
# Annual Reporting Requirements for PCMH Recognition

**REPORTING PERIOD: JANUARY 1–DECEMBER 31, 2022**

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# PCMH Recognition

## What Is Annual Reporting?

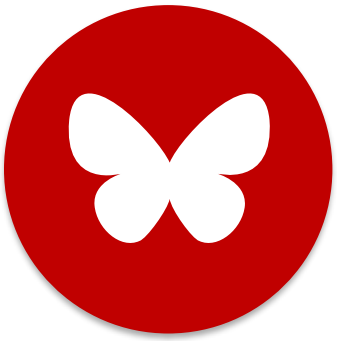
NCQA's PCMH Recognition program lets practices maintain their Recognition status through Annual Reporting. Annual Reporting is the third part—**Succeed**—of the three-part Recognition process introduced in 2017.

## PCMH Recognition Process

**Commit *(Enrollment)***

The practice learns the NCQA PCMH concepts and begins to apply them.

Once the practice knows the concepts and has begun transforming into a PCMH, it enrolls in the Recognition program through NCQA Q-PASS at **qpass.ncqa.org.**



**Transform *(Recognition Process)***

The practice gradually transforms, building on its successes while working toward Recognition. It demonstrates progress by submitting data and evidence for NCQA evaluation using Q-PASS and completing up to three virtual reviews with an assigned NCQA evaluator.

**Succeed *(Annual Reporting)***

**You are here!** The practice continues to implement and enhance the PCMH model to meet the needs of its patients.

Each year, the practice demonstrates to NCQA that its ongoing activities are consistent with the PCMH model and Recognition standards. The annual submission includes attesting to certain policies and procedures and submitting required data or evidence.

# Overview

## How to Sustain Recognition

Each year, a practice sustains its Recognition by demonstrating continuous alignment with PCMH through the combination of attestation and submission of information, data and evidence for selected key criteria that support each concept in the PCMH program:

- Team-Based Care & Practice Organization (TC).
- Knowing & Managing Your Patients (KM).
- Patient-Centered Access & Continuity (AC).
- Care Management & Support (CM).
- Care Coordination & Care Transitions (CC).
- Performance Measurement & Quality Improvement (QI).

## Annual Reporting: Time Frame

Practices are expected to submit their Annual Report each year as part of maintaining PCMH Recognition. The Annual Reporting deadline is based on the timing of their initial Recognition. The Reporting Date is 30 days prior to the Anniversary Date. If necessary, practice can submit a request and rationale to their NCQA representative if they need adjustment of their Reporting Date.

Practices are expected to maintain awareness of the full PCMH program requirements, so they can confidently attest to aligning with the latest updates to the program.

**Preparing for submission:** Practices should download and review the Annual Reporting requirements at least 6 months prior to their Annual Reporting date, so they can plan for their submission and address any deficiencies they find. If the practice has maintained its patient-centered activities, it typically takes no more than 15–40 hours of work per year over several months to prepare for Recognition. Because the Annual Reporting requirements focus on specific key criteria through attestation and evidence submission, with less emphasis on uploading documents, a practice can expect to spend significantly less time preparing evidence for NCQA.

**Submitting:** Once the evidence is prepared to enter, submission (outlined in “Annual Reporting Process” below) on Q-PASS should potentially take less than an hour.

## Submission Platform: Q-PASS

Practices use Q-PASS to enroll for Recognition, sign agreements, access training and other resources, submit evidence, update practice information, track completed evaluations and print certificates using this system.

# Process Step-by-Step

## Annual Reporting Process

**Step 1:** Complete the Questionnaire in Q-PASS.

***Note:*** *Practices **do not** need to create a new account in Q-PASS for Annual Reporting. If you have difficulty finding your account, contact us through **My NCQA** before creating a new one.*

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**Step 2:** Submit the following in Q-PASS by the practice's reporting date (30 days prior to its anniversary date):

- **Annual Questionnaire:** Practices must attest that they have maintained and will continue to meet the requirements of the current PCMH program. No additional evidence is required for this attestation.
- **Evaluation:** This is where practices answer questions or enter data. Practices must meet the minimum number of requirements in each concept category.

***Note:*** *Evidence can be entered in Q-PASS prior to the reporting date, but NCQA only reviews evidence after the practice pays the annual fee and submits the annual report.*

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**Step 3:** NCQA reviews submissions and notifies practices of their sustained Recognition status.

- **Review:** An NCQA evaluator reviews the submission and provides feedback on whether requirements have been met to sustain Recognition.
- **Decision:** An NCQA Review Oversight Committee (ROC) member determines the Recognition decision.

***Note:*** *Practices that do not submit materials on time or that fail to meet requirements may have their Recognition status denied.*

*Annual Reporting requirements may be removed, modified or added over time. Practices will be notified of changes and given time to prepare data and evidence.*

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**Audit:** NCQA randomly selects practices for audit to validate their attestations and submission. If selected, practices are notified through Q-PASS and email. Audits are conducted through virtual review by NCQA staff. Practices are given information on the audit and how to prepare for the review.

***Note:*** *Practices that do not complete the audit or fail to submit or meet requirements during the review may have their Recognition status suspended or denied.*

# Understanding Evidence

## Understanding Evidence That Can Be Shared

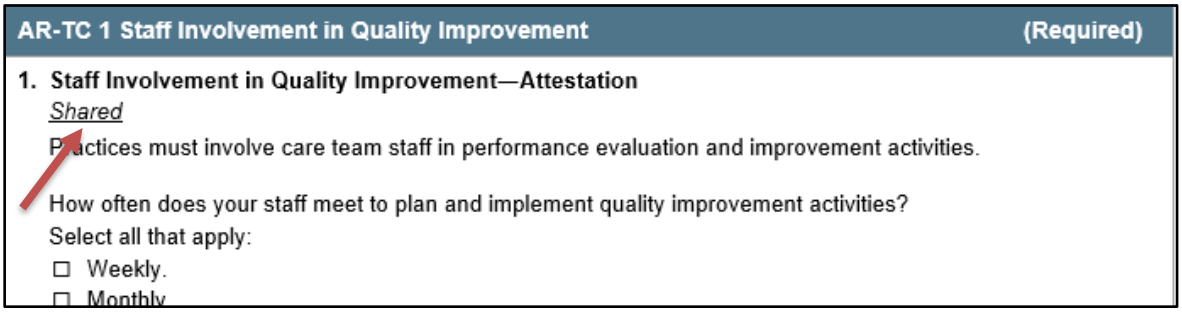
Next to each question in this document is a note indicating whether evidence can be shared. The ability to share evidence across sites can be set up in Q-PASS.

Notes include:

| Evidence | Description |
|---|---|
| **Shared** | May be submitted once through the designated primary site for sites in the group, if all sites in the group share the same process. |
| **Site-specific** | For organizations with multiple sites, requirements require evidence be demonstrated for each site. |

***Note:*** *Refer to the definitions of "practice," "multi-site" and "eligibility" in the* ***PCMH Recognition Policies and Procedures.***

## Example




## Understanding Reporting Periods

Practices submit data to NCQA every year. With these routine submissions, the expectation is that a practice collects and monitors data at least annually and provides NCQA with the most recent report. The reporting period end date must be within 12 months of the practice's Annual Reporting submission date. This allows practices that regularly collect data at quarterly, annual or other intervals to submit data from the reports they use routinely, rather than performing additional data collection to meet NCQA requirements. If a practice is reporting on a standardized measure for QI, the practice should report on the prior calendar year.

## Using the Manual Chart Audit Option

NCQA understands that not every practice may be able to run reports to gather data in the form of a numerator and denominator. Practices that cannot easily generate reports may complete a manual chart audit of at least 30 patient charts. Practices must:

1. Follow the patient sampling methodology from the Record Review Workbook (in Appendix 3 of the PCMH Standards and Guidelines) to choose 30 patient charts at random by visit date. The numerator and denominator should reflect all applicable patients, not only care managed patients.
2. Only enter the numerator, denominator, reporting period and requested information, as dictated by the annual reporting requirements, into Q-PASS. Do not complete or upload a copy of the Record Review Workbook.

***Example:*** *For AR-CC 3, the practice chooses 30 consecutive lab orders from the past year and provides the number of complete lab reports received (one report per order; full results of all tests). The numerator is the number of lab orders for which the practice received complete lab-order results reports; the denominator is 30 lab orders.*

# Glossary for Completing the Annual Reporting Evaluation

## Understanding What Must Be Completed

Each concept consists of requirements organized into categories (e.g., AR-TC 1). It is not necessary to meet all requirements to sustain Recognition. Categories are labeled:

- **Required:** The practice must submit and meet the requirements to sustain Recognition.
- **Option:** The practice must submit and meet one available option defined in each concept.

## Evidence Type Overview

Practices may be asked to provide different types of evidence (found to the right of the question number):

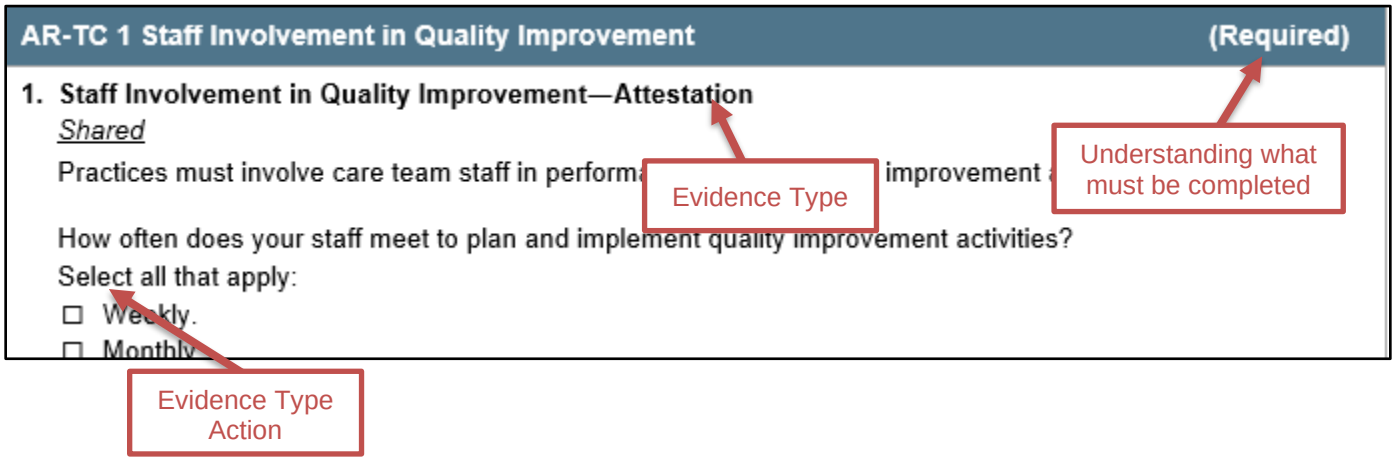
- **Attestation:** The practice attests "yes" or "no" that it meets (or does not meet) the question's requirements, or attests by selecting applicable items, in accordance with PCMH standards and guidelines, and that it can provide evidence if requested.
- **Report:** The practice enters a numerator, denominator and reporting period in the text boxes. The practice might also need to enter numerator and denominator descriptions if they are not already outlined by the component.

## Evidence Type Action

Each question in a category specifies an action the practice must take in Q-PASS to meet requirements.

- **Select one:** The practice attests "yes" or "no" that it meets (or does not meet) the question's requirements, in accordance with PCMH standards and guidelines.
- **Select all that apply:** The practice selects all applicable answers or indicates "Other" and enters the appropriate text.
- **Enter:** The practice enters a numerator and denominator that match specific requirements.

## Example



# Requirements & Options Overview Visual

**Key:** ***Required*** ***Option***

## Team-Based Care and Practice Organization (AR-TC)

*Report the following requirement:*

***AR-TC 1***
***Staff Involvement in Quality Improvement***

## Knowing and Managing Your Patients (AR-KM)

*Report each of the following:*

***AR-KM 1***
***Medication Lists***

***AND***

***AR-KM 2***
***Clinical Decision Support***

## Patient-Centered Access and Continuity (AR-AC)

*Report each of the following:*

***AR-AC 1***
***Timely Clinical Advice by Telephone***

***AND***

***AR-AC 2***
***Patient Visits with Clinician/Team***

## Care Management and Support (AR-CM)

*Report the following:*

***AR-CM 1***
***Care Plans for Care Managed Patients***

## Care Coordination and Care Transitions (AR-CC)

*Report each of the following requirements:*

***AR-CC 1***
***Care Coordination Process***

***AND***

***AR-CC 2***
***Referral Management Process***

***AND*** *report* ***one*** *of the following options:*

***AR-CC 3***
***Lab and Imaging Test Tracking***

***OR***

***AR-CC 4***
***Referral Tracking***

## Performance Measurement and Quality Improvement (AR-QI)

*Report the following requirements:*

***AR-QI 1***
***Clinical Quality Measures***

***AND***

***AR-QI 2***
***Resource Stewardship Measures***

***AND***

***AR-QI 3***
***Patient Experience Measures***

# Crosswalk: Annual Reporting Requirements vs. PCMH Criteria

| AR Requirements | | PCMH Criteria | |
|---|---|---|---|
| **Team-Based Care and Practice Organization (AR-TC)** | | | |
| AR-TC 1: Staff Involvement in Quality Improvement | Required | TC 07 | Core |
| **Knowing and Managing Your Patients (AR-KM)** | | | |
| AR-KM 1: Medication Lists | Required | KM 15 | Core |
| AR-KM 2: Clinical Decision Support | Required | KM 20 | Core |
| **Patient-Centered Access and Continuity (AR-AC)** | | | |
| AR-AC 1: Timely Clinical Advice by Telephone | Required | AC 04 | Core |
| AR-AC 2: Patient Visits with Clinician/Team | Required | AC 11 | Core |
| **Care Management and Support (AR-CM)** | | | |
| AR-CM 1: Care Plans for Care Managed Patients | Required | CM 04 | Core |
| **Care Coordination and Care Transitions (AR-CC)** | | | |
| AR-CC 1: Care Coordination Process | Required | CC 01 | Core |
| AR-CC 2: Referral Management Process | Required | CC 04 | Core |
| AR-CC 3: Lab and Imaging Test Tracking | Option | CC 01 | Core |
| AR-CC 4: Referral Tracking | Option | CC 04 | Core |
| **Performance Measurement and Quality Improvement (AR-QI)** | | | |
| AR-QI 1: Clinical Quality Measures | Required | QI 01 | Core |
| AR-QI 2: Resource Stewardship Measures | Required | QI 02 | Core |
| AR-QI 3: Patient Experience Measures | Required | QI 04 | Core |

# Team-Based Care and Practice Organization (AR-TC)

***The practice continues to involve staff in quality improvement.***

*Report the following:*

| AR-TC 1 Staff Involvement in Quality Improvement | (Required) |
|---|---|

**1. Staff Involvement in Quality Improvement—Attestation**

*Shared*

Practices must involve care team staff in performance evaluation and improvement activities. How often does your staff meet to plan and implement quality improvement activities?

Select all that apply:

- ☐ Weekly.
- ☐ Monthly.
- ☐ Quarterly.
- ☐ Other_____.

# Knowing and Managing Your Patients (AR-KM)

***The practice continues to maintain medication lists and implement clinical decision support.***

*Report the following:*

## AR-KM 1 Medication Lists (Required)

**1. Medication Lists—Report**

*Site-specific*

Practices maintain an up-to-date list of medications for more than 80% of patients.

Enter:

- Numerator: Number of patients from the denominator with an up-to-date medication list.
- Denominator: Number of unique patients seen during the reporting period.
- Reporting period.

## AR-KM 2 Clinical Decision Support (Required)

**1. Clinical Decision Support—Attestation**

*Shared*

Practices must implement clinical decision support following evidence-based guidelines for the care of conditions across at least 4 categories. For which categories does the practice have clinical decision support implemented?

Select all that apply:

- ☐ A mental health condition.
- ☐ A substance use disorder.
- ☐ A chronic medical condition.
- ☐ An acute condition.
- ☐ A condition related to unhealthy behaviors.
- ☐ Well-child or adult care.
- ☐ Overuse/appropriateness issues.

# Patient-Centered Access and Continuity (AR-AC)

***The practice continues to monitor timely access to clinical advice and patient visits with their selected personal clinician.***

*Report the following:*

## AR-AC 1 Timely Clinical Advice by Telephone (Required)

**1. Timely Clinical Advice by Telephone—Report**

*Shared*

Practices outline their expected response time for returning clinical advice by telephone in their documented process.

Enter:

- Numerator: Number of clinical advice calls returned within the expected timeframe.
- Denominator: Number of clinical advice calls during and after business hours.
- Reporting period.

***Note:*** *"Clinical advice" refers to a response to an inquiry about symptoms, health status or an acute/chronic condition. Do not include patient calls regarding referrals, prescription refills or appointment scheduling in the report. The reporting period should include at least 7 consecutive days of data and calls received both during and after business hours.*

## AR-AC 2 Patient Visits with Clinician/Team (Required)

**2. Patient Visits with Clinician/Team—Report**

*Site-specific*

Practices outline their goal in their documented process.

Enter:

- Numerator: Number of patient visits where the patient was seen by their selected personal clinician or care team.
- Denominator: Number of patient visits.
- Reporting period.

***Note:*** *All patients should have a selected personal clinician or care team. A "care team" may be a defined pair of clinicians (e.g., physician and nurse practitioner, physician and resident) or a practice team. The practice may not assign all patients to a site and label this as the care team unless it is a solo clinician site.*

# Care Management and Support (AR-CM)

***The practice continues to complete care plans for patients in care management.***

*Report the following:*

## AR-CM 1 Care Plans for Care Managed Patients (Required)

**1. Care Plans for Care Managed Patients—Report**

*Site-specific*

Practices have a process for identifying patients for care management that incorporates at least 3 categories outlined in CM 01 of the PCMH standards and guidelines or that utilizes comprehensive risk stratification.

Enter:

- Numerator: Number of patients from the denominator with a complete care plan.
- Denominator: Number of patients enrolled in care management.
- Reporting period.

***Note:*** *A complete care plan incorporates a problem list, expected outcome/prognosis, treatment goals, medication management and a schedule to review and revise the plan. Care plans are updated at all relevant visits. At least 75% of patients in care management must have a complete care plan. The practice must identify at least 30 patients in the denominator.*

*For practices that do not have the ability to pull this report in their EHR, refer to the manual chart option utilizing the RRWB (see page 5 for details).*

# Care Coordination and Care Transitions (AR-CC)

***The practice continues to coordinate care with labs, specialists or other care facilities.***

*Report AR-CC 1-2 and report **one** of the following options between AR-CC 3–4:*

## AR-CC 1 Care Coordination Process (Required)

**1. Care Coordination Documented Processes—Attestation**

*Shared*

Does your practice have an implemented documented process for all of the following?
Select one: (Yes/No)

- Lab and imaging tracking until results are available, flagging and following up on overdue results.
- Flagging abnormal lab and imaging results, bringing them to the attention of the clinician.
- Notifying patients/families/caregivers about normal and abnormal diagnostic test results for both lab and imaging.

***Note*:** *Practices must have a documented process for and implement all of the above to sustain PCMH Recognition.*

## AR-CC 2 Referral Management Process (Required)

**1. Referral Processes and Tracking—Attestation**

*Shared*

Does your practice have an implemented documented process for all of the following?
Select one: (Yes/No)

- Giving the consultant/specialist the clinical question, the required timing and the type of referral.
- Giving the consultant/specialist pertinent demographic and clinical data, including test results and the current care plan.
- Tracking referrals until the consultant/specialist's report is available, flagging and following up on overdue reports.

***Note:*** *Practices must have a documented process for and implement all of the above to sustain PCMH Recognition.*

## AR-CC 3 Lab and Imaging Test Tracking (Option)

1. **Tracking Lab Test Results—Report**
   *Site-specific*

   Enter:
   - Numerator: Number of labs ordered for which the practice received a lab order results report.
   - Denominator: Number of lab orders.
   - Reporting period.

2. **Tracking Imaging Test Results—Report**
   *Site-specific*

   Enter:
   - Numerator: Number of imaging tests ordered for which the practice received an imaging results report.
   - Denominator: Number of imaging orders.
   - Reporting period.

***Note:*** *Practices that cannot generate automatic reports may instead complete a manual chart audit of 30 applicable patients (see page 5 for details). If the practice has a very low volume of lab and imaging tests ordered (<30), it should extend the review time frame or choose to report a different reporting option.*

## AR-CC 4 Referral Tracking (Option)

1. **Tracking Referrals—Report** *This measure is the equivalent of CMS #374.*
   *Site-specific*

   Enter:
   - Numerator: Number of patients with a referral for which the referring provider received a report from the provider to whom the patient was referred.
   - Denominator: Number of patients, regardless of age, who were referred by one provider to another provider and had a visit during the measurement period.
   - Reporting period.

***Note*:** *Practices that cannot generate automatic reports may instead complete a manual chart audit of 30 applicable patients (see page 5 for details). If the practice has a very low volume of referrals (<30), it should extend the review time frame or choose to report a different reporting option.*

# Performance Measurement and Quality Improvement (AR-QI)

***The practice continues to collect and use performance measurement data for quality improvement activities.***

*Report the following:*

## AR-QI 1 Clinical Quality Measures (Required)

**1. Clinical Quality Measures—Report**

*Site-specific*

At least annually, the practice monitors at least 5 clinical quality measures across 4 categories (must monitor at least 1 measure of each type):

- Immunization.
- Other preventive care.
- Chronic/acute care.
- Behavioral health.

Enter measure data from the **Measures Reporting** tile on the Organization Dashboard. The practice may choose to report in two ways:

- *If the practice is utilizing a standardized measure outlined in Appendix 5,* it may choose the measure from the drop-down menu in Q-PASS and the measure parameters (e.g., numerator description) will populate.
- *If the practice is utilizing a measure not listed in the standardized measure table,* enter text in fields manually.

Enter:

- Numerator.
- Denominator.
- Reporting period.
- Numerator description.
- Denominator description.

## AR-QI 2 Resource Stewardship Measures (Required)

**2. Resource Stewardship Measures—Report**

*Site-specific*

At least annually, the practice monitors at least 2 measures of resource stewardship (must monitor at least 1 measure of each type):

- Measures related to care coordination.
- Measures affecting health care costs.

Enter measure data from the **Measures Reporting** tile on the Organization Dashboard.

- *If the practice is utilizing a standardized measure outlined in Appendix 5,* it may choose the measure from the drop-down menu in Q-PASS and the measure parameters (e.g., numerator description) will populate.
- *If the practice is utilizing a measure not listed in the standardized measure table,* enter text in fields manually.

Enter:

- Numerator.
- Denominator.
- Reporting period.
- Numerator description.
- Denominator description.

## AR-QI 3 Patient Experience Measure (Required)

**1. Patient Experience Measure—Report**

*Site-specific*

At least annually, the practice monitors at least 1 measure of patient experience relating to 1 of the following categories:

- Access.
- Communication.
- Coordination.
- Whole-person care, self-management support and comprehensiveness.

Enter measure data from the **Measures Reporting** tile on the Organization Dashboard.

Enter:

- Numerator.
- Denominator.
- Reporting period.
- Numerator description.
- Denominator description.