagnoses, such as mental health, allergies, medical and family history, substance abuse and behaviors affecting health. • Clinical findings and current treatment. • Follow-up communication or information. Including the referring clinician's care and treatment plan in the referral, in addition to test results and procedures, can reduce conflicts and duplicate services, tests and treatment. If the practice sends the specialty care plan with the referral, the secondary specialist can develop a corresponding plan of care. Ideally, the specialty care plan, developed in collaboration with the patient/family/caregiver, is coordinated with other plans of care, created in collaboration with the patient/family/caregiver and primary care.	• **Documented process** ***AND*** • **Evidence of implementation**  *PCMH CC 04* *Documented process only*

CC 03 (Core) Referral Management *continued*	
GUIDANCE	**EVIDENCE**
C. A tracking report includes the date when a referral was initiated and the timing indicated for receiving the report. If the secondary specialist does not send a report, the practice contacts the secondary specialist's office and documents its effort to retrieve the report in a log or an electronic system.	• **Documented process** ***AND*** • **Evidence of implementation**  *PCMH CC 04* *Documented process only*
CC 04 (1 Credit) Notification of Secondary Referral Results: Ensures that the primary care clinician and the original referring clinician are notified of secondary referral results.	
GUIDANCE	**EVIDENCE**
The practice has a process for notifying the primary care clinician or the referring clinician, as appropriate, of results from secondary referrals. The practice has a documented process for obtaining permission to share potentially sensitive test results (e.g., results of a mental health evaluation, depression screening, HIV-AIDS lab test) with primary care. Patient refusal is documented in the medical record. Without a process for notification, other referring clinicians or the primary care clinician may not receive results from secondary referrals.	• **Documented process** ***AND*** • **Evidence of implementation**

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Competency B: Diagnostic Test Tracking and Follow-Up. The practice tracks and manages diagnostic tests and shares the results with patients.

CC 05 (Core) Diagnostic Test Management: The practice systematically manages diagnostic tests, including lab and imaging, by:

A. Tracking diagnostic tests until results are available, flagging and following up on overdue results.

B. Flagging abnormal diagnostic results, bringing them to the attention of the clinician.

C. Notifying patients/families/caregivers about normal and abnormal diagnostic test results.

GUIDANCE	EVIDENCE
The practice demonstrates how it manages patient tests and test results (report, log, examples or electronic tracking system). If frequent lab tests are ordered for a patient, the practice provides the patient/family/caregiver (as appropriate) with all initial results, clear expectations for follow-up and a plan for handling abnormal findings. Ineffective management of diagnostic test results can result in less than optimal care and excess costs, and may compromise patient safety. Systematic monitoring helps ensure that needed tests are performed and that results are acted on, when necessary. A. The practice tracks diagnostic tests from when they are ordered until results are available, and flags tests whose results have not been made available. The flag may be an icon that automatically appears in the electronic system or a manual tracking system with a timely surveillance process. The practice follows up with the lab or diagnostic center (and the patient, if necessary) to determine why results are overdue, and documents follow-up efforts until reports are received. B. The practice flags abnormal test results and brings them to the attention of the clinician, to ensure timely follow-up with the patient/family/caregiver. C, D. The practice provides timely notification to patients about test results (normal and abnormal). Filing results in the medical record for discussion during a scheduled office visit does not meet the requirement.	• **Documented process** ***AND*** • **Evidence of implementation** *PCMH CC 01* *Documented process only*

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CC 06 (2 Credits) Lab and Imaging Appropriateness: Uses clinical protocols to determine when diagnostic tests are necessary.	
GUIDANCE	**EVIDENCE**
The practice establishes clinical protocols, based on evidence-based guidelines, to determine when imaging and lab tests are necessary. The practice may implement clinical decision supports to ensure that protocols are used (e.g., embedded in an order entry system). Inappropriate use of imaging or lab tests leads to unnecessary costs and risks and does not enhance patient outcomes.	• **Evidence of implementation** 

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Competency C: Coordinating Care With Health Care Facilities. The practice shares patient treatment information of patients under active management and facilitates their safe care transition between care facilities.

CC 07 (1 Credit) Identifying Unplanned Hospital and ED Visits: Systematically identifies patients with unplanned hospital admissions and emergency department visits.	
GUIDANCE	**EVIDENCE**
The practice has a process for monitoring unplanned admissions and ED visits, including their frequency. The practice works with local hospitals, EDs and health plans to proactively identify patients with recent unplanned visits, provides a report with the proportion of local admissions and demonstrates how it systematically receives notifications from facilities with which the practice has established mechanisms for exchange. Receiving timely notification of patients with unplanned hospital admissions and ED visits allows practices to provide support and coordinate with the hospital or ED. Relying on notification of discharge alone would not meet the intent.	• **Documented process** ***AND*** • **Report**  *PCMH CC 14* *Documented process only*
CC 08 (Core) Sharing Clinical Information: Shares clinical information with admitting hospitals and emergency departments.	
GUIDANCE	**EVIDENCE**
The practice demonstrates timely sharing of information with admitting hospitals and EDs for conditions related to the practice specialty. The practice provides three examples as evidence of implementation Shared information supports continuity in patient care across settings.	• **Documented process** ***AND*** • **Evidence of implementation**  *PCMH CC 15* *Documented process only*
CC 09 (Core) Post-Hospital/ED Visit Follow-Up: Contacts patients/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit.	
GUIDANCE	**EVIDENCE**
The practice contacts patients to evaluate their status after discharge from an ED or hospital, and to make a follow-up appointment, if appropriate, for admissions related to the practice's specialty. The practice's policies define the appropriate contact period. Contact includes offering care to prevent worsening of a condition, clarifying discharge instructions and encouraging follow-up care, which may include, but is not limited to, physician counseling, referrals to community resources and disease or case management or self-management support programs. The practice keeps a log documenting follow-up.	• **Documented process** ***AND*** • **Evidence of implementation**  *PCMH CC 16* *Documented process only*

CC 10 (2 Credits) After Hours Acute Care Coordination: Systematically coordinates with acute care settings after office hours through access to current patient information.	
GUIDANCE	**EVIDENCE**
The practice has a process for coordinating with acute care facilities when a patient is seen after the office is closed. Sharing patient information allows the facility to coordinate patients' care based on their current health needs and to engage with practice staff.	• **Documented Process** ***AND*** • **Evidence of implementation**  *Evidence of implementation only*  *PCMH CC 17* *Documented process only*
CC 11 (1 Credit) Information Exchange During Hospitalization: Exchanges patient information with the hospital during a patient's hospitalization.	
GUIDANCE	**EVIDENCE**
The practice demonstrates that it can send and receive patient information during the patient's hospitalization. ***Note:*** *CC 08 assesses the practice's ability to share information, but the focus of CC 11 is two-way exchange of information.*	• **Documented process** ***AND*** • **Evidence of implementation**  *PCMH CC 18* *Documented process only*
CC 12 (1 Credit) Patient Discharge Summaries: Consistently obtains patient discharge summaries from hospitals and other facilities for admissions related to the practice specialty.	
GUIDANCE	**EVIDENCE**
The practice has a process for obtaining patient discharge summaries for patients following discharge from a hospital or other care facility. The practice shows that it obtains discharge summaries directly or demonstrates participation in a local admission, discharge, transfer (ADT) system. Actively gathering information about patient admissions, discharges or transfers from the hospital and other care facilities improves care coordination, safe handoffs and reduces readmissions.	• **Documented process** ***AND*** • **Evidence of implementation**  *PCMH CC 19* *Documented process only*

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CC 13 (*Maximum* 3 Credits) External Electronic Exchange of Information: Demonstrates electronic exchange of information with external entities, agencies and registries (may select one or more): A. Regional health information organization or other health information exchange source that enhances the practice's ability to manage complex patients. (1 Credit) B. Immunization registries or immunization information systems. (1 Credit) C. Summary of care record to another provider or care facility for care transitions. (1 Credit)	
GUIDANCE	**EVIDENCE**
The practice utilizes an electronic system to exchange patient health record data and other clinical information with external organizations. Exchange of data across organizations supports enhanced coordination of patient care. Practices can demonstrate the electronic exchange by: A. Exchanging patient medical record information to facilitate care management of patients with complex conditions or care needs. B. Share and access electronic data to immunization registries to share immunization services provided to patients. C. Making the summary of care record accessible to another provider or care facility for care transitions. Practices may provide the required evidence for each criterion, for up to three credits. Each is part of CC 13, but is listed separately in Q-PASS for scoring purposes.	• **Evidence of implementation**  *PCMH CC 21*

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Performance Measurement and Quality Improvement (QI)

The practice establishes a culture of data-driven performance improvement on clinical quality, efficiency and patient experience, and engages staff and patients/families/caregivers in quality improvement activities.

Competency A: Measuring Performance. The practice uses measurement data to evaluates its performance and to identify opportunities for improvement.

QI 01 (Core) Measure Performance: The practice monitors (must meet all):

A. At least two clinical measures related to the practice specialty.

B. At least one measure related to care coordination.

C. At least one measure affecting health care costs.

D. Data on availability of major appointment types to meet patient needs and preferences for access.

E. Quantitative patient experience data.

- **Conducts a survey (using any instrument) to evaluate patient/family/caregiver experience across at least three dimensions, such as:**
  - **Access.**
  - **Communication.**
  - **Coordination.**
  - **Person-centered care, self-management support and comprehensiveness.**

F. Qualitative patient experience data.

- **Obtains patient/family/caregiver feedback through qualitative means.**

GUIDANCE	EVIDENCE
Measuring and reporting clinical quality measures helps practices deliver safe, effective, patient-centered and timely care. A. The practice reports at least two clinical measures that apply to the specialty. The practice may meet this requirement through participation in other specialty-specific performance measure and quality improvement programs. B. The practice reports at least one measure related to care coordination (e.g., requesting patient results from primary care, providing timely referral responses). C. The practice reports at least one measure related to health-care costs. When pursuing high-quality, cost-effective outcomes, the practice has a responsibility to consider how it uses resources. D. Patients who cannot get a timely appointment with a specialist may seek out-of-network care, facing potentially higher costs and treatment from a provider who does not know their medical history. The practice consistently reviews the availability of major appointment types (e.g., urgent care, new patient, specialty exams, follow-up) to ensure that it meets the needs and preferences of its patients, and adjusts appointment availability, if necessary (e.g., seasonal changes, shifts in patient needs, practice resources).	• **Report** ***AND*** • **For B and C: Indicate Measure Category** ***AND*** • **For D only: Documented process**  *Report only*

QI 01 (Core) Measure *continued*	
GUIDANCE	**EVIDENCE**
E. The practice (directly or through a survey vendor) conducts a patient survey to assess the patient/family/caregiver experience with the practice. The patient survey may be conducted as a written questionnaire (paper or electronic) or by telephone, and includes questions related to at least three of the following categories: • Access (may include routine, urgent and after-hours care). • Communication with the practice, clinicians and staff (may include "feeling respected and listened to" and "able to get answers to questions"). • Coordination of care (may include being informed and up to date on referrals to specialists, changes in medications and diagnostic results). • Person-centered care/self-management support (may include provision of comprehensive care and self-management support; emphasizing the spectrum of care needs, such as mental health, urgent care, advice, assistance and support for changing health habits and making health care decisions). F. Qualitative methods (e.g., focus groups, individual interviews, patient walkthrough, suggestion box) are another opportunity, distinct from surveys, to obtain feedback from patients. The practice may use a feedback methodology conducive to its patient population, such as "virtual" (e.g., telephone, videoconference) participation. The requirement is not met by: • Comments that were collected on surveys to satisfy QI01, component E, and/or • Feedback collected by a Patient and Family Advisory Committees (PFAC) that represent more than one practice and/or do not depict the entire patient population. **Measure resources** • MIPS Quality Measures https://qpp.cms.gov/mips/quality-measures • AHRQ's National Quality Measures Clearinghouse https://www.qualitymeasures.ahrq.gov/ • National Quality Forum's Quality Positioning System http://www.qualityforum.org/QPS/QPSTool.aspx	

QI 02 (1 Credit) Validated Patient Experience Survey Use: Uses a standardized, validated patient-experience survey tool with available benchmarking data.	
GUIDANCE	**EVIDENCE**
The practice uses a standardized survey tool to collect patient experience data and inform its quality improvement activities. The intent is for the practice to administer a survey that can be benchmarked externally and compared across practices. The practice may use standardized tools, such as the Consumer Assessment of Healthcare Providers and Systems Clinician & Groups Survey (CG-CAHPS), or another standardized survey administered through measurement initiatives providing benchmark analysis external to the practice organization. The survey may not be a proprietary instrument. The practice must administer the entire approved standardized survey (not sections of the survey) to receive credit.	• **Report** 

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Competency B: Set Goals and Improve Performance. The practice sets goals, prioritizes and implements improvement strategies then reevaluates its performance against those goals or benchmarks.

QI 03 (Core) Goals and Actions to Improve: Sets goals and acts to improve: (must include A and two other measure categories) **A. Two clinical quality measures.** **B. A measure related to care coordination.** **C. A measure affecting health care costs.** **D. A measure of appointment availability.** **E. A measure of patient experience.**	
GUIDANCE	**EVIDENCE**
The practice has an ongoing quality improvement strategy and process that includes regular review of performance data and evaluation of performance against goals or benchmarks. Measures selected for improvement are chosen from the same set of measures identified in QI 01. The goal is for the practice to reach a desired level of achievement based on its self-identified standard of care. 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. The Institute for Healthcare Improvement is a resource for the PDSA cycle (http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/). Review and evaluation offer an opportunity to identify and prioritize areas for improvement, analyze potential barriers to meeting goals and plan methods for addressing the barriers. The practice may use the NCQA PCSP Quality Measurement and Improvement Worksheet or demonstrate its own report. Regardless of evidence used, the practice is encouraged to review the instructions included in the worksheet for guidance.	• **Report** ***OR*** • **Quality Improvement Worksheet**
QI 04 (2 Credits) Improved Performance: Achieves improved performance on at least two performance measures.	
GUIDANCE	**EVIDENCE**
The practice demonstrates that it has improved from baseline performance on at least two measures from QI 03. The practice may use the NCQA Quality Measurement and Improvement Worksheet or demonstrate its own report. Regardless of evidence used, the practice is encouraged to review the instructions included in the worksheet for guidance.	• **Report** ***OR*** • **Quality Improvement Worksheet**

Competency C: Assess and Set Goals to Reduce Disparities. The practice seeks to reduce disparities in care for its vulnerable patients by measuring, monitoring and acting to improve on stated goals.

QI 05 *(Maximum 2 Credits)* Health Disparities Assessment: Assesses health disparities using performance data stratified for vulnerable populations: **A. Clinical quality (1 Credit).** **B. Patient experience (1 Credit).**	
GUIDANCE	**EVIDENCE**
The practice stratifies quantitative performance data by race and ethnicity or by other indicators of vulnerable groups that reflect the practice's population demographics (e.g., age, gender, language needs, education, income, type of insurance [Medicare, Medicaid, commercial], disability, health status). The intent is for practices to work toward eliminating disparities in health and delivery of health care for their vulnerable patient populations. **Vulnerable populations** 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). The practice may provide the required evidence for both criterion options, up to two credits. Both are part of QI 05, but each is listed separately in Q-PASS for scoring purposes. The practice may use the NCQA Quality Measurement and Improvement Worksheet or demonstrate its own report. Regardless of evidence used, the practice is encouraged to review the instructions included in the worksheet for guidance.	• **Report** ***OR*** • **Quality Improvement Worksheet**
QI 06 (2 Credits) Vulnerable Patient Feedback: Obtains feedback from vulnerable patient groups on the experiences of disparities in care or services.	
GUIDANCE	**EVIDENCE**
The practice identifies a vulnerable population where data (clinical, resource stewardship, quantitative patient experience, access) show evidence of disparities in care or services. The practice obtains qualitative patient feedback from population representatives to acquire better understanding of disparities and to support quality improvement initiatives to close gaps in care.	• **Report**

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QI 07 (2 Credits) Goals and Actions to Improve Disparities in Care/Service: Sets goals and acts to improve performance on at least one measure of disparities in care or services.	
GUIDANCE	**EVIDENCE**
After assessing performance in care or services among vulnerable populations (QI 05), the practice identifies disparities, sets goals and acts to improve performance. The practice may use the NCQA PCSP Quality Measurement and Improvement Worksheet or demonstrate its own report. Regardless of evidence used, the practice is encouraged to review the instructions included in the worksheet for guidance.	• **Report** ***OR*** • **Quality Improvement Worksheet**
QI 08 (2 Credits) Improved Performance for Disparities in Care/Service: Achieves improved performance on at least one measure of disparities in care or services.	
GUIDANCE	**EVIDENCE**
The practice demonstrates that it has improved from its baseline performance on at least one measure related to disparities in care or services. The practice may use the NCQA PCSP Quality Measurement and Improvement Worksheet or demonstrate its own report. Regardless of evidence used, the practice is encouraged to review the instructions included in the worksheet for guidance.	• **Report** ***OR*** • **Quality Improvement Worksheet**

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Competency D: Report Performance. The practice shares performance data with staff, and may also share data with patients or publicly, for the measures and patient populations identified in Competency A.

QI 09 (Core) Reporting Performance in the Practice: Shares clinician-level or practice-level performance results with clinicians and staff for measures it reports.	
GUIDANCE	**EVIDENCE**
The practice provides individual clinician or practice-level reports to clinicians and practice staff that include a minimum of: • One clinical quality measure • One resource stewardship measure • One patient experience measure Performance results reflect care provided to all patients in the practice (relevant to the measure), not only to patients covered by a specific payer. The practice may use data that it produces or that are provided by affiliated organizations (e.g., a larger medical group, individual practice association, health plan).	• **Documented process** ***AND*** • **Evidence of implementation**  *PCMH QI 15* *Documented process only*
QI 10 (1 Credit) Reporting Performance Publicly or With Patients: Shares clinician-level or practice-level performance results publicly or with patients for measures it reports.	
GUIDANCE	**EVIDENCE**
The practice shares individual clinician or practice-level reports with patients and the public that include a minimum of: • One clinical quality measure • One resource stewardship measure • One patient experience measure Reports reflect care provided by the care team. Performance results reflect care provided to all patients in the practice (relevant to the measure), not only to patients covered by a specific payer. The practice may use data that it produces or that are provided by affiliated organizations (e.g., a larger medical group, individual practice association, health plan).	• **Documented process** ***AND*** • **Evidence of implementation**  *PCMH QI 16* *Documented process only*

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QI 11 (2 Credits) Patient/Family/Caregiver Involvement in Quality Improvement: Involves the patient/family/caregiver in quality improvement activities.	
GUIDANCE	**EVIDENCE**
The practice has a process for involving patients/ families/caregivers in its quality improvement efforts or on the practice's Patient and Family Advisory Council (PFAC). At a minimum, the process specifies how patients and families are selected, their role on the quality improvement team and the frequency of team/PFAC meetings. Ongoing inclusion of patients/families/caregivers in quality improvement activities adds the patient voice to patient-centered care.	• **Documented process** ***AND*** • **Evidence of implementation**
QI 12 (1 Credit) Electronic Submission of Measures: Electronically reports clinical quality measures to an external entity such as Medicare, a Medicaid agency or a health plan.	
GUIDANCE	**EVIDENCE**
The practice electronically produces and transmits clinical quality measures related to practice specialties to an external entity such as Medicare, a state Medicaid agency or a health plan. The external entity's requirement determines the number of measures submitted. Data submitted are not based on claims and include the entire relevant patient population, not a sample.	• **Evidence of implementation**
QI 13 (*Maximum* 2 Credits) Value-Based Payment Arrangements: Is engaged in value-based payment arrangements. **A. Engages in upside risk (1 Credit).** **B. Engages in two-sided risk (2 Credits).**	
GUIDANCE	**EVIDENCE**
The practice participates in a value-based contracting program and provides information about its participation or a copy of the executed agreement. Value-based contracts represent a shift from fee-for-service billing to compensating practices and providers for administering quality care to patients. Participation in these programs signals that a practice is willing to be accountable for the value of care it provides, rather than volume of care. A. **Upside risk:** The clinician/practice receives incentives for meeting performance expectations, but does not share losses if costs exceed targets. B. **Two-sided risk:** The clinician/practice receives incentives for meeting performance expectations regarding quality and cost, but incurs penalties if it does not.	• **Agreement** ***OR*** • **Evidence of implementation**  *PCMH QI 19*