Crosswalk of Rhode Island PCMH Cost Management Strategies to

NCQA PCMH Standards and

Transforming Clinical Practice Initiative Phase Milestones

January 15, 2016

The following standards must be met by primary care practices seeking PCMH designation from Rhode Island payers in order to qualify for medical home financial support, consistent with terms of the OHIC-approved 2016 Care Transformation Plan.

Practices that have received NCQA PCMH Level 3 designation will be deemed to have met all requirements listed below that are substantially the same as one or more NCQA PCMH requirements.

**Requirement #1: The practice develops and maintains a high-risk patient registry:**

| **The practice must perform all of the following functions:** |  |  |  | **Must be implemented or deemed met by the end of:** |
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| **Cost Management Requirement** | **NCQA Requirement** | **OHIC Deeming Recommendation** | **PCMH-Kids Common Contract Language** | **Yr 1** | **Yr 2** | **Yr 3** |
| 1. The practice has developed and implemented a methodology for identifying patients at high risk for future avoidable use of high cost services (referred to as “high-risk patients).
 | 2011 NCQA PCMH 3, Element B requires the practice to have specific criteria and a process based on these criteria to identify patients with complex or high-risk medical conditions for whole-person care planning and management. Criteria may include high level of resource use, frequent visits for urgent or emergent care, frequent hospitalizations, multiple co-morbidities, psychosocial status, advanced age with frailty and multiple risk factors.2014 NCQA PCMH 4, Element A requires practices to establish a systematic process for identifying patients who may benefit from care management services. Factors to consider include behavioral health conditions, high cost/high utilization and poorly controlled or complex conditions | NCQA: Allow deemingTCPI: allow deeming if Milestone 4D is achieved | Attachment C requires NCQA Level 2 by end of Contract Year 1 and Level 3 by end of Contract Year 2. Attachment C: “Practice shall meet the care coordination reporting requirements as agreed upon by the payers and providers. Care coordination reporting requirements will be determined by March 31, 2016.” Attachment J: “PCMH-Kids will define methods for identifying high-risk patients” | x |  |  |
| 1. Using information from a variety of sources, including payers and practice clinicians, the practice updates the list of high-risk patients at least quarterly.
 | 2011 NCQA PCMH 3, Element B lists in the explanation a variety of possible sources for identifying patients.2014 NCQA PCMH 4, Element A requires a systematic process and in the explanation lists a variety of possible sources for identifying patients. | Allow partial NCQA and partial TCPI deeming. Separately verify that practices are using payers and practice clinicians to update high-risk patient lists and that the time period for updating the high-risk patient list is being met. | See above #1. Attachment C: “Practice will continue to report quarterly on care coordination activities as agreed upon by the payers and providers.”Attachment D: “High risk panel reports shall be reported (by the health plan to the practice regarding eligible Subscribers) quarterly”Hannah notes: no specific requirement of the practice to update high risk list quarterly. Could possibly build into care coordination reporting requirements.  | x |  |  |
| 1. To identify high-risk patients, the practice has developed a risk assessment methodology that includes at a minimum the consideration of the following factors:
	1. assessment of patients based on co-morbidities;
	2. inpatient utilization
	3. emergency department utilization
 | 2011 NCQA PCMH 3, Element B in the explanation lists factors a practice must consider, including co-morbidities, high level of resources, and frequent hospitalizations.2014 NCQA PCMH 4, Element A details factors a practice must consider in determining the patient’s risk status, including specific types of co-morbidities such as behavioral health conditions, and social determinants of health. ‘Poorly controlled or complex conditions’ is also listed as a factor. The factors also include consideration of high cost/high utilization. ED and IP utilization is specifically mentioned in the explanation section.  | NCQA: Allow deemingTCPI: Do not allow deeming, because the requirement is too broadly stated. | See above #1. Attachment C: “Care coordination shall focus in part on high risk patients who are judged to have likelihood of near term use of high intensity services.”Hannah notes: No specific requirement yet. Could possibly build into care coordination reporting requirements. Also NCQA deeming allowed.  | x |  |  |

**Requirement #2: The practice offers Care Management/Care Coordination Services with a focus on high-risk patients enrolled with the carriers that are funding the care management/care coordination services. Care Management/Care Coordination services include services provided by practice staff other than the designated care manager or care coordinator when services provided promote care management and care coordination and are provided under the direct supervision of the Care Manager or Care Coordinator.**

| **The practice must perform all of the following functions:** | **Must be implemented or deemed met by the end of:** |
| --- | --- |
| **Cost Management Requirement** | **NCQA Requirement** | **Deeming Recommendation** | **PCMH-Kids Common Contract Language** | **Yr 1** | **Yr 2** | **Yr 3** |
| 1. The practice has a designated resource(s) that at the minimum includes a trained licensed Registered Nurse or trained licensed RN or social worker care coordinator for pediatric practices to provide care management/care coordination services that focuses on providing services to high-risk patients.
 | 2011 NCQA PCMH 3 requires practices to systematically identify patients and to manage and coordinate care based on their condition, needs and on evidence-based guidelines.2014 NCQA PCMH 4 requires practices to systematically identify patients and to manage and coordinate care based on their needs. | NCQA: Allow partial deeming. Separately verify that the practices are employing an RN/LPN or social worker as CM/CC.TCPI: N/A | Attachment J: “Practice may hire or designate staff for care coordination including, but not limited to a nurse care manager, behavioral health prover, parent consultant, or peer navigator.” Hannah notes: we explicitly allow care coordination to be filled by other level of staff, NOT required to be RN or SW.  | x |  |  |
| 1. The practice has an established methodology for the timely assignment of levels of care management/care coordination service needed by high-risk patients based on risk level, clinical information including disease severity level and other patient-specific characteristics. The purpose of the assessment is to promptly identify which high-risk patients should be in the care manager’s/care coordinator’s active caseload at any point in time.
 | No NCQA requirement. | NCQA: N/ATCPI: allow partial deeming. Separately verify that practice’s methodology is consistent with the Affordability Standard requirement to consider clinical information including severity level and other patient-specific characteristics. | Attachment J: “The level of care coordination required to implement the care plan will vary and is determined by a stratification model based on the assessed level of need of the family, taking into account the requirements for carrying out care plans and the resources available to the family.” | x |  |  |
| 1. The care manager/care coordinator completes within a specified period of time (from the time that the high-risk patient is placed in the care manager’s/care coordinator’s active caseload)[[1]](#footnote-1) a patient assessment based on the patient’s specific symptoms, complaints or situation, including the patient’s preferences and lifestyle goals, self-management abilities and socioeconomic circumstances that are contributing to elevated near-term hospitalization and/or ED risk.

For children and youth, the care coordinator shall complete a family assessment that includes:* 1. a family status and environment assessment (i.e., assessment of medical/behavioral/dental health status; social supports of family and friends; financial needs; family demands, relationships, and functioning; cultural beliefs and values of family; strengths/assets of child, youth, family/caregivers, and current goals of child, youth & family), and
	2. a growth and development assessment (i.e., assessment of child/youth developmental progress/status; child/youth strengths/assets; school performance and needs, and emotional/behavioral strengths and needs).
 | 2011 PCMH 3, Element C, (Must Pass) requires the care team to collaborate with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit for at least 75% of high-risk patients. NCQA PCMH 4, Element B: The care team and patient family/caregiver collaborate (at relevant visits) to develop and update an individual care plan for at least 75% of high risk patients; Care plan incorporates the patient preferences and functional lifestyle goals, identifies treatment goals, assesses and addresses potential barriers to meeting goals, includes a self-management plan and is given in writing to the patient/family/caregiver | NCQA: The 2011 and 2014 NCQA requirements are not prescriptive about time frame for completing the patient assessment and care plan. Allow NCQA deeming regarding content of patient assessment. Separately verify that the practice has established and implemented a process within specified timeframes for assessing and adding new patients onto the High Risk Patient List, based on care manager capacity. TCPI: do not allow deeming, as TCPI’s requirements are not sufficiently specific. | Attachment J: “Complete a child/youth and family assessment *that includes family status and home environment assessment (i.e., assessment of medical/behavioral/dental health status; social supports of family and friends; financial needs; family demands, relationships, and functioning; cultural beliefs and values of family; strengths/assets of child, youth, family/caregivers, and current goals of child, youth and family) and growth and development assessment (i.e., assessment of child/youth developmental progress/status; child/youth strengths/assets; school performance/needs, and emotional/behavioral strengths and needs)”*Hannah notes: we did not specify timeframe to do assessment.  | x |  |  |
| 1. Working with the patient and within two weeks of completing the patient assessment, the care manager/care coordinator completes a written care plan, that includes:
	1. a medical/social summary
	2. risk factors
	3. treatment goals
	4. patient-generated goals
	5. barriers to meeting goals
	6. an action plan for attaining patient’s goals
 | 2011 NCQA PCMH 3, Element C requires the practice to complete a care plan for at least 75% of the patients identified as high risk. The care plan must include relevant treatment goals.2014 NCQA PCMH 4, Element B: Care plan incorporates the patient preferences and functional lifestyle goals, identifies treatment goals, assesses and addresses potential barriers to meeting goals, includes a self-management plan and is given in writing to the patient/family/caregiver.2014 NCQA PCMH 4 requires that 75% of patients on high risk list have a care plan. | 2011 NCQA PCMH requirements do not specify the content of the care plan in sufficient detail and do not specify a time table for completing the care plan.Do not allow deeming.2014 PCMH NCQA requirements do not specify a time table for completing care plans. Allow deeming regarding content of written patient care plan. Separately verify that the practice is meeting the timeline.TCPI: do not allow deeming, as TCPI’s requirements are not sufficiently specific. | See above. Attachment J: “Working with the family, develop a written care plan, including a medical summary, action plan, and, if needed, an emergency plan, that reflects mutual goals. *Update the written care plan on a regular basis”*We did not specify a timeline. Cedar is using 45 days from identification to do the assessment and care plan.  | x |  |  |
| 1. The care management/care coordination resources update the written care plan on a regular basis, based on patient needs to affect progress towards meeting existing goals or to modify an existing goal, but no less frequently than semi-annually.
 | 2011 NCQA PCMH 3, Element C requires the care team to review and update treatment goals at each relevant visit.2014 NCQA PCMH 4 requires regular updating and that 75% of patients on high risk list have a care plan. | NCQA: Allow partial deeming and separately verify that practices are developing care plan for all patients on the high-risk patient list and are meeting the timeframe for updating the care plan. TCPI: do not allow deeming, as TCPI’s requirements are not sufficiently specific. | Attachment J: “Working with the family, develop a written care plan, including a medical summary, action plan, and, if needed, an emergency plan, that reflects mutual goals. *Update the written care plan on a regular basis”*Hannah note: we did not specify semi-annually. Could possibly build into care coordination reporting requirements. |  | x |  |
| 1. For high-risk patients known to be hospitalized or in a SNF, the care management/care coordination resources shall contact the patient and/or the hospital discharge planner and begin transition-of-care planning at least 24-hours prior to the patient’s discharge.
 | 2011 and 2014 NCQA PCMH 5, Element C, Factor 4 requires practices to proactively contact patient/families for appropriate follow-up care within an appropriate period following a hospital admission or ED visit. No timeframes are specified. | NCQA: Allow partial deeming and separately verify that the practices are beginning TOC planning within the required timeframe.TCPI: Do not allow deeming as the standards are not consistent. | Attachment C: “establish a procedure for outpatient transitions; i.e. a connection with hospitals for notification of emergency department visits and coordination of patients transitioning from hospital (example in Attachment K)”Hannah note: did not include specific requirements on timing of TOC planning. A practice could include in their transitions procedure (Attachment K).  |  | x |  |
| 1. The care management/care coordination resources contact every high-risk patient who has been discharged from hospital inpatient services after discharge to determine care management needs.[[2]](#footnote-2)
 | 2011 and 2014 NCQA PCMH 5, Element C, Factor 4 requires practices to proactively contact patient/families for appropriate follow-up care within an appropriate period following a hospital admission or ED visit. No timeframes are specified. | NCQA: Allow partial deeming and separately verify that the practices are meeting the specific timeframe for completing the outreach contacts.TCPI: allow deeming | Hannah note: did not include specific requirements on outreach. A practice could include in their transitions procedure (Attachment K).  | x | x | x |
| 1. The care management/care coordination resources contact every known high-risk patient who has had an Emergency Department visit for a situation or condition that is related to or contributes to the patient’s high-risk status.[[3]](#footnote-3)
 | 2011 and 2014 NCQA PCMH 5, Element C, Factor 4 requires practices to proactively contact patient/families for appropriate follow-up care within an appropriate period following a hospital admission or ED visit. No timeframes are specified. | NCQA: Allow partial deeming and separately verify that the practices are meeting the specific timeframe for completing the outreach contacts.TCPI: allow deeming | Hannah note: did not include specific requirements on outreach. A practice could include in their transitions procedure (Attachment K). | x | x | x |
| 1. The care management/care coordination resources complete a medication reconciliation after a high-risk patient has been discharged from inpatient services; to the extent possible the medication reconciliation is conducted in person.[[4]](#footnote-4)
 | 2011 NCQA PCMH 3, Element D specifies percentages of care transitions for which medication reconciliations are to be done. 2014 NCQA PCMH 4, Element C (Critical Factor): practice reviews and reconciles medications for more than 50% of patients received from care transitions (factor 1); with patients/families for more than 80% of care transitions (Factor 2). Medication reviews must occur at least annually, at transitions of care and at relevant visits, as defined by the practices. | NCQA: Allow partial deeming and separately verify that the practices are meeting the specific timeframe for completing the medication reconciliations.TCPI: allow deeming if the practice has selected medication management review as one of its case management strategies. | Hannah note: did not include specific requirements on timing. A practice could include in their transitions procedure (Attachment K). | x | x | x |
| 1. The care management/care coordination resources arrange for, and coordinate all medical, developmental, behavioral health and social service referrals and tracks[[5]](#footnote-5) referrals and test results on a timely basis for high-risk patients.
 | 2011 and 2014 NCQA PCMH 5, Element A requires practices to systematically track tests and coordinate care across specialty care, facility-based care and community organizations.2011 and 2014 NCQA PCMH 5 Element B, (Must Pass) requires practices to track and follow-up on referrals. Practices are to track referrals that are “determined by the clinician to be important to a patient’s treatment, or as indicated by practice guidelines. This includes referrals to medical specialists, mental health and substance abuse specialists and other services. | NCQA: Allow deemingTCPI: allow deeming once milestone Phase 4.E is achieved. | Attachment J: “[Care coordinator will] Arrange for, set up, and coordinate *all medical, developmental, behavioral health, and social* referrals, and track referrals and test results.” | x |  |  |
| 1. The care management/care coordinator resources provide health and lifestyle coaching for high-risk patients designed to enhance the patient’s/caregiver’s self/condition-management skills.
 | 2011 NCQA PCMH 4, Element A (Must Pass) requires the practice to conduct activities to support patient/families in self-management, including providing educational resources and referrals to educational resources, using self-management tools, providing healthy behaviors coaching, and developing and document self-management plans and goals.2014 NCQA PCMH 4, Element E Factors 2, 3 and 4 require practices to use materials to support patients, families/caregivers in self-management and shared decision making. | NCQA: Allow deemingTCPI: Do not allow deeming, as the standard is too general. | Attachment J: “Provide condition-specific and related medical, financial, educational, and social supportive resource information, while coaching for the transfer of health-management skills supportive of partnerships with families to care for their children and youth.” | x |  |  |
| 1. Practices shall provide patient-engagement training to care managers/care coordinators, as necessary, to achieve these requirements
 | 2014 NCQA PCMH 2, Element 6 requires practices to train and assign members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavioral change. | NCQA: all deeming. Patient engagement will necessarily be a topic of these training activities because it is foundational to self-management, self, efficacy and behavioral change.TCPI: allow partial deeming. Separately verify that training topics include patient engagement. | Attachment F: “Practice care coordination staff will attend at least one full-day CTC care coordination training (approximately 8 hours). Training will include separate, pediatric-specific tracks.”Hannah notes: could include patient engagement in this training.  | x |  |  |
| 1. The care management/care coordination resources have in-person or telephonic contact with each high-risk patient at intervals consistent with the patient’s level of risk.
 | 2011 NCQA PCMH 3, Element C requires the practice to develop care plans for at least 75% of high-risk patients and to follow-up with patients/families who have not kept important appointments.2014 NCQA PCMH 4, Element B requires care plans for 75% of high risk patients, but includes no contact requirements | NCQA: The 2011 and 2014 NCQA standards do not include specific contact requirements.Do not allow deemingTCPI: No not allow deeming, as the requirement is too general. | Attachment J: “*The level of care coordination required to implement the care plan will vary and is determined by a stratification model based on the assessed level of need of the family, taking into account the requirements for carrying out care plans and the resources available to the family.* *The care plan is continuously monitored and updated with new assessments, goal setting, and care planning.* “Attachment J: “Promote communications with families and among professional partners, and define minimal intervals between communications” | x |  |  |
| 1. The care management/care coordination resources participate in relevant team-based care meetings to assure whole-person care is provided to high-risk patients.

For pediatric practices, participants in practice-initiated team meetings may include primary care and specialist providers, school liaisons, behavioral health providers, developmental specialists, government support program representatives (e.g., SSI), and social service agency representatives. | 2011 NCQA PCMH 1, Element G requires the practice to use a team to provide a range of patient care services.2014 NCQA PCMH 2, Element D (Must Pass) requires that the practice uses a team to provide a range of patient services by holding a scheduled patient care team meeting or structured communication process focused on individual patient care (Factor 3, CRITICAL factor). NCQA Explanation states that all clinical staff are members of the team.  | NCQA: Allow deemingTCPI: do not allow deeming, as the requirement is too general. | Attachment J: “Ensure the health care team integrates multiple sources of health care information; communicate this summary *to the patient/caregiver*, thereby building caregiver skills and fostering relationships between the health care team and families.”Attachment J: “Coordinate family-centered team meetings (across organizations as needed).” | x |  |  |
| 1. The care management/care coordination resources use HIT to document and monitor care management service provision.
 | No NCQA requirement. | NCQA: N/ATCPI: do not allow deeming, as requirements are not consistent. | Attachment J: “Use health information technology to effectively deliver and continually monitor care coordination and the effectiveness of service delivery.” | x |  |  |
| 1. The care management/care coordination resources participate in formal practice quality improvement initiatives to assess and improve effectiveness of care management service delivery
 | 2011 NCQA PCMH 1, Element G, Factor 8 and 2014 NCQA PCMH 2, Element D, Factor 9 (Must Pass): The practice uses the team to provide a range of patient services by involving the care team in the practice’s performance evaluation and quality improvement activity.2014 NCQA PCMH 6 Element B: At least annually, the practice measures or receives quantitative data on at least 2 measures related to care coordination; 6 Element D: acts to improve at least one measure from measures resources use and care coordination. | NCQA: Allow deemingTCPI: Allow partial deeming when Phase 2.H is achieved. Separately verify that PDSA cycles assess and improve effectiveness of care management service deliveryAllow deeming when Phase 4.A milestone is achieved. | Hannah notes: we do not have this requirement. NCQA deeming allowed.  | x |  |  |

**Requirement #3: The practice improves access to and coordination with behavioral health service.**

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| **Cost Management Requirement** | **NCQA Requirement** | **Deeming Recommendation** | **PCMH-Kids Common Contract Language** |
| **The practice has implemented one of the following approaches to behavioral health integration by the end of Year 1** |
| 1. To promote better access to and coordination of behavioral health services, the practice has developed preferred referral arrangements with community behavioral health providers such that appointments are available consistent with the urgency of the medical and behavioral health needs of the practice’s patients and there is an operational protocol adopted by the PCP and the preferred specialists for the exchange of information. The terms of the preferred arrangement are documented in a written agreement.
 | 2011 NCQA PCMH 1, Element E requires a PCMH to coordinate patient care across multiple settings, including behavioral health.2014 NCQA PCMH 5, Element B, Factor 3: the practice maintains agreements with behavioral health provider. Agreements typically indicate the type of information that will be provided when referring a patient to a specialist and expectations regarding timeliness and content of response from the specialist.2014 NCQA PCMH 5, Element B, Factor 4: Integrates behavioral healthcare providers within the practice site. | 2011 PCMH NCQA requirements lack specificity around better coordinating behavioral health services.2014 PCMH NCQA requirements address only exchange of information, not timely access to services. 2014 NCQA PCMH 5, Factor 4 is not a critical factor. NCQA: Do not allow deeming.TCPI: Do not allow deeming. Requirements regarding behavioral health integration are insufficiently specific. | Hannah notes: we did not require a documented written agreement. A practice may choose to include all required information in a compact required for NCQA.  |
| 1. To promote better access to and coordination of behavioral health services, the practice has arranged for a behavioral health provider(s) to be co-located (or virtually located) at the practice for at least one day per week and assists patients in scheduling appointments with the on-site provider(s).
 | No NCQA requirement. | NCQA: N/ATCPI: same as above. | Hannah notes: we did not require and explicitly stated that this would not be financially feasible to require in the current contract.  |
| 1. To promote better access to and coordination of behavioral health services, the practice is implementing or has implemented a co-located (or virtually located), integrated behavioral health services model that is characterized by licensed behavioral health clinicians serving on the care team; the team sharing patients, and sharing medical records, and the practice promoting consistent communications at the system, team and individual provider levels that includes regularly scheduled case conferences, and warm hand-off protocols.
 | No NCQA requirement. | NCQA: N/ATCPI: same as above. | Hannah notes: we did not require and explicitly stated that this would not be financially feasible to require in the current contract. |

**Requirement #4: The practice expands access to care both during and after office hours (defined as access beyond weekdays between 9am and 5pm).**

| **Cost Management Requirement** | **NCQA Requirement** | **Deeming Recommendation** | **PCMH-Kids Common Contract Language** | **Must be implemented or deemed met by the end of:** |
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| **The practice must perform all of the following functions:** | **Yr 1** | **Yr 2** | **Yr 3** |
| 1. The practice has a written policy to respond to patient telephone calls within the following timeframes:* 1. For urgent medical/behavioral calls received during office hours, return calls are made the same day.
	2. For urgent calls received after office hours, return calls are made within 1 hour.
	3. For all non-time-sensitive calls, return calls are made within 2 business days of receiving the call.
 | 2011 NCQA PCMH 1, Element B: requires the practice to have a written process and defined standards, and demonstrates that it monitors performance against the standards for providing timely clinical advice by telephone when the office is not open. 2014 NCQA PCMH 1, Element B: requires the practice to have a written process and defined standards for providing access to clinical advise and continuity of medical record information at all times and regularly assesses its performance on providing timely clinical advise (CRITICAL factor); providing continuity of medical record information for care and advice when the office is closed. The time frame is defined by the practice to meet the clinical needs of the patient population.  | NCQA: Allow partial deeming. Separately verify that the practices have written policies that meet the specified time frames for responding to patient calls. TCPI: Do not allow deeming, as the requirements are not sufficiently specific. | Attachment C: “The Practice will submit the After Hours Protocol. The Protocol for the Practice will include: the strategy for accessing weekends, holidays & extended hours of care, location, hour of operations, and protocols outlining how the Practice’s Eligible Subscribers can access care from these sites as an alternative to emergency room care. The Practice shall include a plan for extended hours, past normal hours of business operation. Hannah notes: no requirement explicitly for phone calls.  | x |  |  |
| 2. The practice has implemented same-day scheduling, such that patients can call and schedule an appointment for the same day.[[6]](#footnote-6) | 2011 NCQA PCMH has a written process and defined standards for providing same-day appointments (Factor 1).2014 NCQA PCMH 1, Element A, Factor 1: Patient centered access: (Must Pass): The practice has a written process and defined standards and regularly assesses its performance on : Providing same day appointments for routine and urgent care (Critical Factor) | NCQA 2011: Allow deeming if the practice passes Factor 1.NCQA 2014: Allow deeming.TCPI: Do not allow deeming, as requirements are not sufficiently specific. | See above requirement for After Hours Policy. Hannah notes: no requirement for same-day scheduling. Most pediatricians do this already. NCQA deeming allowed.  | x | x | x |
| 3. The practice has an agreement with (or established) an urgent care clinic or other service provider which is open during evenings and weekends when the office is not open as an alternative to receiving Emergency Department care. | No NCQA requirement. | N/ATCPI: Do not allow deeming, as requirements are not sufficiently specific. | See above for requirement of having After Hours Policy. Hannah notes: do not require an agreement with urgent care clinic or other service provider, just that policy say how a patient can access care other than emergency room.  | x |  |  |
| 4. The practice utilizes formal quality improvement processes to assess and improve the effectiveness of its programs to expand access. | 2011 does not include QI initiatives to improve access.2014 NCQA PCMH 1, Element A, Factor 6 requires practices to act “on identified opportunities to improve access.” The Explanation for Factor 6 states: The practice may participate in or implement a rapid-cycle improvement process, such as Plan-Do-Study-Act (PDSA), that represents a commitment to ongoing quality improvement and goes beyond setting goals and taking action. | NCQA 2011: Do not allow deeming.NCQA 2014: Allow deeming.TCPI: Allow partial deeming if Phase 2 H is met. Separately verify that PDSA cycles are designed to assess and improve the effectiveness of its programs to expand access.Allow deeming once Phase 4. A milestone is achieved. | Hannah notes: did not require. NCQA deeming allowed.  | x |  |  |
| **The practice must perform *at least 2* of the following functions:** |
| 1. The practice has created a secure web portal that enables patients to:
* send and receive secure messaging
* request appointments
* request referrals
* request prescription refills
* review lab and imaging results[[7]](#footnote-7)

The practice clearly communicates to patients that the portal should not be used for urgent matters and that patients should call the practice under such circumstances. | 2011 NCQA PCMH 1, Element C, Factors 5 and 6 requires practices to have electronic access, including requesting appointments or prescription refills (Factor 5) and referrals or test results (Factor 6).2014 NCQA PCMH 1, Element C, Factor 6: Patients can request appointments, prescription refills, referrals and test results; this is also a core meaningful use requirement | NCQA: Allow deeming.TCPI: N/A | Hannah notes: did not require. NCQA deeming allowed.  | x | x | x |
| 1. The practice has expanded office hours so that services are available at least two mornings or two evenings a week for a period of at least 2 hours beyond standard office hours.[[8]](#footnote-8)
 | 2011 NCQA PCMH 1, Element BG, Factor 2 requires practices to provide access to routine and urgent-care appointments outside regular business hours.2014 NCQA PCMH 1, Element A, Factor 2: requires practices to provide routine and urgent care appointments outside of regular business hours. Practices are encourages to assess the needs of its practice for appointments outside normal business hours and then to evaluate if these appointment times meet the needs of the patient. If a practice is not able to provide care beyond regular business hours (e.g., small practice with limited staffing), it may arrange for patients to receive care from other (Non-ER) facilities or clinicians. NCQA examples of extended access include:•Offering daytime appointments when the practice would otherwise be closed for lunch (on some or most days). •Offering daytime appointments when the practice would otherwise close early (e.g., a weekday afternoon or holiday). | The 2011 and 2014 NCQA standards are not specific regarding expanded office hours.NCQA: Do not allow deeming.TCPI: N/A | Hannah notes: did not require because practices said they either met this already or it was not financially feasible to require in our contract.  |  | x | x |
| 1. The practice has expanded office hours so that services are available at least four hours over the weekend. Services may be provided by practice clinicians or through an affiliation of clinicians, so long as the affiliated physicians are able to share medical information electronically on a near real- time basis through either a shared EMR system or by ready access to a patient’s practice physician who has real-time access to patient’s medical records.[[9]](#footnote-9)
 | 2011 and 2014 NCQA PCMH standards: Same as above. NCQA is less specific regarding to what extent hours must be expanded. | The 2011 and 2014 NCQA standards are not specific regarding expanded office hours.NCQA: Do not allow deeming.TCPI: N/A | Hannah notes: did not require because practices said they either met this already or it was not financially feasible to require in our contract. |  | x | x |

**Requirement #5: The practice refers patients to referral service providers who provide value-based care.**

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| **Cost Management Requirement** | **NCQA Requirement** | **Deeming Recommendation** | **PCMH-Kids Common Contract Language** | **Must be implemented by the end of:** |
| **The practice must perform all of the following functions:** | **Yr 1** | **Yr 2** | **Yr 3** |
| 1. The practice has developed referral protocols for its patients for at least two of the following:
	1. one high-volume specialty, such as cardiovascular specialist, pulmonary specialist, orthopedic surgeon or endocrinologist;
	2. laboratory services;
	3. imaging services;
	4. physical therapy services, and
	5. home health agency services.
 | 2011 NCQA PCMH 5, Element B, Factor 4: practice establishes and documents agreements with specialists in the medical record if co-management is needed.2014 NCQA PCMH 5, Element B, Factor 2: practice maintains formal and informal agreements with a subset of specialists based on established criteria.Agreements typically indicate the type of information that will be provided when referring a patient to a specialist and expectations regarding timeliness and content of response from the specialist. | The NCQA 2011 and 2014 standards do not address the value-based care as a factor that should be considered in creating referral arrangements and views the requirement as relating to the exchange of information.NCQA: Do not allow deeming.TCPI: Allow partial deeming and separately verify that the community partners include those required under Requirement 5.1. | Hannah notes: did not require as compacts with specialists were not seen to be necessary for pediatrics. A practice may choose to include all OHIC required information in a compact established for NCQA credit.  | x |  |  |
| 1. Should one or more payers provide the practice with readily available, actionable data, the practice has used such data and any other sources to identify referral service providers who provide higher quality services at costs lower than or the same as their peers (i.e., “high-value referral service providers”) and prioritizes referrals to those providers.
 | 2011 NCQA PCMH 5 does not address use of data to make specialty referrals.2014 NCQA PCMH 5, Element B, Factor 1 requires the practice to consider available performance information on consultants/specialists when making referral recommendations. (Must-Pass) | The NCQA 2011 and 2014 standards list potential sources of performance information, but does not focus on information related to “high-value referral service providers.”NCQA: Do not allow deeming.TCPI: N/A | Hannah notes: did not require on behalf of practices. NCQA deeming allowed. There is a *loose* requirement of the plans in Attachment D: “Plans will make best efforts to report cost and quality data to inform referral protocols” [plans to report to practices]s |  | x |  |

1. Assessment is initiated within one week, with at least three contact attempts (if needed) within two weeks. Assessment must be completed within two weeks of caseload assignment, unless patient is non-responsive to outreach. [↑](#footnote-ref-1)
2. During Year 1 contact must occur within 72 hours of discharge and in Years 2 and 3 contact must occur within 48 hours. [↑](#footnote-ref-2)
3. During Year 1 contact must occur within 72 hours of an ED visit and in Years 2 and 3 contact must occur within 48 hours. [↑](#footnote-ref-3)
4. During Years 1 and 2 reconciliation must be completed within 7 days of discharge. During year 3, reconciliation must be completed within 72 hours of discharge. [↑](#footnote-ref-4)
5. Consistent with 2014 NCQA PCMH recognition Standard 5, Element B, “tracking” here means that the practice “tracks referrals until the consultant or specialist’s report is available, flagging and following up on overdue reports.” [↑](#footnote-ref-5)
6. During Years 1 and 2, same-day scheduling must be available for urgent care. In year 3, same-day scheduling must be available for urgent and routine care. Consistent with the AHRQ definition contained within the CAHPS survey, routine care is defined by OHIC to mean care that patients believe they need, but not “right away.” [↑](#footnote-ref-6)
7. All functions, except lab and imaging, must be functional in Years 1 and 2. All functions must be functional in Year 3. [↑](#footnote-ref-7)
8. During Year 1 these requirements are waived. During Year 2, expanded office hours must be available for urgent care. During Year 3, expanded office hours must be available for urgent and routine care. [↑](#footnote-ref-8)
9. During Year 1 these requirements are waived. During Year 2, expanded office hours must be available for urgent care. During Year 3, expanded office hours must be available for urgent and routine care. [↑](#footnote-ref-9)