

Standards and Guidelines for NCQA Patient-Centered Medical Home 2014



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The PCMH Advisory Committee

NCQA began planning for the next version of the PCMH standards shortly after the 2011 standards were released. From the 2011 release date, we solicited, received and catalogued suggestions for future modifications. Early in 2013, we assembled the PCMH Advisory Committee, a diverse, 21-member committee composed of representatives from practices, medical associations, physician groups, health plans and consumer and employer groups. The committee met throughout 2013 to discuss and analyze draft standards, PCMH data analysis and public comment results.

The committee shaped updates to accomplish the following in PCMH 2014:

1. Emphasize team-based care.
2. Focus care management on high-need populations.
3. Set the bar higher and align quality improvement activities with the Triple Aim.¹
4. Align with Meaningful Use Stage 2 (MU2).
5. Further integration of behavioral healthcare.

The importance of this committee cannot be overstated. Its members gave their time, energy, enthusiasm and a willingness to hear and compromise on opposing perspectives. The PCMH 2014 standards are a reflection of their hard work and collaboration.

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¹<http://www.ihl.org/Engage/Initiatives/TripleAim/Pages/default.aspx>

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Overview

NCQA's Patient-Centered Medical Home 2014

Patient-centered medical homes (PCMH) are transforming primary care practices into what patients want: a focus on patients themselves and their health care needs. Medical homes are the foundation for a health care system that gives more value by achieving the “Triple Aim” of better quality, experience and cost. This is the overview to our vision for achieving that goal; it chronicles the PCMH evolution to date, the challenges that lie ahead and potential solutions to those challenges—some already underway, some yet to be developed.

As of February 2014, 7,066 practices were recognized as PCMHs by NCQA, which has the nation's largest PCMH program. To earn NCQA Recognition, practices must meet rigorous standards for addressing patient needs; for example, offering access after office hours and online so patients get care and advice, where and when they need it. PCMHs get to know patients in long-term partnerships, rather than through hurried, sporadic visits. They make treatment decisions with their patients, based on patient preference. They help patients become engaged in their own healthy behaviors and health care.

Everyone in the practice—from clinicians to front desk staff—works as a team to coordinate care from other providers and community resources. This maximizes efficiency by ensuring that highly trained clinicians are not performing tasks that can be accomplished by other staff, and helps avoid costly and preventable complications and emergencies through a focus on prevention and managing chronic conditions.

A growing body of evidence documents the many benefits of medical homes, including better quality, patient experience, continuity, prevention and disease management. Studies show lower costs from reduced emergency department (ED) visits and hospital admissions, reduced income-based disparities in care and lower rates of provider burnout.

PCMHs' power to improve the quality, cost and experience of primary care, however, only begins the broad change our health care system needs. Other providers and facilities must build on PCMH foundations to establish patient-centered care throughout health care. This is beginning in the patient-centered specialty practices (PCSP), which help specialists become part of medical neighborhoods to improve quality and access.

Adoption of patient-centered strategies is also underway in many emerging accountable care organizations (ACO). ACOs build on a solid PCMH foundation to coordinate doctors, hospitals, pharmacies, other providers and community resources and make sure people get all the care they need. They share savings from reduced waste and inefficiency if they also improve quality.

Goals for PCMH and Beyond

- Primary care clinicians will deliver safe, effective and efficient care that is well coordinated across the medical neighborhood and optimizes the patient experience.
- Primary care will be the foundation of a high-value health care system that provides whole-person care at the first contact. Everyone in primary care practices—from physicians and advanced practice nurses to medical assistants and frontline staff—should practice to the highest level of their training and license in teams, to support better access, self-care and care coordination.
- PCMHs will show the entire health care system what patient-centered care looks like: care that is “respectful of and responsive to individual patient preferences, needs, and values, and ensures that patient values guide all clinical decisions.” Individuals and families get help to be actively engaged in their own healthy behaviors and health care, and in decisions about their care.
- PCMHs will revitalize the “joy of practice” in primary care, making it more appealing and satisfying.

This vision is becoming reality in many parts of the country. For example, in Vermont, NCQA-Recognized PCMHs are being widely adopted as the foundation for the state’s “Blueprint for Health.” Purchasers and policymakers there are engaging a broader set of providers—specialists, hospital systems and community providers of social and long-term services and supports—to align incentives for better value.

The medical neighborhood. Although primary care is the foundation for delivery system transformation, PCMHs cannot change the entire system alone. Data sharing among primary care, specialists, hospitals and other providers is needed to maximize coordination and management. Our current payment system drives greater use of services, especially high-volume services for hospitals and many specialists. Primary-care spending is low and a small share, compared with other providers, which limits access to capital for information technology and other systems to support outreach, patient engagement and analysis. Other parts of the system must also have strong incentives to change if we are to realize better outcomes.

Patient-centered specialty practices. Specialty-care clinicians provide many services and many patients seek specialists’ care directly without primary care consultation. For patients with certain chronic conditions, specialists serve as primary-care providers for extended periods. Creating better ways for information to flow effectively among primary-care clinicians and specialists is critical for care coordination and reducing duplicate care. In 2013 NCQA launched the Patient-Centered Specialty Practice (PCSP) program to recognize specialists that use systems and processes needed to support patient-centered care, including strong communication with other providers.

Accountable care organizations. ACOs are bringing communities of doctors, hospitals and other providers together to improve outcomes and lower costs. They share in savings if they can show improved quality. Medicare and other insurers now support these “shared savings” opportunities. PCMHs provide the solid foundation that ACOs must build on to ensure quality, patient-centered care. ACOs can help build and redistribute funding to primary care, to develop the critically important PCMH infrastructure.

Behavioral healthcare. This is a key focus for better integration, particularly in Medicaid, where many high-cost enrollees have behavioral conditions. Integrating behavioral healthcare poses additional challenges from heightened privacy concerns, culture differences and patients’ tendency to avoid primary care. Unaddressed behavioral conditions can exacerbate physical conditions, which increases disability and cost. Medicaid “health home” initiatives are now working to bring primary care into behavioral health practices or to provide behavioral healthcare expertise in primary care settings. Some states use NCQA’s PCMH and PCSP standards to define health home capabilities.

Public health: Bringing complementary strengths of public health and primary care together has great potential. Some public health providers—school-based, HIV and community health centers—provide primary care and can be PCMHs. The Health Resources and Services Administration is helping community health centers become PCMHs. North Carolina is using public health staff to visit at-risk pregnant women in their homes, to help primary care providers engage these patients and get them better prenatal care. Vermont is connecting its PCMHs and providers of long-term services and supports, to deliver much-needed information and care coordination to patients. Going forward, it will be critical to help all PCMHs connect with community resources that can also improve health.

Work site, retail clinics and pharmacies. Work-site clinics increasingly serve as employees’ main primary care setting. Retail clinics that treat minor problems in drug stores and other convenient settings are expanding to address wellness, health promotion and chronic care management. Many refer patients back to community primary-care clinicians for follow-up. Pharmacies are also taking on new roles with immunizations, health and wellness screenings, adherence and other medication management services. As these options gain in popularity and scope, it becomes increasingly important that they share information with PCMHs.

NCQA PCMH Evolution

The American Academy of Pediatrics introduced the medical home concept in 1967. A generation later, in 2004 the specialty of family medicine called for all patients to have a “personal medical home.” In 2003 NCQA launched Physician Practice Connections, a PCMH precursor program. In 2007, leading primary care associations released the Joint PCMH Principles. In 2008, NCQA launched the first PCMH Recognition program, with updates to raise the bar in 2011 and 2014. NCQA’s PCMH program is the largest, with over 34,600 clinicians at 6,800 sites as of December 31, 2013—about 10 percent of all primary care clinicians.

Year	Version	Elements of the Program
2003	Physician Practice Connections (PPC)	This PCMH precursor recognized use of systematic processes and health IT to: <ul style="list-style-type: none"> • Know and use patient history. • Follow up with patients and other providers. • Manage patient populations and use evidence-based care. • Employ electronic tools to prevent medical errors.
2008	Physician Practice Connections—Patient-Centered Medical Home (PPC-PCMH)	The first PCMH model implemented the Joint Principles, emphasizing: <ul style="list-style-type: none"> • Ongoing relationship with personal physician. • Team-based care. • Whole-person orientation. • Care coordination and integration. • Focus on quality, safety and enhanced access.
2011	PCMH 2011	<ul style="list-style-type: none"> • Explicitly incorporated health information technology Meaningful Use criteria. • Added content and examples for pediatric practices on parental decision making, age-appropriate immunizations, teen privacy and other issues. • Added voluntary distinction for practices that participate in the CAHPS PCMH survey of patient experience and submit data to NCQA. • Added content and examples for behavioral healthcare.
2014	PCMH 2014	<ul style="list-style-type: none"> • More integration of behavioral healthcare. • Additional emphasis on team-based care. • Focus care management for high-need populations. • Encourage involvement of patients and families in QI activities • Alignment of QI activities with the Triple Aim: improved quality, cost and experience of care. • Alignment with health information technology Meaningful Use Stage 2.

Broad support. Many public- and private-sector initiatives support PCMH transformation. The Department of Defense is working to transform its primary care practices into NCQA PCMHs. The Department of Health and Human Services is helping hundreds of community health centers and Federally Qualified Health Centers to become PCMHs. The Office of the National Coordinator for Health Information Technology’s Regional Extension Centers provide technical assistance to practices. Congress is advancing legislation to move Medicare beyond demonstration programs in selected states to support PCMHs nationwide, with new payments to reward value and non-face-to-face chronic care management services. In addition, states and private insurers have programs in place to support PCMHs in more than three dozen states.

Practices of all sizes earn NCQA Recognition. Most have fewer than eight clinicians; more than a third have one or two. More than 75 percent of NCQA PCMHs have achieved Level 3 Recognition, representing the most advanced capabilities.

PCMH penetration is greatest in states that provide the most technical and financial support in making the transformation. In New York State, for example, 25 percent of all primary-care practitioners are in NCQA-Recognized PCMHs.

Attributes for success. There are many paths to becoming successful PCMHs—they do not all look alike and generally consider local circumstances and preferences. NCQA has identified several attributes that contribute to PCMH success:

- Financial or technical assistance, or both, to help create and sustain the transformation. Practices value practical examples and support for meeting requirements, and worry about maintaining their financial viability.
- Organization leadership, a team-based approach, health information technology and delegating self-management education and proactive care reminders to nonphysician team members.
- Involving patients and families in practice improvement efforts through advisory committees, ombudsmen or navigators.
- A systems approach to QI that results in data, standard measurements, technical assistance, leadership and personnel.

PCMH 2014

Development

Pediatricians performed the early work on the “medical home” concept, which focused on care of children with special needs. The concept was developed further by a collaboration of primary care physician societies* and was articulated in the 2007 Joint Principles of the Patient-Centered Medical Home and reflected in NCQA’s 2008 Physician Practice Connections®—Patient-Centered Medical Home™ (PPC®-PCMH™) standards. These Joint Principles continued as the foundation of the NCQA PCMH 2011 standards.

The PCMH 2014 standards will move the transformation of primary care practices forward, while ensuring that recognition is within reach of practices of varying sizes, configurations (e.g., solo, multi-site, community health center), electronic capabilities, populations served and locations (e.g., urban, rural).

Standards development was a rigorous process that included significant research; input from an engaged, multi-stakeholder advisory committee and from many others; results of an open public comment period; and interviews with NCQA-Recognized practices.

The Consumer Perspective

In developing the PCMH 2014 standards, we were guided by a strong consensus that we expand the patient-centered perspective. To ensure that we captured this vantage point, the advisory committee included a patient partner, consumer organization representatives and researchers working on related patient-centered areas, and we encouraged consumer participation during the public comment process.

Public Comment

We posted the draft standards on the NCQA Web site and solicited comments from a wide group of stakeholders. We received more than 1,600 comments from more than 150 respondents, including health care providers, health plans, consumer groups and government agencies. There was a high degree (nearly 90 percent of comments received) of support for the proposed standards, especially the increased emphasis on patient-centered, team-based care coordinated across the health care system.

*The American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP) and the American Osteopathic Association (AOA).

In addition to the formal public comment period, we received useful suggestions from others for further revisions and changes, which we incorporated into the final version of the standards after review by our stakeholder advisory committee, NCQA's Clinical Programs Committee and the NCQA Board of Directors.

The Standards

The PCMH 2014 program's six standards align with the core components of primary care.

1. PCMH 1: Patient-Centered Access.
2. PCMH 2: Team-Based Care.
3. PCMH 3: Population Health Management.
4. PCMH 4: Care Management and Support.
5. PCMH 5: Care Coordination and Care Transitions.
6. PCMH 6: Performance Measurement and Quality Improvement.

The Must-Pass Elements

Six must-pass elements are considered essential to the patient-centered medical home, and are required for practices at all recognition levels. Practices must achieve a score of 50% or higher on must-pass elements:

1. PCMH 1, Element A: Patient-Centered Appointment Access.
2. PCMH 2, Element D: The Practice Team.
3. PCMH 3, Element D: Use Data for Population Management.
4. PCMH 4, Element B: Care Planning and Self-Care Support.
5. PCMH 5, Element B: Referral Tracking and Follow-Up.
6. PCMH 6, Element D: Implement Continuous Quality Improvement.

Recognition Levels and Point Requirements

There are three levels of NCQA PCMH Recognition; each level reflects the degree to which a practice meets the requirements of the elements and factors that comprise the standards. For each element's requirements, NCQA provides examples and requires specific documentation.

The NCQA Recognition levels allow practices with a range of capabilities and sophistication to meet the standards' requirements successfully. The point allocation for the three levels is as follows.

- **Level 1:** 35–59 points and all 6 must-pass elements.
- **Level 2:** 60–84 points and all 6 must-pass elements.
- **Level 3:** 85–100 points and all 6 must-pass elements.

Initial Recognition vs. Renewal

To acknowledge that practices with current NCQA Level 2 or Level 3 Recognition have taken steps toward practice redesign and have systems in place that enabled their existing recognition level, NCQA offers a streamlined process for renewal through reduced documentation requirements. Practices that satisfactorily demonstrated basic medical home transformation can focus on more advanced aspects of redesign for their renewal applications.

Note: *Even though some elements do not require a practice to submit documentation, the practice must be able to produce documentation if it is selected for audit.*

Optional Distinction for Use of Standardized Patient Experience Survey

NCQA offers special acknowledgment for practices reporting results from a standardized patient experience survey. This option requires practices to use the Medical Home version of the CAHPS Clinician and Group Survey (CAHPS PCMH). Practices can earn distinction for collecting data through a certified vendor using the standardized survey, following the defined methods and reporting the results to NCQA.

Table 1: Summary of NCQA PCMH 2014 Standards

Standard	Summary of Requirements
PCMH 1: Patient-Centered Access	The practice provides 24/7 access to team-based care for both routine and urgent needs of patients/families/caregivers.
PCMH 2: Team-based Care	The practice provides continuity of care using culturally and linguistically appropriate, team-based approaches.
PCMH 3: Population Health Management	The practice provides evidence-based decision support and proactive care reminders based on complete patient information, health assessment and clinical data.
PCMH 4: Care Management and Support	The practice systematically identifies individual patients and plans, manages and coordinates care, based on need.
PCMH 5: Care Coordination and Care Transitions	The practice systematically tracks tests and coordinates care across specialty care, facility-based care and community organizations.
PCMH 6: Performance Measurement and Quality Improvement	The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience.

Table 2: Integration of PCMH 2014 Development Goals Into Standards

Development Goal	Additional Details
1. Emphasis on team-based care.	<ul style="list-style-type: none"> • PCMH 2, Element D: Is now a must-pass element. • Team-focused elements moved to the new <i>PCMH 2: Team-Based Care</i>. • To highlight the importance of the patient as part of the team, incorporating patients in improvement activities moved from PCMH 6 to PCMH 2.
2. Focus care management on high-need populations.	<ul style="list-style-type: none"> • Evidence-based decision support on an expanded range of topics (previously “three important conditions”) moved to <i>PCMH 3: Identify and Manage Populations</i>. <ul style="list-style-type: none"> – Element D: Use Data for Population Management: Practices proactively identify and support patient populations using evidence-based guidelines related to preventive care services, immunizations, chronic and acute care services, patients not recently seen by the practice and medication monitoring or alerts. – Element E: Implement Evidence-Based Decision Support: Practices use evidence-based guidelines to implement point of care clinical decision support for mental health or substance use disorders, a chronic medical condition, an acute condition, a condition related to unhealthy behaviors, well child or adult care and overuse/appropriateness issues. • Practices consider patients who may benefit from care management and self-care support. <ul style="list-style-type: none"> – PCMH 4, Element A: Identify Patients for Care Management: Practices establish a systematic process and criteria to monitor the total percentage of the population identified for care management. This requires considering behavioral health needs, patients experiencing high cost/high utilization, poorly controlled or complex conditions, social determinants of health and referrals by outside organizations (insurers, health systems, ACO) and nominations from care team staff, family and caregivers.
3. Higher bar and alignment of QI activities with the Triple Aim.	<ul style="list-style-type: none"> • Practices make efforts to improve in patient experience, cost and clinical quality. • Practices conduct activities at least annually and are subject to audit; renewing practices continue to benefit from streamlined requirements for existing capabilities to focus on improving outcomes and submit data from the previous 2 cycles of measurement.

Development Goal	Additional Details
4. Align with Meaningful Use Stage 2 (MU2)	<ul style="list-style-type: none"> All Meaningful Use Stage 2 requirements, both core and menu, are embedded within the PCMH Standards and Guidelines. MU2 is not a requirement for recognition. Practices without a certified EHR may submit documentation to meet factors related to MU2.
5. Further integration of behavioral health-care.	<ul style="list-style-type: none"> Updated criteria delineate capability for treating unhealthy behaviors and conditions related to mental health or substance abuse. Practices communicate the scope of services available, including how behavioral concerns are addressed. PCMH 5, Element B: Referral Tracking and Follow-Up, factor 3: Practices maintain agreements with behavioral healthcare providers. Factor 4 gives credit for integration of behavioral healthcare into the practice site.

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Policies and Procedures PCMH 2014

Section 1: PCMH 2014 Eligibility and the Application Process

The NCQA PCMH Recognition program is a practice-based evaluation for clinicians who provide care in primary care specialties. The program evaluates primary care provided to all patients in the practice. Recognition status lasts for three years.

Definitions

Practice One or more clinicians (including all eligible primary care clinicians) who practice together and provide patient care at a single geographic location and must include all eligible primary care clinicians at the site. “Practicing together” means that all the clinicians in a practice:

- Follow the same procedures and protocols.
- Have access to (as appropriate) and share medical records (paper and electronic) for all patients treated at the practice site.

Electronic and paper-based systems and procedures support clinical and administrative functions (e.g., scheduling, treating patients, ordering services, prescribing, maintaining medical records and follow-up).

Multi-site group Three or more primary care practice sites using the same systems and processes, including an electronic medical record system.

Note: NCQA offers *Patient-Centered Specialty Practice (PCSP) Recognition for non-primary care specialty practices, separate from PCMH recognition.*

Eligibility

Clinicians who qualify for PCMH

- Clinicians who hold a current, unrestricted license as a doctor of medicine (MD), doctor of osteopathy (DO), advanced practice registered nurse (APRN), or physician assistant (PA).
- Only clinicians that a patient/family can select as a Personal Clinician are eligible to be listed in addition to the practice Recognition on NCQA’s Web site
 - The practice may define a “personal clinician” as:
 - A residency group under a supervising clinician or faculty physician, although residents are not identified individually for selection as personal clinicians.
 - A combination physician and APRN or PA who share a panel of patients.
- Physicians, APRNs (including nurse practitioners, clinical nurse specialists) and PAs who practice in the specialty of internal medicine, family medicine or pediatrics, with the intention of serving as the personal clinician for their patients.

These clinicians will be identified individually with the recognized practice.
- Physician-led practices applying with identified APRNs or PAs:
 - Patients may choose the APRN or PA as their primary care clinician, **or**
 - APRNs or PAs share a panel of patients as a primary care team with the physician.

Clinicians who do not qualify

- Nonprimary care specialty clinicians and APRNs and PAs who do not have a panel of patients.

Special circumstances

- Practices that do not have a physician with a panel of patients at the site may achieve NCQA Recognition with the following considerations:
 - It is allowed according to the scope of practice determined by state law.
 - Practices are reviewed against the same requirements as physician-led practices.

Note: *If the state requires physician oversight of a practice site, the physician does not need to be identified and the patients choose the APRN or PA as their primary care clinician.*

Fee Schedule Information

There are four fee schedules.

1. **Standard Survey Pricing** applies to a practice applying for the first time or for renewal.
2. **Discounted Survey Pricing** applies to practices that are in an initiative.
3. **Multi-Site Group Survey Pricing** includes a multi-site survey fee based on the number of practices and a discounted survey fee for each site included in the group.
4. **Add-On Survey Pricing** applies only to practices with a current recognition status and allows a practice to advance to a higher level.

NCQA periodically updates fee schedules on the program Web site and in resources published in the application materials. Organizations purchasing a survey tool are notified of changes in the fee schedule 30 days before a change is made. Survey pricing is determined by the fee schedule in effect when a practice submits its survey tool for evaluation.

An application fee is due for each practice site undergoing a survey and is based on the number of eligible clinicians that intend to be listed (in NCQA's online Recognition Directory) for the practice site if they achieve NCQA Recognition. Clinicians practicing at more than one practice site are considered in the fee calculation for each site.

Recognition Program Partners in Quality

What is a Partner in Quality? Entities providing no-cost support services for practices seeking NCQA Recognition are acknowledged as NCQA PCMH Recognition Program Partners in Quality for as long as they provide support.

An NCQA Partner in Quality initiative encourages eligible MDs, DOs, nurse practitioners, PAs, practices, members and program participants to achieve NCQA Recognition, by providing additional recognition, learning collaborative support, onsite training, coverage of application fees or other financial rewards.

Who can lead an initiative? Initiatives may be led by a health plan, a coalition of plans, state medical societies, regional extension centers or other government entity, a business coalition, a collaboration of plans and businesses, a professional organization or a nonprofit quality improvement or disease awareness organization.

Some initiatives are funded by grants or legislation and are part of a broader health care strategy. NCQA supports these positive collaborations among clinicians and organizations by offering a discount on application fees.

Caveats	<ul style="list-style-type: none"> • Only eligible clinicians and practices are accepted for evaluation. • NCQA shares clinician or practice status with the initiative, to the extent authorized by the supported clinician or practice. • NCQA approves the Recognition Program Partner in Quality’s external communications regarding its initiative, to ensure alignment with policies and procedures.
Discounted application fee	<p>NCQA identifies Recognition Program Partners in Quality on its Web site. The practice enters an NCQA-issued discount code to qualify for a discounted application fee.</p> <p>The discount code is provided to supported practices or clinicians by their PCMH Recognition Program Partner in Quality.</p>

Start-to-Finish Pathway

NCQA developed the Start-to-Finish Pathway to help practices navigate the steps (or “nodes”) of the recognition process. Available on NCQA’s Web site, each interactive node provides information specific to an applicant’s location in the recognition process.

Start-to-Finish has three phases:

1. *Before—Learn It.* Phase 1 helps applicants determine if they are eligible for the NCQA PCMH Recognition program.
2. *During—Earn It.* Phase 2 guides applicants through the application process, the transformation of the practice to a medical home and the survey submission steps. Applicants can also determine if they can apply as a multi-site.
3. *After—Keep It.* Phase 3 describes how practices can promote their recognition, upgrade to another recognition level and maintain their recognition status.

NCQA encourages practices to attend Start-to-Finish training. Dates and times are posted on the Recognition Programs Web page.

The PCMH 2014 Online Application Process

All eligible clinicians practicing together at the practice site applying for recognition must be included on the PCMH application.

Applicants use a Web-based module (the online application) for the PCMH recognition application process. NCQA recommends that applicants with complex structures (i.e., multi-site groups, groups with clinicians who practice both primary care and other specialty care, practices with eligible nonphysician clinicians) complete the eligibility approval process *before* proceeding with the application.

Application Components

- **Account Information.** Organization account name, contact person, telephone number and address.
- **NCQA Legal Documents.** Before submitting the application, the practice completes two Agreements:
 - The PCMH Recognition Program Agreement.
 - The HIPAA Business Associate Agreement.

Note: *Unless state law requires modifications, all organizations sign NCQA’s standard PCMH 2014 Template Agreement. Requests for modifications to the standard Agreement must be submitted at least three months before the preferred application submission date.*

- **Practice Site Information.** The name and address of each site in the organization, the sponsor identification (if applicable), the site contact information and the mailing address.
- **Multi-Site Eligibility Approval Request and Eligibility Call.** For practices considering a multi-site evaluation, completing the multi-site eligibility approval request and eligibility call will determine if the practice group is eligible for the Multi-site Survey process.
- **Clinician Information.** The number and name of each eligible clinician and each practice site where they deliver care.
Note: Changes may be made to the clinicians identified with a practice site any time during the recognition period.
- **Application Form.** Each survey requires a separate application form to be completed for each site.

The PCMH 2014 Multi-Site Application

The multi-site application process is an option for organizations or medical groups with three or more practice sites that share an electronic record system and standardized policies and procedures across all practice sites. Practice sites do not all have to submit the survey tool at the same time or be the same specialty or size.

The multi-site application process does not allow organizationwide recognition; instead, it relieves eligible organizations from providing repetitive responses and documentation that would be the same for all sites.

Determining Multi-Site Eligibility

Organizations use their recognition account to submit a Multi-Site Approval Request Form.

Practices must answer “yes” to these questions

- Can your organization sign one PCMH program agreement to cover all sites applying for recognition?
- Currently and for a minimum of three months, have all the practice sites applying for recognition shared and used in the same way, a practice management system, registry or EHR to document patient care for administration and billing?
- Currently and for a minimum of three months, have all the practice sites applying for recognition operated under the same policies and procedures?

Note: Responses must reflect processes and systems currently in place and that have been in place for a minimum of three months.

After submitting a Multi-Site Approval Eligibility Request, organizations will be contacted to set up a call with a recognition manager, to determine their eligibility. The manager approves sites to purchase survey tools.

Multi-Site Corporate and Site-Specific Survey Tool Submission

Note: Multi-site practices should obtain approval through the Multi-site Eligibility Call before purchasing survey tools. It is not necessary to purchase all required survey tools at once.

- Step 1** An organization submits a corporate survey tool with approved multi-site elements before submission of the first practice site's survey tool.
- Step 2** NCQA reviews and scores the corporate survey tool within 30 days of submission and makes scoring available to the organization.
- Step 3** The organization completes site-specific survey tools for each site with responses to the remaining elements.
- Step 4** NCQA merges scored corporate survey tool elements with practice site survey tools before submission to show full scoring.
- Step 5** NCQA reviews and finalizes scoring and makes a recognition decision for each practice site within 60 days of submission of the site's survey tool.
- Step 6** Organization repeats steps 3–5 for eligible practice sites within the 3 year recognition period of the first recognized site.
- Step 7** All multi-site practice recognitions share the first recognized site's 3 year end date.

Practice Readiness Evaluation

Practices can conduct a readiness self-evaluation on the PCMH standards and elements before submitting the survey tool to NCQA. To be most accurate, the evaluation should thoroughly assess the practice's systems and include responses to questions, completed worksheets (as needed) and evaluation of supporting documentation. The survey tool estimates the score for each standard and element and provides an overall preliminary score.

During the evaluation While a practice conducts its readiness evaluation, NCQA surveyors do not have access to the survey tool, to data or to referenced documentation. The information is secure and confidential and for the practice's use only. NCQA does not access the practice's survey tool or information during this period, except for system maintenance.

The practice may revise its readiness evaluation, enter comments and update or re-link documents as often as it wants. NCQA will not review documentation prior to survey submission.

Complete the Application

Step 1 Order the PCMH 2014 Online Application from NCQA.

Obtain PCMH application materials online, free of charge, at <http://www.ncqa.org/Communications/Publications/index.htm>, or contact NCQA's Customer Support staff at 888-275-7585.

Practices receive a confirmation e-mail from NCQA with the subject **Publication Order Confirmation**.

Note: Practices that do not receive a confirmation e-mail should check with the e-mail contact on the application order before contacting NCQA.

Step 2 Access the PCMH Online Application system. Practices receive instructions in an e-mail with the subject **Accessing Your NCQA PCMH Recognition Online Application**.

A PCMH 2014 survey tool must be ordered for each practice site being submitted for recognition.

Note: Confirm eligibility *before* purchasing survey tools. Practices that do not receive the e-mail should check with the e-mail contact on the application order before contacting NCQA.

Step 3 Sign the program agreement and the Business Associate Agreement electronically or submit signed agreements to NCQA.

Step 4 Submit the online application to NCQA. Submit the application before submitting the survey tool.

NCQA requires one week to process the application. Practices receive a confirmation e-mail from NCQA when the application is received, and a separate e-mail indicating that the survey tool is ready for access and survey submission.

Step 5 Submit the application fee to NCQA before or concurrently with the PCMH survey tool. NCQA cannot review a survey tool until payment is received.

Prepare and Submit the ISS Survey Tool

Practices should review the PCMH standards to determine if they perform the functions required by the elements under each standard. The *Explanation* section of each element will help determine practice capabilities.

Step 1 Respond to questions. Indicate the response for each factor that corresponds to the practice's capabilities.

Step 2 Complete the optional worksheet and workbook (if applicable). One or both worksheets may need to be completed.

The worksheet and workbook can be downloaded and saved to a computer with the practice name. The practice enters the information in the worksheet or workbook and submits it with the survey tool, following the directions in the survey tool.

1. **The Quality Measurement and Improvement Worksheet** (Microsoft Word)—PCMH 1, Element A, factor 6 and PCMH 6, Elements D and E. This worksheet documents quality measurement and improvement efforts. Alternatively, the practice can create a report based on a query of its electronic system. Refer to the *Explanation* section in the elements listed in this paragraph.
2. **The Record Review Workbook** (Microsoft Excel)—(PCMH 3, Element C; PCMH 4, Elements B and C). The practice reviews selected patient records, following NCQA methodology, and enters medical record information in the worksheet for the elements listed. The workbook calculates the percentage of patients whose required information is documented in the medical record. Refer to the *Instructions* tab in the workbook for details.

Alternatively, the practice can create a report based on a query of its electronic system. Refer to the *Explanation* section in the elements listed in the previous paragraph.

Step 3 Upload and link documentation. Enter documents that demonstrate how the practice meets all the factors in the elements. Elements describe required documentation.

To minimize document management and encourage an efficient review, link *no more than three documents per element*. Some elements will only require one document. Multiple document sources may be combined into a single document (e.g., one Word document with several reports or examples, one PDF).

The ISS cannot accept documents in HTML format. Highlight or identify information in the documents that meets the standard. Only legible documents will be considered.

The survey tool provides instructions for entering and linking documentation to elements. Linked documents are listed in a document library and referenced by element.

Until the survey tool is submitted, practices can revise responses, enter comments and update or change the documents.

Note

- Protected health information (PHI), as defined by the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations, must be removed or blocked out from submitted documents, including patient identifiers, unless the survey tool requests the information. If an element or factor requests an aspect of PHI (e.g., a date of service), include only the minimum information necessary to satisfy the intent of the element or factor. Do not include additional identifiers as part of the documentation (e.g., a member's chart number or account number).
- NCQA does not require (and practices should never submit) documentation with patient names, social security numbers, dates of birth, street addresses, e-mail addresses or telephone numbers.
- For many elements, the best documentation is a screen shot from a computer the practice uses. **Only submit de-identified patient data and examples.** Create a Word document; cut and paste screen shots to the document; or scan documents and create a PDF. Save Word documents using text boxes to block PHI as read-only. For more information, refer to the definitions of **PHI** and **de-identify** in the Glossary.
- Practices may provide Web links to data or Web sites.

Step 4 Submit the application and the application fee.

Note: A submission is not complete until NCQA receives the application and establishes an electronic link between the survey tool and the NCQA server.

Step 5 Submit the survey tool with the attached documentation. Practices can review a copy of the completed survey tool and all attached documents, and can modify the survey tool, but the official copy sent to NCQA is considered final for NCQA evaluation. Practices will not have access to NCQA's copy of the completed survey tool and no changes can be made after it is submitted. Practices cannot view NCQA's evaluation of results until it is final.

NCQA sends an e-mail confirming receipt of the survey tool and the start of the review period. NCQA staff review and assess the completeness of application data and survey tool materials. Practices are notified if additional information is required.

Clinician list. NCQA lists eligible clinicians for practices that receive recognition. An eligible clinician may be listed at more than one practice site. Recognized practices that want to add or delete clinicians must submit updated information to PCMH@ncqa.org. All additional eligible clinicians are listed on NCQA's Web site.

Section 2: The Recognition Process

NCQA Survey Tool Review

The Review

NCQA starts the review upon execution of the program Agreement and the Business Associate Agreement, submission of the survey tool and payment of all fees. Reviewers evaluate responses and documentation against program standards and determine scores for each element. In general, NCQA makes a recognition decision within 60 days.

If an applicant is a one of a group of practices participating in a Multi-Site Survey, NCQA reviews the Multi-Site Survey first and applies the results to all practices in the group, then reviews the survey tools with site-specific data.

The Audit

NCQA reserves the right to audit a practice that has applied for or holds a current NCQA Recognition, including while the applicant's survey is under review. An audit validates documentation and stated procedures and responses given by a practice in its application and survey tool. NCQA audits 5 percent of practices, either by specific criteria or randomly.² Audits may be completed by e-mail, teleconference, Webinar or other electronic means, or by onsite review.

Practice sites selected for audit are notified and sent instructions. The established current procedures for audit will be applied. The first level of review is verification of the submitted survey tool. The practice may be asked to forward copies of the source documents and explanations, to substantiate the information in the survey tool.

- *If the application is verified and no issues are discovered*, the practice is notified that the audit is complete and the application for recognition is processed.
- *If an audit requires an onsite review*, NCQA conducts the review within 30 calendar days of notifying the practice of its intent to conduct an audit.
- *If audit findings indicate that information submitted by the practice is incorrect or documentation does not meet the PCMH standards*, the application for NCQA Recognition may be denied, scores may be reduced or additional documentation may be required. NCQA notifies the practice of audit findings and the recognition decision within 30 days after conclusion of the audit.

If a practice's application for recognition is denied because of an audit, it may request Reconsideration of the decision. Refer to *Reconsideration* for more information.

Failure to agree to an audit, failure to pass an onsite audit or failure to pass an audit of survey tool responses and documented elements may result in a status of "Not Recognized."

²Random selection of applications is based on a predetermined target to achieve a 5 percent audit rate.

PCMH 2014 Standards

There are six PCMH standards, with one overall score. Each standard is composed of specific elements. Standards evaluate a practice's ability to function as a patient-centered medical home.

1. PCMH 1: Patient-Centered Access.
2. PCMH 2: Team-Based Care.
3. PCMH 3: Population Health Management.
4. PCMH 4: Care Management and Support.
5. PCMH 5: Care Coordination and Care Transitions.
6. PCMH 6: Performance Measurement and Quality Improvement.

A Standard's Structure

Standard statement	A brief statement of the standard's purpose.
Element	<p>The scored component of a standard that provides details about performance expectations. NCQA evaluates each element in a standard to determine how well the practice meets the element's requirements.</p> <p>Of the 27 elements in PCMH 2014, 6 are must-pass elements. Refer to <i>The Must-Pass Elements</i> in the <i>Overview</i>.</p>
Factor	<p>A scored item in an element. For example, an element may require the practice to demonstrate that its policies and procedures include four specific items; each item is a factor. When an element includes multiple numbered factors, the scoring indicates the number of factors that the practice must meet to achieve each scoring level.</p> <p>Critical factor. A <i>critical factor</i> is required for practices to receive more than minimal points—or, for some factors, any points. Critical factors are identified in the scoring section of the element.</p>
Scoring	The level of performance the practice must demonstrate to receive a specified percentage of element points. Each element has up to five possible scoring levels (100%, 75%, 50%, 25%, 0%).
Explanation	Specific requirements that the practice must meet and guidance for demonstrating performance against the factor. The explanation provides detailed information to the practice about what NCQA looks for, how the element relates to other elements, terms used and the evaluation process.
Examples	<p>Required documentation. Describes the evidence practices must submit to demonstrate performance against specific elements. The list of documentation sources in each element is not prescriptive, nor does it exclude other potential sources. There may be acceptable alternatives that demonstrate performance.</p> <p>The practice must show documentation of policies and processes that have been in place for at least 3 months. Generally, data should be no more than 12 months old.</p>

Types of documentation

Practices may use four basic types of documentation to demonstrate performance.

1. *Documented process*. Written statements describing the practice's policies and procedures (e.g., protocols or other documents describing actual processes or forms [e.g., referral forms, checklists, flow sheets]). The documented process must include a date of implementation or revision (at least three months prior to submission of the survey tool).
2. *Reports*. Aggregated data showing evidence of action, including manual and computerized reports the practice produces to manage its operations, such as a list of patients who are due for a visit or test.
3. *Records or files*. Actual patient files or registry entries that document an action. Files are a source for estimating the extent of performance against an element. There are two ways to measure performance:
 - A query of electronic files yielding a count, **or**
 - The sample selection process provided by NCQA—instructions for choosing a sample and a log for reviewing records are in the Record Review Workbook, attached to the PCMH Web-based survey tool.
4. *Materials*. Prepared materials the practice provides to patients or clinicians (e.g., clinical guidelines, self-management and educational resources such as brochures, Web sites, videos and pamphlets).

Scoring Guidelines**Elements**

The survey tool multiplies the element's scoring level by its weight in points to determine the element score. As determined by NCQA and provided for in the each element's *Explanation* section, some elements may be scored NA if they do not apply to the practice.

Calculating the standard score

The survey tool adds the scores received for all elements in a standard to determine the standard score.

Calculating the overall score

The survey tool adds the scores received for all standards to determine the final score.

Final Decision and Recognition Levels

The practice’s recognition determination is based on its overall performance (numeric score) against the standards and achievement of each must-pass element at the 50% scoring level.

Recognition Level	Points	Must-Pass Elements
Level 1	35–59 points	6 of 6
Level 2	60–84 points	6 of 6
Level 3	85–100 points	6 of 6

Scoring decision results are shown in the Final Results section of the survey tool. This section consists of tabular findings on:

- Scores for each element and standard.
- Number of must-pass elements achieved.
- The total score.

The NCQA Recognition Program Review Oversight Committee (RP-ROC) reviews findings, makes scoring decisions and incorporates scores into the final version of the survey tool, which generates the practice’s results.

RP-ROC members are physicians who have expertise in practice systems and who, as determined by NCQA, have no conflict of interest with the practice.

Certificates NCQA issues an official Recognition Certificate acknowledging that the practice met the standards.

Duration of status Recognition status lasts three years. To achieve a higher level of recognition status, practices can apply for an Add-On Survey. Refer to *Section 3: Additional Information*.

Reporting results...

...to the practice NCQA gives the practice a final version of the survey tool that includes the final status and level, as well as numerical scores on all elements and all standards.

...to the public Recognized practices and associated eligible clinicians are added to the Recognition Directory, a list of practices and eligible clinicians on NCQA’s Web site (recognition.ncqa.org/).

NCQA does not report practices whose status is Not Recognized.

NCQA reserves the right to release and to publish results of the practice’s performance under specific standards, elements, factors and reporting categories.

...to organizations NCQA periodically provides data about recognized practices and eligible clinicians to a organizations that use or reward NCQA Recognition.

Data may include type of recognition program, recognition level, effective dates, practice site address, tax identification number, clinician name, specialties, state, license number and NPI.

Section 3: Additional Information

Add-On Survey

Practices have two options to improve their recognition level: an Add-On Survey.

Level 1 or Level 2 recognition Practices that receive Level 1 or Level 2 recognition status may apply for an Add-On Survey within the three-year recognition period, to move to Level 2 or Level 3 Recognition. This does not extend the three-year recognition period. Practices that receive a decision of Not Recognized may use this process to build on their previous submission within 12 months of their decision.

For each Add-On Survey, the practice requests and receives an updated survey tool with a new license number to submit data for elements for which it earned a score of 75% or below. NCQA evaluates data for the elements submitted and produces a new total score for the standards.

NCQA evaluates the submitted elements according to the process described in this document and sends the results to the practice. If the practice achieves recognition at a new level, NCQA reports the new level.

Conversion Survey

Practices that have achieved NCQA PCMH 2011 Level 3 Recognition are eligible for conversion to PCMH 2014 by completing the survey and submitting documentation for specific elements. Practices must submit documentation in order to be scored.

Organizations that want to convert must have a current NCQA PCMH Recognition with at least a year remaining on the current recognition at the time of submission. Conversion does not extend the duration of the current recognition and PCMH 2014 Recognition level is a result of the scoring achieved on the conversion survey.

Renewing Recognition

Practices should apply for renewal at least two months before their recognition expiration date.

During recognition, NCQA expects practices to maintain the standards for the level for which they were recognized. Therefore, renewing practices are required to show they have met the requirements for designated elements for at least two years.

NCQA offers a streamlined process for renewal through reduced documentation requirements for practices with current NCQA Level 2 or Level 3 Recognition. Practices that demonstrated basic medical home transformation can focus on more advanced aspects of redesign for their renewal applications.

To take advantage of the reduced documentation requirements for selected elements, renewing practices must follow renewal instructions in the online application materials.

Note: *Even though some elements do not require a practice to submit documentation, practices must be able to produce documentation if selected for audit.*

Reconsideration

Practices may request Reconsideration of any NCQA Recognition Level or Not Recognized status decision. Practices must complete a Reconsideration request form found on NCQA's website. NCQA must receive a Reconsideration request form via email within 30 days after a practice is notified of a corporate eligible element decision or has received a specific recognition level or a status of Not Recognized. The receipt date will govern.

- *Corporate Survey.* NCQA must receive the Reconsideration request for corporate eligible elements within 30 days after the NCQA decision is rendered for the corporate eligible elements. The date the practice is notified will govern.
- *Practice Site Survey.* NCQA must receive the Reconsideration request for practice site elements within 30 days after the NCQA Recognition Level or Not Recognized status decision is rendered. The date the practice is notified will govern.

A Reconsideration fee is required in accordance with the fee scheduling in effect at the time of the Reconsideration request. The fee schedule can be found on NCQA's website (Programs > Recognition > NCQA PCMH & PCSP Recognition Program Pricing), along with instructions for remitting payment via the Recognition Programs Payment Portal. The portal provides the ability to pay securely online via credit card, and also includes instructions for mailing in a paper check.

On the Reconsideration request form, the practice must describe the reason for requesting the Reconsideration and list standards or elements for which it requests Reconsideration. Additional documentation may not be submitted.

NCQA refers Reconsideration requests to the Reconsideration Committee, made up of NCQA staff and Review Oversight Committee (ROC) members who were not involved in making the original Recognition decision and do not have a conflict of interest with the practice. NCQA staff review relevant documentation and make a recommendation to a group of ROC members. The ROC members review the documentation and make a Reconsideration decision. The Reconsideration Committee's decision is final and is sent to the practice via email. No further right of appeal exists.

NCQA updates a practice's survey to reflect changes in scoring or level, if applicable, and if the Reconsideration results in a higher Recognition level, the practice is issued a new certificate and the NCQA Web site and data feeds are updated accordingly.

Applicant Obligations

By submitting the PCMH application to NCQA, the applicant agrees to the following:

- To the best of its knowledge and belief, the information submitted for survey is correct and was obtained using procedures specified in the PCMH survey tool and PCMH Policies and Procedures.
- To release the information to NCQA that NCQA deems pertinent.
- To abide by the terms of the signed application agreement and the guidelines for advertising PCMH recognition, these procedures and instructions and all other published NCQA policies, procedures and rules.
- To function in a manner consistent with the Joint Principles for Patient Centered Medical Homes (AAFP, AAP, ACP, AOA, 2007), modified to focus on team-based care led by an eligible clinician, which may include a physician or a nurse practitioner operating within the appropriate scope of practice of the state.
- For any clinician identified with the practice's recognition, to notify NCQA within 30 calendar days of receiving notice of a final determination by a state or federal agency with respect to an investigation, request for corrective action, imposition of sanctions or change in licensure or qualification status.

- To notify NCQA of any material changes in the structure or operation of the practice, or merger, acquisition or consolidation of the practice, in accordance with these policies.
- To notify NCQA of any change in submitted clinicians listed with the practice's recognition. Addition of clinicians under a current recognition is subject to the same approval process and eligibility verification as that used with the initial set of clinicians applying for recognition. Added clinicians must be of the same specialty type as one or more currently recognized clinicians. If they are not, this is considered a separate survey.
- To maintain a level of functioning at least at the level of the recognition status, based on the standards in effect at time of the survey, and to submit evidence as such during the period of recognition.
- To submit an annual attestation, upon request.

Complaint Review Process

NCQA accepts written complaints from patients, members or practitioners regarding recognized clinicians and practices. Upon receipt of such a complaint, NCQA will:

1. Review the complaint to determine that the clinician or practice is recognized by NCQA.
2. Determine if the complaint is germane to the recognition held by the clinician or practice.
3. Obtain a release to share the complaint with the clinician or practice if the complaint involves personal health information or a quality-of-care issue.
4. Forward the complaint to the clinician or practice within 30 calendar days, with a request that the clinician or practice review and respond directly to the individual filing the complaint, and copy NCQA on the response.
5. Review the response from the clinician or practice to determine whether the complaint was handled in accordance with NCQA requirements and whether all issues raised in the complaint have been addressed.

Failure to comply with NCQA's complaint review process is grounds for suspension or revocation of recognition status.

Reporting Hotline for Fraud and Misconduct

NCQA does not tolerate submission of fraudulent, misleading or improper information by organizations as part of their survey process or for any NCQA program.

NCQA has created a confidential and anonymous Reporting Hotline to provide a secure method for reporting perceived fraud or misconduct, including submission of falsified documents or fraudulent information to NCQA that could affect NCQA-related operations (including, but not limited to, the survey process, the HEDIS measures and determination of NCQA status and level).

How to Report

- **Toll-Free Telephone:**
 - English-speaking USA and Canada: **855-840-0070** (not available from Mexico).
 - Spanish-speaking North America: **800-216-1288** (from Mexico, user must dial 001-800-216-1288).
- **Web Site:** <https://www.lighthouse-services.com/ncqa>
- **E-Mail:** reports@lighthouse-services.com (must include NCQA's name with the report).
- **Fax:** 215-689-3885 (must include NCQA's name with the report).

Discretionary Survey

NCQA may review a practice while a Recognized status is in effect. The purpose of such a review is to validate the appropriateness of an existing Recognition decision.

Structure Discretionary Surveys are targeted to address issues indicating that a practice may not continue to meet the NCQA standards in effect at the time of recognition. The scope and content of the review are determined by NCQA. NCQA conducts the survey using the standards in effect at the time of the practice's last survey.

If a Discretionary Survey requires an onsite review, NCQA conducts the review within 60 calendar days of the notification by NCQA of the intent to conduct a Discretionary Survey.

Survey costs are borne by the practice and correspond to the complexity and scope of the survey and NCQA pricing policies in effect at the time of survey.

Change in status NCQA may suspend the practice's Recognized status pending completion of a Discretionary Survey. Upon completion of the survey and after the ROC's decision, the practice's status may remain the same as it was before notification of the Discretionary Survey, or it may change. The practice has the right to Reconsideration of the determination if its Recognized status changes because of the Discretionary Survey.

Suspension of Recognition

Grounds for suspending a practice's Recognized status pending a Discretionary Survey include, but are not limited to the following circumstances:

- Facts or allegations suggesting an imminent threat to the health and safety of patients.
- Allegations of fraud or other improprieties in information submitted to NCQA to support recognition.
- The practice has been placed in receivership or rehabilitation.
- State, federal or other duly authorized regulatory or judicial action restricts or limits the practice's operations.

Revoking Decisions

NCQA may revoke PCMH recognition in the following circumstances:

- The practice submits false data.
- The practice misrepresents the credentials of a clinician.
- The practice misrepresents its NCQA PCMH Recognition status.
 - When communicating with patients, third-party payers, health plans and others, practices that earn PCMH recognition may represent themselves as having been recognized by NCQA for meeting PCMH standards, but may not characterize themselves as "NCQA approved," "NCQA endorsed," or "NCQA Certified." Mischaracterization or other similarly inappropriate statements is grounds for revocation of status.
- An eligible clinician is suspended or the professional license is revoked.
- The practice has been placed in receivership or rehabilitation and is being liquidated.
- State, federal or other duly authorized regulatory or judicial action restricts or limits the practice's operations.
- NCQA identifies a significant threat to patient safety or care.
- The practice fails to remain in compliance with PCMH standards.

Mergers, Acquisitions and Consolidations

Recognized practices must report to NCQA any merger, change in practice location, acquisition or consolidation activity in which they are involved. NCQA considers the circumstances and determines the need for additional information and for a further evaluation.

Revisions to Policies and Procedures

At its sole discretion, NCQA may amend any PCMH policy and procedure. Notice of and information about modifications or amendments are posted publicly on NCQA's Web site 30 calendar days before the effective date of the modification or amendment. Practices that do not agree with policy changes may withdraw from the recognition program, but fees paid to NCQA will not be refunded.

Disclaimer

A recognition decision and the resulting status designation are based on the exercise of NCQA's professional evaluative judgment and the determination of the ROC. NCQA is not bound by any numerical or quantitative scoring system or other quantitative guidelines or indicators that in its sole discretion it may have used, consulted or issued to assist reviewers and others during the course of the evaluative process.

NOTE

NCQA RECOGNITION DOES NOT CONSTITUTE A WARRANTY OR ANY OTHER REPRESENTATION BY NCQA TO THIRD PARTIES (INCLUDING, BUT NOT LIMITED TO, EMPLOYERS, CONSUMERS OR PATIENTS) REGARDING THE QUALITY OR NATURE OF THE HEALTH CARE SERVICES PROVIDED OR ARRANGED FOR BY THE PRACTICE.

THE PROVISION OF MEDICAL CARE IS SOLELY THE RESPONSIBILITY OF THE PRACTICE AND ITS CLINICIANS. RECOGNITION IS NOT A REPLACEMENT FOR THE PRACTICE'S EVALUATION, ASSESSMENT AND MONITORING OF ITS PROGRAMS AND SERVICES.