

Draft Rhode Island 2017 Care Transformation Plan
Recommended to the Health Insurance Commissioner Kathleen C. Hittner
December 16, 2015

The Care Transformation Advisory Committee recommends that Health Insurance Commissioner Kathleen C. Hittner adopt the following Care Transformation Plan for 2017. This plan is intended to supersede the previously adopted 2016 plan.

I. Background

This 2017 Care Transformation Plan is adopted pursuant to Section 10(c)(2)(A) of Regulation 2: Powers and Duties of the Office of the Health Insurance Commissioner (OHIC), by Kathleen C. Hittner, Health Insurance Commissioner.

Pursuant to Section 10(c)(2)(A) of Regulation 2, the Care Transformation Advisory Committee submitted to the Health Insurance Commissioner a 2017 Care Transformation Plan which is designed to move primary care practice transformation activities towards achieving OHIC's 2019 target of 80% of Rhode Island primary care clinicians practicing in a Patient-Centered Medical Home (PCMH).¹ A plan was developed over the course of four Committee meetings.

II. Definition of Patient-Centered Medical Home

Cognizant that being recognized as a PCMH by an external organization does not mean that a practice has effectively implemented PCMH processes to improve cost and quality of care, the Committee developed the following three-part definition of PCMH against which RI primary care practices will be evaluated:

- a. Practice is participating in or has completed a formal transformation initiative² (e.g., CTC-RI, PCMH-Kids, [RIQI'S TCPI Program](#), or a payer- or ACO-sponsored program) and/or practice has obtained NCQA Level 3 recognition.
- b. [Practice has implemented the following specific cost-management strategies according to the implementation timeline, included in the Plan as Attachment A](#) (strategy development and implementation at the practice level rather than the practice site level is permissible):

¹ OHIC Regulation 2 Section 10(c)(1)

² A formal PCMH transformation initiative is a structured training program for primary care providers and support staff with a pre-defined curriculum and technical assistance based on an evidence-based PCMH transformation model and designed to systematically build the skills within the practice to function as a PCMH.

- i. develops and maintains a high-risk patient registry that tracks patients identified as being at risk of avoidable intensive service use in the near future;
 - ii. practice uses data to implement care management³, focusing on high-risk patients and interventions that will impact ED and inpatient utilization;
 - iii. implements strategies to improve access to and coordination with behavioral health services;
 - iv. expands access to services both during and after office hours;
 - v. develops service referral protocols informed by cost and quality data provided by payers; and
 - vi. develops/ maintains an avoidable ED use reduction strategy.
- c. Practice has demonstrated meaningful performance improvement. During 2016 OHIC shall define the measures for assessing performance and the precise definition of “meaningful performance improvement” in consultation with the Advisory Committee.

III. PCMH Target for 2017

OHIC requires that by December 31, 2017 each insurer subject to the Affordability Standards shall increase the percentage of its primary care network functioning as a PCMH by 10 percentage points from the level achieved as of December 31, 2016.

Beginning January 1, 2017, to be considered a PCMH for the purposes of this calculation, a practice must meet all requirements specified in the definition of PCMH delineated in Section II of the Care Transformation Plan and consistent with the Implementation Timeline included as Attachment A, and be receiving support payments from insurers that are consistent with the PCMH Financial Support Model, detailed in Section V.

IV. Stakeholder Activities Promote PCMH Adoption

The following activities in 2016 and 2017 will help advance PCMH transformation by Rhode Island primary care practices. The activities are designed to both engage new

³ Practices shall implement “care coordination” for children, which is a broader set of services not exclusively focused on high-risk patients. See R Antonelli, J McAllister, J. Popp. “Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework.” The Commonwealth Fund, publication number 1277, May 2009.

primary care practices in practice transformation and to improve the performance of practices previously engaged in PCMH transformation.

1. All-Payer Claims Database (APCD) Provider Profiles

The Commissioner should work with the APCD to develop:

- a. PCP and high volume specialist profiles (e.g., cardiologists, orthopedists, endocrinologists) using quality, utilization and cost measures, and
- b. ACO-based profiles that can be used to identify key focus areas for population health improvement.

Estimated Costs:

APCD Analytics Vendor: \$20,000

In-kind contribution from existing state staff

Potential/Tentative Funding Source: State Innovation Model (SIM) Grant Funds

2. Data Access and Use Learning Sessions

During the fall Advisory Committee convening, Committee members noted that transforming practices still continue to face challenges with data use. Therefore, the Commissioner shall require that CTC-RI and RIQI hold two joint learning sessions specific to data access and use.

Estimated cost: \$8000 per session; \$16,000 for two sessions: Conference for 150 participants

- Light breakfast
- Lunch: sandwiches and salads
- AV equipment
- Room rental
- Printed materials

Funding source: insurers, in an amount proportionate to their insured book of business in Rhode Island

3. Care Management Learning Activities

The Commissioner shall request the transformation initiatives (CTC-RI, RIQI, and PCMH-Kids) continue to provide and to coordinate their care management/care coordination learning activities. These learning activities can consist of learning sessions or academies or a series of monthly webinars or a combination of in-person learning sessions and webinars with a comparable number of “contact hours” as two full-day learning sessions.

Estimated cost: \$8000 per session; \$16,000 for two sessions, to be funded by insurers:

- Conference for 150 participants
- Light breakfast
- Lunch: sandwiches and salads
- AV equipment
- Room rental
- Printed materials

Funding source: insurers, in an amount proportionate to their insured book of business in Rhode Island

4. Monitoring for Cost Management Strategies/High-Risk Care Management

The Commissioner shall work with payers, CTC-RI and RIQI to develop a pilot program to focus on monitoring of the implementation of the cost management strategies, and high-risk care management activities.

Estimated cost: N/A

In-kind contributions from OHIC, CTC-RI, RIQI, providers, and insurers.

5. Practice Facilitation

In order to support practices effectively during the transformation process, the Committee recognizes the value of providing consistent, on-going practice facilitation resources particularly to practices that are having difficulty with the transition. Since an increasing number of organizations, including payers, CTC-RI and RIQI, are providing practice facilitation resources to practices, the Committee recommends that the Commissioner work with all such organizations to coordinate the deployment of those scarce resources. OHIC shall work with CTC-RI, the

payers, and RIQI to identify and target resources for practice facilitation deployment to maximize the impact of these resources.

Estimated Costs: N/A

In-kind contributions from OHIC, CTC-RI, RIQI, providers, and insurers.

6. Annual Care Transformation Advisory Committee Meetings

Pursuant to the Affordability Standards, Section 10(c)(2)(A), the Care Transformation Advisory Committee will reconvene on or around October 1, 2017 to review the success of the prior year's plan while learning from the past year's experience, and develop the next annual Care Transformation Plan. OHIC shall hold between three and four meetings to develop the Care Transformation Plan for 2018.

V. PCMH Financial Model

OHIC shall require insurers to adopt the following two-stage payment model to sustain primary care transformation in practices beginning January 1, 2016. Insurers shall minimally apply this model to practices that have met the OHIC definition of a PCMH delineated in Section II, above. This includes those practices participating in a formal transformation initiative (e.g., CTC-RI, PCMH-Kids or a payer or ACO-sponsored program).

- **First Stage:** Practices actively engaged in first-time PCMH transformation activity and without NCQA recognition Level 3 or practices with NCQA recognition Level 3, but which have not yet met the cost management strategies or performance improvement requirements within the timeframe outlined in Part II, receive both infrastructure and care management (CM) (care coordination for pediatrics) PMPM payments. Practices are eligible to receive infrastructure payment for a maximum of 24 months or until NCQA PCMH Level 3 recognition is achieved, whichever occurs first. If the practice is part of an ACO, the payer may make the CM PMPM payment to the ACO, but the ACO must use that payment to finance CM services at the practice site earning the payment.
- **Second Stage:** Practices with NCQA Level 3 recognition and which have implemented the cost management strategies and demonstrated performance improvement receive a CM PMPM payment and have an opportunity to earn a performance bonus. If the practice is part of an ACO, the payer may make

the CM PMPM payment to the ACO, but the ACO must use that payment to finance the CM services at the site earning the payment.

Example Scenarios for Practices Engaged in Practice Transformation:

Example	NCQA Level 3	All Required Cost Management Activities Implemented	Performance Improvement Achieved	Care Management PMPM	Infrastructure Payment PMPM	Performance Bonus Opportunity
1	✓	✓	✓	✓	X	✓
2	✓	X (but still within 12-month timeframe for implementation)	X (but still within 24-month timeframe for implementation)	✓	✓	X
3	✓	X (but still within 12-month timeframe for implementation)	✓ (but still within 24-month timeframe for implementation)	✓	✓	X
4	✓	✓ (but still within 12-month timeframe for implementation)	X (but still within 24-month timeframe for implementation)	✓	✓	X
5	✓	X (and 12-month timeframe for implementation has passed)	X (and 24-month timeframe for implementation has passed)	X	X	X
6	X (newly participant)	X but still within 12-	X (but still within 24-	✓	✓	X

	ing in a formal transformation initiative)	month timeframe for implementation)	month timeframe for implementation)			
7	X	X (and 12-month timeframe for implementation has passed)	X (and 24-month timeframe for implementation has passed)	X	X	X

The purpose of the CM PMPM payment is to support development and maintenance of a care management function within that practice and is not limited to supporting a care manager, per se. The purpose of the infrastructure payment is to compensate practices for the time and effort involved in achieving NCQA PCMH Level 3 recognition and establishing basic policies and procedures necessary for PCMH function, including developing clinical data capture, reporting and analysis capacity.

The monetary levels of support for CTC-RI and for PCMH-Kids are determined by the program participants, subject to the approval of OHIC. The monetary levels of support for practices with NCQA Level 3 recognition not currently participating in a formal transformation initiative (e.g., CTC-RI, PCMH-Kids, and payer or ACO-sponsored program) should be independently determined by the payers.

To assure that the care management function is being implemented as effectively as possible, payers should conduct regular CM evaluations. OHIC shall work with the payers to follow the Committee recommendation that large volume practices and ACOs have an evaluation annually and that other practices receive evaluations on a rotating basis, possibly every two-to-three years. The evaluations should be designed to provide helpful, real-time feedback to the care managers.

The financial model shall become effective in 2016.

Estimated minimum cost, to be funded by insurers:

- CTC-RI

- PCMH-Kids: ~18,000 covered children at \$TBD pmpm, effective January 1, 2016
- Care manager evaluations: evaluators' time (this estimate will be revised as conversations continue with payers to develop the scope and model for this evaluation)

VI. Conclusion

This 2017 Care Transformation Plan is derived from the draft recommendations of the Care Transformation Advisory Committee. It advances progress towards the goals set forth in the OHIC Affordability Standards.

Draft

Implementation Timeline for Financial Payment Model, Cost Management Strategies and
Performance Improvement Requirements
December 15, 2015

I. Cost Management Strategies Requirements

2016		
A. Primary Care Practices Seeking Designation as a PCMH under OHIC's Affordability Standards		
Date	Activity	Comment
Practice Notification	<ul style="list-style-type: none"> • Insurers notify their primary care networks of OHIC PCMH standards and specific insurer's requirements to receive financial support payments. • OHIC has identified a transformation agent capable of creating and monitoring an on-line application available to primary care practices that want to "self-identify" for OHIC PCMH status. • By April 30, 2016, insurers will notify practices of the specifics around the financial support payments, including amount and timing. 	<ul style="list-style-type: none"> • At a minimum, each insurer must notify practices that it wants to count towards achieving its PCMH 2016 target. To avoid duplicate notices being sent to practices, OHIC recommends that insurers coordinate with CTC to send one notice to each practice on behalf of all insurers. • OHIC anticipates that practices currently participating in a recognized transformation initiative will constitute most, if not all, of the practices being evaluated under the OHIC PCMH standards. However, OHIC believes that it is important to provide other practices with the opportunity to self-identify. • The location of the web application has not been identified, but it could be an entity supporting practice transformation.
Requirement 1: Transformation	<p>The practice's participation status in the transformation initiative is determined either actively or passively by September 30, 2016:</p> <ul style="list-style-type: none"> • <u>active</u>: online submission through a website • <u>passive</u>: OHIC gathers data from 	<ul style="list-style-type: none"> • OHIC is currently receiving NCQA data directly from NCQA. • The website maintained by the entity supporting practice transformation will provide "self-identified" practices with an opportunity to report transformation information. • All practices with 2 or more years of transformation

	2016	
	<p>transformation agents (e.g., CTC-RI, PCMH-Kids, RIQI's TPCI initiative)</p> <p>Practice's NCQA Level 3 status is determined by OHIC as of September 30, 2016.</p>	<p>experience must have achieved NCQA Level 3 by September 30, 2016, since they will have already received infrastructure payments for at least two years and will be in at least their third year of transformation activity.</p>
Requirement 2: Cost Strategies	<p>Practices with more than 2 years of transformation experience will be required to meet Year 1 requirements as of September 30, 2016. Practices with less than 2 years of transformation experience will be expected to meet Year 1 requirements by September 30, 2017.</p>	<ul style="list-style-type: none"> • The self-assessment will be submitted to OHIC via a web-based program, such as Survey Monkey, no later than September 30 annually. • This information is needed by the end of September to give OHIC sufficient time to analyze all data received, to determine which practices meet the definition and to notify practices and insurers of the results of its analysis. • Practices will earn a "pass" if they have implemented 80% or more of the Cost Management Strategies required for the year for which they are reporting.
Requirement 3: Performance Improvement regarding quality measures	<p>Submit data¹ by September 30, 2016, but no requirement to show improvement during look-back period.</p>	<ul style="list-style-type: none"> • OHIC has determined that meaningful performance data must be practice-wide. Therefore, data must come either from practice submissions or from the All-Payer Claims Database (APCD). Because the APCD is not yet fully functional, OHIC would like to assess the feasibility of practices submitting data to CTC or some other organization promoting practice transformation. • Regardless of the source of the data, practices would not be required to demonstrate improvement until September 30, 2017. • The 2016-submitted data will help to set a baseline for measuring transformation.

¹ The measurement data and data sources are yet to be defined.

2016		
<p>Payment Model (for practices meeting the three PCMH definition requirements and included in the insurer's PCMH count for OHIC target compliance purposes)</p>	<p>Eligible to receive infrastructure and CM/CC payments as of January 1, 2016, so long as the practice is participating in a transformation initiative.</p>	<p>Practices with Less than 2 Year of Transformation Experience</p> <ul style="list-style-type: none"> The payment model outlines minimum requirements for payers to meet. Payers may have existing (or future) contracts with providers whose terms exceed these minimum standards. Once a practice attains NCQA Level 3 recognition, the payer is not required to make infrastructure payments. In 2016, payers would be expected to make financial payments to practices that participate in a recognized transformation initiative. The payer is expected to continue making financial payments as of January 1, 2017, only if the practice 1) participates in a transformation initiative, and 2) was successful in meeting the Cost Management Strategies requirements. The payer is expected to continue making financial payment as of January 1, 2018, only if the practice, 1) achieved NCQA Level 3 recognition, 2) was successful in meeting Cost Management Strategies requirements, and 4) was able to show improvement based on data submitted on September 30, 2017. Payment levels are either those agreed upon under a specific transformation initiative or those negotiated between the insurer and the provider. <p>Practices with More Than 2 Years of Transformation Experience</p> <ul style="list-style-type: none"> In 2016, payers would be expected to make financial payments to practices that have achieved NCQA Level 3 recognition and are being counted towards the plan's PCMH target. Payers would be expected to make financial payments to these practices in 2017 only if the practices

2016		
		<p>demonstrated compliance with NCQA Level 3 and Year 1 Cost Strategy implementation requirements by September 30, 2016.</p> <ul style="list-style-type: none"> • Payers would be expected to make financial payments to these practices in 2018 only if the practices demonstrated compliance with all three definitional requirements by September 30, 2017.

B. OHIC Activities		
<p>Initiative Launch: Between November 1, 2015 and April 30, 2016:</p> <ul style="list-style-type: none"> • Coordinate with CTC and payers to create list of practices that payers want to include in PCMH target calculation for 2016. • Payers work with CTC and among themselves to send letter to practices informing them of opportunity for Financial Payments. • 4/30/16: Create OHIC webpage with PCMH information. • 4/30/16: Work with transformation program to create physician application portal and application process. • On-going: Advertise PCMH initiative. <p>By September 30, 2016 and annually thereafter:</p> <ul style="list-style-type: none"> • Determine applicant practices' participation status in transformation initiatives. • Collect and analyze NCQA Level 3 recognition information. <p>By November 1, 2016 and annually thereafter:</p> <ul style="list-style-type: none"> • Create and maintain website to collect Cost Management Strategies Survey results and to upload performance measurement data (if practice-reported). Obtain performance measurement data from APCD, when functional. • Collect and analyze Cost Management Strategies Survey results. • Collect and analyze performance improvement data. • Add practices' participation status and NCQA Level to database. • Identify practices that meet the OHIC PCMH definition; respond to inquiries regarding methodology. • Calculate insurance compliance with OHIC target. • Notify practices of the results of OHIC's assessment. • Notify insurers of the results of OHIC's assessment of practices and target compliance calculation. • Obtain information from payers, transformation initiatives and through practice applications to identify and notify insurers of new applicant practices. 		

<p>Ongoing</p> <ul style="list-style-type: none"> • Maintain and update webpage with PCMH information and monitor application portal. • Promote awareness of PCMH initiative. • Obtain insurer and provider input regarding OHIC definition of PCMH and implementation processes.
--

II. Practices Qualifying to be Included in the Calculation of PCMH Targets

Target Year/ Practice Category	As of December 31, 2016	As of December 31, 2017	As of December 31, 2018
Practices with <u>less than</u> 2 years of transformation experience as of September 30, 2016	Practices achieving NCQA PCMH Level 3 recognition OR receiving Financial Payments consistent with the Financial Payment Model	Practices that meet the following requirements: <ul style="list-style-type: none"> • Participated in a transformation initiative from January 1 through September 30, 2017 • Completed Cost Strategy self-assessment and met Year 1 requirements • Submitted performance measurement data and demonstrated improvements. 	Practices that meet the following requirements: <ul style="list-style-type: none"> • Participated in a transformation initiative from January 1 through September 30, 2018 OR achieved NCQA PCMH Level 3 recognition • Completed Cost Strategy self-assessment and met Year 2 requirements • Submitted performance measurement data and demonstrated improvements.
Practices with <u>more than</u> 2 years of transformation experience as of September 30, 2016	Practices achieving NCQA PCMH Level 3 recognition OR receiving Financial Payments consistent with the Financial Payment Model AND implemented Year 1 Cost Management Strategies	Practices that meet the following requirements: <ul style="list-style-type: none"> • Participated in a transformation initiative from January 1 through September 30, 2017 OR achieved NCQA PCMH Level 3 recognition. • Completed Cost Strategy 	Practices that meet the following requirements: <ul style="list-style-type: none"> • Participated in a transformation initiative from January 1 through September 30, 2018 OR achieved NCQA PCMH Level 3 recognition • Completed Cost Strategy self-assessment and met Year 3

Target Year/ Practice Category	As of December 31, 2016	As of December 31, 2017	As of December 31, 2018
		self-assessment and met Year 2 requirements. <ul style="list-style-type: none"> • Submitted performance measurement data and demonstrated improvements. 	requirements <ul style="list-style-type: none"> • Submitted performance measurement data and demonstrated improvements.

Crosswalk of Rhode Island PCMH Cost Management Strategies to
 NCQA PCMH Standards and
 Transforming Clinical Practice Initiative Phase Milestones
 December 14, 2015

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 <u>all</u> of the following functions:				Must be implemented or deemed met by the end of:		
Cost Management Requirement	NCQA Requirement	TCPI Requirement	OHIC Deeming Recommendation	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 comorbidities, psychosocial status, advanced age with frailty and multiple risk factors.	<u>Phase 3. H:</u> Practice has identified high risk patients and has ensured they are receiving appropriate care and case management services. <u>Phase 4. D:</u> Practice has process in place for identifying 90% of high risk patients on a monthly basis and has ensured that 75% are receiving appropriate care and case management	NCQA: Allow deeming TCPI: allow deeming if Milestone 4D is achieved	x		

The practice must perform <u>all</u> of the following functions:					Must be implemented or deemed met by the end of:		
Cost Management Requirement	NCQA Requirement	TCPI Requirement	OHIC Deeming Recommendation	Yr 1	Yr 2	Yr 3	
	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.	services as part of their continuous practice improvement plan.					
2. 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.	<u>Phase 3. H:</u> Practice has identified high risk patients and has ensured they are receiving appropriate care and case management services. <u>Phase 4. D:</u> Practice has process in place for identifying 90% of high risk patients on a monthly basis and has ensured that 75% are receiving appropriate care and case management services as part of their continuous practice	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.	x			

The practice must perform <u>all</u> of the following functions:					Must be implemented or deemed met by the end of:		
Cost Management Requirement	NCQA Requirement	TCPI Requirement	OHIC Deeming Recommendation	Yr 1	Yr 2	Yr 3	
		improvement plan.					
3. To identify high-risk patients, the practice has developed a risk assessment methodology that includes at a minimum the consideration of the following factors: <ul style="list-style-type: none"> a. assessment of patients based on co-morbidities; b. inpatient utilization c. emergency department utilization 	<p>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.</p> <p>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.</p>	<p><u>Phase 2.A:</u> Practice starts to capture and analyze population, disease specific, and relevant quality measures for utilization, billing data and tests ordered from their registry, practice management or EHR system to drive clinical practice improvement and resulting in reduced unnecessary tests and hospitalizations.</p>	<p>NCQA: Allow deeming</p> <p>TCPI: Do not allow deeming, because the requirement is too broadly stated.</p>	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 <u>all</u> of the following functions:				Must be implemented or deemed met by the end of:		
Cost Management Requirement	NCQA Requirement	TCPI Requirement	Deeming Recommendation	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.	None comparable	NCQA: Allow partial deeming. Separately verify that the practices are employing an RN/LPN or social worker as CM/CC. TCPI: N/A	x		
2. 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	No NCQA requirement.	Practice identifies patient risk stratification by disease, health risk and other conditions. (Phase 3H)	NCQA: N/A TCPI: allow partial deeming. Separately verify that practice's methodology is consistent with the Affordability Standard requirement to consider clinical information	x		

The practice must perform <u>all</u> of the following functions:				Must be implemented or deemed met by the end of:		
Cost Management Requirement	NCQA Requirement	TCPI Requirement	Deeming Recommendation	Yr 1	Yr 2	Yr 3
promptly identify which high-risk patients should be in the care manager's/care coordinator's active caseload at any point in time.			including severity level and other patient-specific characteristics.			
3. The care manager/care coordinator completes within a specified period of time (<u>from the time that the high-risk patient is placed in the care manager's/care coordinator's active caseload</u>) 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: a. 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,	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,	<u>Phase 1.F:</u> Practice has in place mechanisms for addressing the needs of their patients/families to be active partners in care.	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.	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.

The practice must perform <u>all</u> of the following functions:				Must be implemented or deemed met by the end of:		
Cost Management Requirement	NCQA Requirement	TCPI Requirement	Deeming Recommendation	Yr 1	Yr 2	Yr 3
relationships, and functioning; cultural beliefs and values of family; strengths/assets of child, youth, family/caregivers, and current goals of child, youth & family), and b. 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).	assesses and addresses potential barriers to meeting goals, includes a self-management plan and is given in writing to the patient/family/caregiver					
4. 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: a. a medical/social summary b. risk factors c. treatment goals d. patient-generated goals e. barriers to meeting goals f. 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,	<u>Phase 1.F:</u> Practice has in place mechanisms for addressing the needs of their patients/families to be active partners in care. <u>Phase 3.E:</u> Practice routinely creates and /or maintains shared care plans and utilizes shared decision-making tools to incorporate patient	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	x		

The practice must perform <u>all</u> of the following functions:				Must be implemented or deemed met by the end of:		
Cost Management Requirement	NCQA Requirement	TCPI Requirement	Deeming Recommendation	Yr 1	Yr 2	Yr 3
	<p>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.</p> <p>2014 NCQA PCMH 4 requires that 75% of patients on high risk list have a care plan.</p>	<p>preferences and goals in care management process.</p>	<p>content of written patient care plan. Separately verify that the practice is meeting the timeline.</p> <p>TCPI: do not allow deeming, as TCPI's requirements are not sufficiently specific.</p>			
<p>5. 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.</p>	<p>2011 NCQA PCMH 3, Element C requires the care team to review and update treatment goals at each relevant visit.</p> <p>2014 NCQA PCMH 4 requires regular updating and that 75% of patients on high risk list have a care plan.</p>	<p><u>Phase 1. F:</u> Practice has in place mechanisms for addressing the needs of their patients/families to be active partners in care.</p>	<p>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.</p> <p>TCPI: do not allow deeming, as TCPI's requirements are not sufficiently specific.</p>	x		
<p>6. For high-risk patients known to be hospitalized or in a SNF, the care management/care coordination resources shall contact the patient</p>	<p>2011 and 2014 NCQA PCMH 5, Element C, Factor 4 requires practices to proactively</p>	<p><u>Phase 3.N:</u> Practice follows up with patients within 24 hours after an</p>	<p>NCQA: Allow partial deeming and separately verify that the practices are beginning TOC</p>		x	

The practice must perform <u>all</u> of the following functions:				Must be implemented or deemed met by the end of:		
Cost Management Requirement	NCQA Requirement	TCPI Requirement	Deeming Recommendation	Yr 1	Yr 2	Yr 3
and/or the hospital discharge planner and begin transition-of-care planning at least 24-hours prior to the patient's discharge.	contact patient/families for appropriate follow-up care within an appropriate period following a hospital admission or ED visit. No timeframes are specified.	emergency room visit or hospital discharge	planning within the required timeframe. TCPI: Do not allow deeming as the standards are not consistent.			
7. 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	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.	<u>Phase 3.N:</u> Practice follows up with patients within 24 hours after an emergency room visit or hospital discharge	NCQA: Allow partial deeming and separately verify that the practices are meeting the specific timeframe for completing the outreach contacts. TCPI: allow deeming	x	x	x
8. 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	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	<u>Phase 3.N:</u> Practice follows up with patients within 24 hours after an emergency room visit or hospital discharge	NCQA: Allow partial deeming and separately verify that the practices are meeting the specific timeframe for completing the outreach contacts. TCPI: allow deeming	x	x	x

² During Year 1 contact must occur within 72 hours of discharge and in Years 2 and 3 contact must occur within 48 hours.

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.

The practice must perform <u>all</u> of the following functions:				Must be implemented or deemed met by the end of:		
Cost Management Requirement	NCQA Requirement	TCPI Requirement	Deeming Recommendation	Yr 1	Yr 2	Yr 3
	following a hospital admission or ED visit. No timeframes are specified.					
9. 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	<p>2011 NCQA PCMH 3, Element D specifies percentages of care transitions for which medication reconciliations are to be done.</p> <p>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</p>	<p><u>Phase 2. F:</u> The practice implements at least three specific care management strategies for patients in higher risk cohorts, samples may include, but are not limited to: -integration of behavioral health -self-management support for at least 3 high risk conditions - medication management review</p>	<p>NCQA: Allow partial deeming and separately verify that the practices are meeting the specific timeframe for completing the medication reconciliations.</p> <p>TCPI: allow deeming if the practice has selected medication management review as one of its case management strategies.</p>	x	x	x

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.

The practice must perform <u>all</u> of the following functions:				Must be implemented or deemed met by the end of:		
Cost Management Requirement	NCQA Requirement	TCPI Requirement	Deeming Recommendation	Yr 1	Yr 2	Yr 3
	by the practices.					
10. The care management/care coordination resources arrange for, and coordinate all medical, developmental, behavioral health and social service referrals and tracks ⁵ referrals and test results on a timely basis for high-risk patients.	<p>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.</p> <p>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</p>	<p><u>Phase 3. M:</u> Practice tracks and supports patients when they obtain services outside the practice.</p> <p><u>Phase 4. E:</u> Practice tracks patients, on a monthly basis, when they obtain services outside of the practice.</p>	<p>NCQA: Allow deeming</p> <p>TCPI: allow deeming once milestone Phase 4.E is achieved.</p>	x		

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.”

The practice must perform <u>all</u> of the following functions:				Must be implemented or deemed met by the end of:		
Cost Management Requirement	NCQA Requirement	TCPI Requirement	Deeming Recommendation	Yr 1	Yr 2	Yr 3
	services.					
11. 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.	<p>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.</p> <p>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.</p>	<u>Phase 3.E.</u> Practice routinely creates and/or maintains shared care plans and utilizes shared decision making tools to incorporate patient preferences and goals in care management process.	<p>NCQA: Allow deeming</p> <p>TCPI: Do not allow deeming, as the standard is too general.</p>	x		
12. Practices shall provide patient-engagement training to care managers/care coordinators, as necessary, to achieve these	No NCQA requirements	<u>Phase 1. C.</u> Practice starts to train at least 50% of staff in improvement methods	<p>NCQA: N/A</p> <p>TCPI: allow partial deeming. Separately</p>	x		

The practice must perform <u>all</u> of the following functions:				Must be implemented or deemed met by the end of:		
Cost Management Requirement	NCQA Requirement	TCPI Requirement	Deeming Recommendation	Yr 1	Yr 2	Yr 3
requirements		and tools. Staff starts to understand the process of improvement and how to test changes in daily workflows. Staff is trained on optimal team-based practice. <u>Phase 1. D.</u> Practice has a process in place for training staff on data quality problems when they are detected.	verify that training topics include patient engagement.			
13. 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	<u>Phase 1.F:</u> Practice has in place mechanisms for addressing the needs of their patients/families to be active partners in care.	NCQA: The 2011 and 2014 NCQA standards do not include specific contact requirements. Do not allow deeming TCPI: No not allow deeming, as the requirement is too general.	x		
14. The care management/care coordination resources participate in relevant team-based care meetings to assure whole-person	2011 NCQA PCMH 1, Element G requires the practice to use a team to provide a range of patient	<u>Phase 3. D:</u> Practice sets clear expectations for each team member's functions	NCQA: Allow deeming TCPI: do not allow deeming, as the	x		

The practice must perform <u>all</u> of the following functions:				Must be implemented or deemed met by the end of:		
Cost Management Requirement	NCQA Requirement	TCPI Requirement	Deeming Recommendation	Yr 1	Yr 2	Yr 3
<p>care is provided to high-risk patients.</p> <p>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.</p>	<p>care services.</p> <p>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.</p>	<p>and responsibilities to optimize efficiency, outcomes and accountability.</p>	<p>requirement is too general.</p>			
<p>15. The care management/care coordination resources use HIT to document and monitor care management service provision.</p>	<p>No NCQA requirement.</p>	<p><u>Phase 1. E:</u> Practice establishes measures, plans and a baseline for intentionally minimizing unnecessary testing and procedures.</p> <p><u>Phase 2.A:</u> Practice starts to capture and analyze population, disease specific and relevant quality measures for utilization, billing data and tests ordered</p>	<p>NCQA: N/A</p> <p>TCPI: do not allow deeming, as requirements are not consistent.</p>	x		

The practice must perform <u>all</u> of the following functions:				Must be implemented or deemed met by the end of:		
Cost Management Requirement	NCQA Requirement	TCPI Requirement	Deeming Recommendation	Yr 1	Yr 2	Yr 3
		from their registry, practice management or EHR system to drive clinical practice improvement and resulting in reduced unnecessary tests and hospitalizations.				
16. The care management/care coordination resources participate in formal practice quality improvement initiatives to assess and improve effectiveness of care management service delivery	<p>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.</p> <p>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</p>	<p>Phase 2. H: Practice incorporates regular improvement methodology to execute change ideas in rapid cycle. Use a plan-do-study-act (PDSA) quality improvement cycle of small scale tests of change in the practice setting.</p> <p>Phase 4. A: Practice uses utilization reports on a monthly basis and continuously makes clinical improvement changes such as 24/7 access to care, same as tracking</p>	<p>NCQA: Allow deeming</p> <p>TCPI: Allow partial deeming when Phase 2.H is achieved. Separately verify that PDSA cycles assess and improve effectiveness of care management service delivery</p> <p>Allow deeming when Phase 4.A milestone is achieved.</p>	x		

The practice must perform <u>all</u> of the following functions:				Must be implemented or deemed met by the end of:		
Cost Management Requirement	NCQA Requirement	TCPI Requirement	Deeming Recommendation	Yr 1	Yr 2	Yr 3
	resources use and care coordination.	number of patients triaged after hours, number of same day appointments for emergent problems, number of patients being discharged from the hospital and needing an appointment with 24 hours after discharge, and the practice continues to decrease the no show rate over time.				

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

Cost Management Requirement	NCQA Requirement	TCPI Requirement	Deeming Recommendation
The practice has implemented <u>one</u> of the following approaches to behavioral health integration by the end of Year 1			
<p>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.</p>	<p>2011 NCQA PCMH 1, Element E requires a PCMH to coordinate patient care across multiple settings, including behavioral health.</p> <p>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.</p> <p>2014 NCQA PCMH 5, Element B, Factor 4: Integrates behavioral healthcare providers within the practice site.</p>	<p><u>Phase 2. F:</u> The practice implements at least three specific care management strategies for patients in higher risk cohorts, samples may include, but are not limited to: -integration of behavioral health -self-management support for at least 3 high risk conditions -medication management review</p>	<p>2011 PCMH NCQA requirements lack specificity around better coordinating behavioral health services.</p> <p>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.</p> <p>NCQA: Do not allow deeming.</p> <p>TCPI: Do not allow deeming. Requirements regarding behavioral health integration are insufficiently specific.</p>
<p>2. To promote better access to and coordination of behavioral health services, the practice has arranged</p>	<p>No NCQA requirement.</p>	<p>Same as above</p>	<p>NCQA: N/A</p> <p>TCPI: same as above.</p>

<p>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).</p>			
<p>3. 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.</p>	<p>No NCQA requirement.</p>	<p>Same as above</p>	<p>NCQA: N/A TCPI: same as above.</p>

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	TCPI Requirements	Deeming Recommendation	Must be implemented or deemed met by the end of:		
The practice must perform all of the following functions:				Yr 1	Yr 2	Yr 3
<p>1. The practice has a written policy to respond to patient telephone calls within the following timeframes:</p> <ul style="list-style-type: none"> a. For urgent medical/behavioral calls received during office hours, return calls are made the same day. b. For urgent calls received after office hours, return calls are made within 1 hour. c. For all non-time-sensitive calls, return calls are made within 2 business days of receiving the call. 	<p>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.</p> <p>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</p>	<p><u>Phase 1. F:</u> Practice has in place mechanisms for addressing the needs of their patients/families to be active partners in care.</p> <p><u>Phase 4. A.</u> Practice uses utilization reports on a monthly basis and continuously makes clinical improvement changes such as 24/7 access to care, 'same as' tracking number of patients triaged after hours, number of same day appointments for emergent problems, number of patients</p>	<p>NCQA: Allow partial deeming. Separately verify that the practices have written policies that meet the specified time frames for responding to patient calls.</p> <p>TCPI: Do not allow deeming, as the requirements are not sufficiently specific.</p>	x		

Cost Management Requirement	NCQA Requirement	TCPI Requirements	Deeming Recommendation	Must be implemented or deemed met by the end of:		
	the office is closed. The time frame is defined by the practice to meet the clinical needs of the patient population.	being discharged from the hospital and needing an appointment with 24 hours after discharge, and the practice continues to decrease the 'no show' rate over time.				
2. The practice has implemented same-day scheduling, such that patients can call and schedule an appointment for the same day. ⁶	<p>2011 NCQA PCMH has a written process and defined standards for providing same-day appointments (Factor 1).</p> <p>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)</p>	Same as Number 1, above.	<p>NCQA 2011: Allow deeming if the practice passes Factor 1.</p> <p>NCQA 2014: Allow deeming.</p> <p>TCPI: Do not allow deeming, as requirements are not sufficiently specific.</p>	x	x	x
3. The practice has an agreement with	No NCQA requirement.	Same as Number 1,	N/A	x		

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.”

Cost Management Requirement	NCQA Requirement	TCPI Requirements	Deeming Recommendation	Must be implemented or deemed met by the end of:		
(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.		above.	TCPI: Do not allow deeming, as requirements are not sufficiently specific.			
4. The practice utilizes formal quality improvement processes to assess and improve the effectiveness of its programs to expand access.	<p>2011 does not include QI initiatives to improve access.</p> <p>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.</p>	<p><u>Phase 2.H</u> Practice incorporates regular improvement methodology to execute change ideas in rapid cycle. Use a plan-do-study-act (PDSA) quality improvement cycle of small scale tests of change in the practice setting.</p> <p><u>Phase 4. A.</u> Practice uses utilization reports on a monthly basis and continuously makes clinical improvement changes such as 24/7 access to care, same as tracking number of patients triaged after hours, number of same day</p>	<p>NCQA 2011: Do not allow deeming.</p> <p>NCQA 2014: Allow deeming.</p> <p>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.</p> <p>Allow deeming once Phase 4. A milestone is achieved.</p>	x		

Cost Management Requirement	NCQA Requirement	TCPI Requirements	Deeming Recommendation	Must be implemented or deemed met by the end of:		
		appointments for emergent problems, number of patients being discharged from the hospital and needing an appointment with 24 hours after discharge, and the practice continues to decrease the no show rate over time.				
The practice must perform at least 2 of the following functions:						
<p>1. The practice has created a secure web portal that enables patients to:</p> <ul style="list-style-type: none"> • send and receive secure messaging • request appointments • request referrals • request prescription refills • review lab and imaging results⁷ <p>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.</p>	<p>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).</p> <p>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</p>	N/A	<p>NCQA: Allow deeming.</p> <p>TCPI: N/A</p>	x	x	x

⁷ All functions, except lab and imaging, must be functional in Years 1 and 2. All functions must be functional in Year 3.

Cost Management Requirement	NCQA Requirement	TCPI Requirements	Deeming Recommendation	Must be implemented or deemed met by the end of:		
<p>2. 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</p>	<p>2011 NCQA PCMH 1, Element BG, Factor 2 requires practices to provide access to routine and urgent-care appointments outside regular business hours.</p> <p>2014 NCQA PCMH 1, Element A, Factor 2: requires practices to provide routine and urgent care appointments outside of regular business hours. Practices are encouraged 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.</p>	N/A	<p>The 2011 and 2014 NCQA standards are not specific regarding expanded office hours.</p> <p>NCQA: Do not allow deeming.</p> <p>TCPI: N/A</p>		x	x

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.

Cost Management Requirement	NCQA Requirement	TCPI Requirements	Deeming Recommendation	Must be implemented or deemed met by the end of:		
	NCQA examples of extended access include: <ul style="list-style-type: none"> •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). 					
3. 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	2011 and 2014 NCQA PCMH standards: Same as above. NCQA is less specific regarding to what extent hours must be expanded.	N/A	The 2011 and 2014 NCQA standards are not specific regarding expanded office hours. NCQA: Do not allow deeming. TCPI: N/A		x	x

⁹During 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.

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

Cost Management Requirement	NCQA Requirement	TCPI Requirements	Deeming Recommendation	Must be implemented by the end of:		
The practice must perform <u>all</u> of the following functions:				Yr 1	Yr 2	Yr 3
<p>1. The practice has developed referral protocols for its patients for at least two of the following:</p> <ul style="list-style-type: none"> a. one high-volume specialty, such as cardiovascular specialist, pulmonary specialist, orthopedic surgeon or endocrinologist; b. laboratory services; c. imaging services; d. physical therapy services, and e. home health agency services. 	<p>2011 NCQA PCMH 5, Element B, Factor 4: practice establishes and documents agreements with specialists in the medical record if co-management is needed.</p> <p>2014 NCQA PCMH 5, Element B, Factor 2: practice maintains formal and informal agreements with a subset of specialists based on established criteria.</p> <p>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.</p>	<p><u>Phase 2. B:</u> Practice has identified community partners and other points of care that their patients are using and has formal agreement in place with these partners.</p>	<p>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.</p> <p>NCQA: Do not allow deeming.</p> <p>TCPI: Allow partial deeming and separately verify that the community partners include those required under Requirement 5.1.</p>	x		
<p>2. Should one or more payers provide the practice with readily available, actionable data, the practice has used such data and any other</p>	<p>2011 NCQA PCMH 5 does not address use of data to make specialty referrals.</p>	<p>N/A</p>	<p>The NCQA 2011 and 2014 standards list potential sources of performance information, but does not</p>		x	

<p>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.</p>	<p>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)</p>		<p>focus on information related to “high-value referral service providers.”</p> <p>NCQA: Do not allow deeming.</p> <p>TCPI: N/A</p>			
--	---	--	---	--	--	--