NCQA Resource Sheet

The tables below share guidelines for ensuring accurate, high-quality data. If your practice's data do not align with guidance in the tables, it is not a guarantee that criteria will be marked Not Met. To help us understand your circumstances, describe why data do not align with guidance. This will provide context to the RP Operations Manager and the Review Oversight Committee.

These guidelines include a checklist of the minimum requirements in ***CM 04.***

Verify Size of Patient Population		
Step 1—Collect the following information	Patient population (number of unique patients seen in the last calendar year): KM 09: Diversity denominator..... KM 10: Language denominator.....	
Step 2—Review the data	Are the numbers consistent? For example, if a practice sees 10,000 patients in 1 year, but the denominator for KM 09 (with 6 months of data) is 1,000, the data are not consistent. The practice's KM 09 denominator should be aligned with 5,000 patients. NCQA would ask the practice to rerun the data and work with its vendor if there is a reporting issue. ***Note:*** *A full year is recommended for KM 09 and KM 10 to fully represent the patient population, but it is not required.*	
Criteria	**Data Consistency Questions**	**Recommended Guidelines & Logic**
CM 01–CM 03: Care Management	Is the percentage of care managed patients reasonable for your practice size? **Numerator:** Total number of patients enrolled in care management. **Denominator:** Total number of patients in the practice.	**Review CM 01 and rework data.** Ensure that only patients enrolled in care management are counted. Care management targets a subset of higher-need or at-risk patients, not only "average" patients. Care plans *are not* for acute conditions or for patients who are not enrolled in care management. *This guidance applies to CM 02 as well.*
	Is the number of care managed patients <30?	**Review CM 01 and rework data.** Ensure the practice addresses a minimum of three categories identified in CM 01. Expand the categories if necessary to meet the minimum requirement. CM 01: Establish a systematic process and criteria for identifying patients who may benefit

		from care management (must include at least three): A. Behavioral health conditions. B. High cost/high utilization. C. Poorly controlled or complex conditions. D. Social determinants of health. E. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff, patient/family/caregiver.
Criteria	**Data Consistency Questions**	**Recommended Guidelines & Logic**
CC 01: Imaging Test Management	Is the denominator 30, or do <40% of adult patients receive an imaging order? **Numerator:** Number of images ordered for which the practice received a results report. **Denominator:** Number of imaging orders in the reporting period.	**Did the practice use the Record Review Workbook (Transforming practices)?** Enter a note advising the ROC that the workbook was used. **Does the practice have a reliable system in place to capture data?** On average, more than 40% of adult patients will have an imaging study completed during the year. If the denominator is small, enter a note advising the ROC how the practice's system captures the data. ***Note:*** *Pediatric practices typically have considerably lower imaging studies than adult practices.*
QI 01: Clinical Quality Measures	Does the denominator seem appropriate for the patient population size? The denominator should be all patients in the patient population, as defined by CMS eCQM measures, less allowable exceptions. See **the eCQI Resource Center's** website. Select the measure specification identified with the performance year (e.g., for a 2024 submission, select the version with (2023) stated).	**Did the practice use the Record Review Workbook (Transforming practices)?** Enter a note advising the ROC that the workbook was used. **Is the report pulling data correctly?** Contact the EHR vendor to ensure the report is pulling data correctly. *If yes:* Enter a note to the ROC explaining why the data appear large. *If no:* Request a custom measure, and work with the vendor to correct the report for next year's submission.
	Is CMS 147: Influenza Immunization <18%?	**Is the practice documenting influenza immunizations provided elsewhere?** CMS 147 captures immunization *status*—not only immunizations provided at the practice, but those that are self-reported or carried out elsewhere (e.g., pharmacy, immunization clinic). Enter the practice's workflow in a note to the ROC. Address workflow to capture immunization

		status for future reporting if CMS 147 is being submitted.

Criteria	Data Consistency Questions	Recommended Guidelines & Logic
	Are the denominators appropriate when the measure applies to "patients" or "visits"?	Most commonly, CMS 22: Screening for High Blood Pressure and Follow-Up for Ages 18+; CMS 69: BMI Screening and Follow-Up for Ages 18+; CMS 2: Depression Screening and Follow-Up for Ages 12+. Explain the inconsistency in a note to the ROC.
QI 02: Resource Stewardship Measures	Does the denominator seem appropriate for the patient population size?	**Is the report pulling data correctly?** Contact the EHR vendor to ensure the report is pulling data correctly. *If yes:* Enter a note to the ROC explaining why the data appear large. *If no:* Request a custom measure, and work with the vendor to correct the report for next year's submission.
	Is CMS: 146: Appropriate Testing for Pharyngitis <52% ***and/or*** Is CMS 154: Appropriate Treatment for Upper Respiratory Infection <60%?	**Does the practice have a reliable system in place to capture data?** Typically, primary care practices see many URIs per year. If the denominator is small, enter a note advising the ROC how the practice's system captures the data. **What version of the measures is the vendor using?** CMS 146v11 and CMS 154v11 are the correct measure specification versions for 2023 measurement year (2024 submission year). If the vendor is using an older version (age limit 18), provide the vendor with the correct version for future reporting (refer to the links below). Request a custom measure to report for this year. ***Note:*** *Specifications change yearly. Refer to the **eCQI Resource Center** yearly to obtain the current version of measures.* *The year posted at the end of the measure title is the measurement year (1 year prior to the submission year).* **Is the practice coding to capture these patients?** Review the specifications to ensure the practice is capturing the correct data for further reporting. The practice may request a custom measure for this year.

Criteria	Data Consistency Questions	Recommended Guidelines & Logic
		Version 11 specifications (MY 2023) **CMS 146: Appropriate Testing for Pharyngitis** **CMS 154: Appropriate Treatment for Upper Respiratory Infection**
	Is CMS 50: Closing the Referral Loop <46%?	**Does the practice have a reliable system in place to capture data?** Closing the referral loop between PCP and specialist ensures patient safety, reduces duplicated tests and improves successful coordination across clinicians. If the denominator is small, enter a note advising the ROC how the practice's system captures the data. ***Note:*** *Per CMS measure specifications, "If there are multiple consultant reports received by the referring clinician which pertain to a particular referral, use the first consultant report to satisfy the measure."*

General Data Guidance

If percentages are questionable, confirm with the vendor that reports are pulling data correctly.

If data are being pulled correctly, enter an explanation to give the ROC context for the final decision.

If the report is not pulling data correctly, request a custom measure and work with the vendor to correct the eCQM for next year's reporting.

eCQM Average Percentage Guidance

This table displays the eCQM standardized measure names and a percentage that is one standard deviation below the average percentage submitted by PCMH practices to NCQA. Please review your data with this table.

Measure Name	Submitted Percentage*
CMS 147: Influenza Immunization	18%
CMS 127: Pneumococcal Vaccination	43%
CMS 117: Childhood Immunization Status	21%
CMS 124: Cervical Cancer Screening	40%
CMS 130: Colorectal Cancer Screening	44%
CMS 125: Breast Cancer Screening	49%
CMS 69: Body Mass Index Screening and Follow-Up Plan	64%
CMS 138: Tobacco Use: Screening and Cessation Intervention (Rate 1)	67%
CMS 138: Tobacco Use: Screening and Cessation Intervention (Rate 2)	38%

*If your submitted percentage is less than the percentage in the column, enter a descriptive note in Q-PASS. Percentages for inverse measures will be greater than the percentage in the column (CMS 122).

Measure Name	Submitted Percentage*
CMS 138: Tobacco Use: Screening and Cessation Intervention (Rate 3)	37%
CMS 22: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	43%
CMS 349: HIV Screening	47%
CMS 155: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (Rate 1)	78%
CMS 155: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (Rate 2)	53%
CMS 155: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Rate 3)	60%
CMS 153: Chlamydia Screening in Women	41%
CMS 139: Fall: Screening for Future Fall Risk	66%
CMS 136: Follow-Up Care for Children Prescribed ADHD Medication (ADD) (Rate 1)	29%
CMS 136: Follow-Up Care for Children Prescribed ADHD Medication (ADD) (Rate 2)	50%
CMS 2: Screening for Depression and Follow-Up Plan	58%
CMS 137: Initiation and Engagement of Substance Use Disorder Treatment (Rate 1)	16%
CMS 137: Initiation and Engagement of Substance Use Disorder Treatment (Rate 2)	40%
CMS 161: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	66%
CMS 159: Depression Remission at Twelve Months	5%
CMS 128: Anti-depressant Medication Management (Rate 1)	20%
CMS 128: Anti-depressant Medication Management (Rate 2)	29%
CMS 177: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	24%
CMS 165: Controlling High Blood Pressure	57%
CMS 122: Diabetes HbA1C Poor Control (>9%) *(Inverse Measure)*	*>42%*
CMS 131: Diabetes Eye Exam	33%
CMS 347: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Rate 1)	70%
CMS 347: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Rate 2)	66%
CMS 347: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Rate 3)	65%
CMS 149: Dementia: Cognitive Assessment	79%
CMS 50: Closing the Referral Loop	46%
CMS 68: Documentation of Current Medications in the Medical Record	79%
CMS 146: Appropriate Testing for Pharyngitis	52%
CMS 154: Appropriate Treatment for Upper Respiratory Infection (URI)	60%

*If your submitted percentage is less than the percentage in the column, enter a descriptive note in Q-PASS. Percentages for inverse measures will be greater than the percentage in the column (CMS 122).

CM 04: Person-Centered Care Plan Guidance

An NCQA patient-centered care plan has five requirements

- ✓ *Problem list:* Gives the patient and their providers a global view of the patient's health.
- ✓ *Medication management:* A list of all medications the patient is currently taking (not only medication adjustments made during a visit with a provider).
- ✓ *Expected outcomes/prognosis:* The clinical goal; for example, decrease A1c by 2 points.
- ✓ *Treatment goals:* The patient's goals; for example, reduce A1c by 2 points by eating fried fast food only once a week.
- ✓ *Schedule to review and revise:* A specific date or schedule, such as "every 2 months." A schedule is important for both the patient and care team; it lets them check in, celebrate successes, talk about barriers and update the plan if necessary.

A robust care plan includes the five requirements above plus any (or all) of these components:

1. *Patient preferences and goals (CM 06).* Goals that are personal to the patient. For example, "I want to walk in a 5K next summer," "I want to dance at my grandson's wedding next spring." If goals are meaningful, a patient may be more likely to adhere to the care plan.
2. *Patient barriers to goals (CM 07).* This is another reason to schedule follow-up visits: Addressing barriers early helps the patient from deviating from the plan and supports their success.
3. *Self-management plans (CM 08).* Self-management instructions help patients through day-to-day challenges. They may also reduce ED visits—the patient can manage changes in their condition on their own with a self-management tool.
4. *Person-centered outcomes approach (CM 10).* This component of the care plan quantifies a patient's progress in meeting their personal goal, using a patient-reporting outcome measure (PROM) or a goal attainment scale.
5. *Person-centered outcomes approach (CM 11).* This involves monitoring and follow-up with the patient: revisiting the PROM or goal attainment scale and comparing the initial score with a new score. Is the patient getting closer to meeting their personal goals, or does the care plan need to be revised?

A care plan should be created collaboratively by patient and provider, and should be easily understood by the patient/family/caregivers. This gives the patient ownership of their health and confidence in meeting their goals.