Physician Quality

PQ 1: Measures and Methods

The organization uses standardized measures of quality and valid measures of cost, resource use or utilization when measuring the quality and affordability of care provided by physicians.

Intent

When an organization measures physician quality and cost of services, it uses widely accepted measures and methods that produce valid and reliable results.

Element A: Standard Quality Measures

The organization uses measures from standardized sources to assess the quality of its individual physicians, practices or medical groups.

Summary of changes

Clarifications

- Converted scoring to Met, Partially Met, Not Met.
- Replaced references to NQF with PQM throughout the element.
- Removed outdated references throughout the element.
- Added new standardized measure sources under "Selecting standardized measures."

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~At least 70% of the measures used by the organization to measure physician quality meet the element~~	~~At least 60% but fewer than 70% of measures used by the organization to measure physician quality meet the element~~	~~At least 50% but fewer than 60% of measures used by the organization to measure physician quality meet the element~~	~~At least 20% but fewer than 50% of measures used by the organization to measure physician quality meet the element~~	~~Fewer than 20% of measures used by the organization to measure physician quality meet the element~~

Met	Partially Met	Not Met
At least 50% of the measures used by the organization to measure physician quality meet the element	No scoring option	Fewer than 50% of measures used by the organization to measure physician quality meet the element

Data source Documented process

Scope of review NCQA scores this element once for the program.

Look-back period *For Initial and Renewal Surveys:* NCQA looks for evidence that the required activities were completed in conjunction with the most recent version or cycle of actions included in the scope of review.

Explanation **THIS IS A MUST-PASS ELEMENT**.

~~The organization must earn a score of 50% or higher in order to achieve certification.~~

Documentation

NCQA reviews the organization's documented processes (e.g., program descriptions, measure specifications) demonstrating the quality measures the organization uses.

Documentation of a process includes:

- A complete inventory of all measures it uses to evaluate physicians, practices and medical groups for the program.
- The actual specifications used by the organization.
- If the organization is seeking credit for the measure as a standardized measure, a copy of the specification for the standardized measure maintained by the measure steward.

Note: *The organization is not required to provide a copy of measure specifications for any measure for which NCQA is the measure steward (e.g., NCQA HEDIS Volume 2 Technical Specifications) if it adjusts the measure according to the Rules for Allowable Adjustments. If the organization makes adjustments to the measure outside the Rules for Allowable Adjustments, it must provide a copy of the measure specifications that specifies the adjustments that were made.*

Unit of measurement

The organization may measure performance for any of the following:

- Individual physicians.
- Practices.
- Medical groups.

Note: *Throughout these standards and guidelines,* ***physician*** *and* ***physician level*** *means any of these units of measurement.*

A **practice** is one physician or a group of physicians at a single geographic location practicing together. **Practicing together** means that for all the physicians in a practice, the following criteria are met:

- The single site is the location of practice for at least the majority of their clinical time.

- Nonphysician staff follow the same procedures and protocols as physician staff.
- Medical records (paper or electronic) for all patients treated at the practice are available to and shared by all physicians, as appropriate.
- The same systems—electronic (computers) and paper-based—and procedures support both clinical and administrative functions: scheduling time, treating patients, ordering services, prescribing, keeping medical records and follow-up.

A **medical group** or **physician organization** is a group of physicians that comprises more than one practice site.

The unit of measure may vary by measure and may be different from the unit with which the organization contracts.

Customers, consumers and purchasers

Customers include both **consumers** (individuals) and **purchasers** (organizations).

Consumers are individuals who use measurement information to help them choose a health plan or physician. Depending on the type of organization, consumers may also referred to as **patients** or **members**. Consumers' relationship to the organization may be **indirect** and through a purchaser (e.g., employer, health plan) or **direct** (e.g., an information provider that makes information publicly available on a Web site). **Purchasers** are organizations that contract directly with the organization being certified to display or otherwise use the results of measurement and action. Purchasers may be employers, states or health plans.

Prospective purchasers and consumers can benefit from information on quality, cost and resource or physician use to inform their choice of health plan, network or physician.

Determining the percentage of measures standardized for scoring PQ 1, Element A

NCQA counts each quality measure that the organization uses to measure physicians in the program under review. A **quality measure** evaluates an aspect of clinical performance or patient experience where data can help identify "better" performance or "worse" performance, with respect to care or service provided. NCQA considers structural measures endorsed by the Partnership for Quality Measure (PQM) ~~NQF~~ to be quality measures.

When counting measures:

- All measures count if the organization has primary and secondary measures (e.g., physicians are first considered against the primary set of measures and, if they do not meet thresholds or have insufficient observations, are then considered against secondary measures).
- Each measure in a program counts once, even when it applies to more than one specialty. Similarly, all measures count even if they apply only to some specialties.

- When using a measure with multiple indicators ~~composite measures~~, each individual indicator ~~measure of a discrete aspect of care where physicians' performance is specifically measured~~ counts as a measure ~~(e.g. Comprehensive Adult Diabetes Care (CDC) from HEDIS-PM is a composite measure that includes the following 11 measures: HbA1c testing, HbA1c control <7% for a selected population, HbA1c control <8.0%, HbA1c poor control >9.0%, eye exam (retinal) performed, LDL-C screening, LDL-C control, medical attention for nephropathy, blood pressure control, foot examination and smoking status and cessation advice or treatment. It would count as 11 measures.~~
- Non-~~NQF~~PQM endorsed patient experience surveys are counted as one measure for the entire survey. The CAHPS® Clinician & Group Survey ~~CAHPS-CG~~ questions or composites count as separate measures.
- ~~Measures of the same clinical process in~~ Different age stratifications within the same measure do not count as individual measures ~~(e.g., Chlamydia Screening in Women (CHL) from HEDIS-PM includes two age stratifications for ages 16-20 and 21-24 counts as one measure)~~.

A criterion that is not a quality measure as defined by the standards is removed from the denominator in this element and is not counted as a quality measure in Element D. The numerator is all measures in the denominator where the original measure specification is the same as the organization's implemented version.

Selecting standardized measures

The organization selects areas of quality to assess, including clinical quality or patient experience, and selects measures for those areas. The following are considered standardized measures for all levels (i.e., individual physician, practice, medical group):

- **~~NQF~~PQM-endorsed measures:** Find information on the full set of ~~NQF~~PQM-endorsed measures at ~~http://www.qualityforum.org~~ https://p4qm.org/. The complete specifications for ~~NQF~~PQM measures are available from the organization that developed and submitted the measures to ~~NQF~~PQM.
- ~~Other standardized measures include:~~
- Measures developed by national accreditors (e.g., NCQA, The Joint Commission).
- ~~Measures developed by the AMA PCPI. Find the complete list of AMA PCPI measures at http://www.ama-assn.org/ama/pub/ category/4837.html.~~
- Measures developed by national specialty medical boards that belong to the ABMS or the Bureau of Osteopathic Specialists, and that use measures for granting or maintaining certification.
- Measures developed by government agencies (e.g., CMS, AHRQ) or state agencies.
- Measures required for the ~~Physician Quality Reporting System~~ Quality Payment Program ~~PQRS~~(QPP).
- Measures included in CMS Star Ratings.
- Measures included in the Medicaid Adult or Child Core Set.
- Measures included in the Core Quality Measures Collaborative (CQMC) core measure sets.

- Eligible Clinician eCQMs (https://ecqi.healthit.gov/ep-ec?qt-tabs_ep=ec-ecqms&global_measure_group=eCQMs).

Note: Measures from sources other than above are not standardized measures.

Following standardized measure specifications

For a measure to be considered as being from one of the sources listed above, the organization must follow the measure specifications for the level at which it is measuring ~~(e.g., measures specified for the health plan level are not acceptable as physician-level measures)~~. This includes all numerator and denominator inclusions and exclusions, measured time periods and specified data sources. An organization that uses the most current specifications from the measure steward meets the intent of this element, even if the ~~NQF~~PQM endorsement has not been updated.

The organization must provide the original-source, standardized measure specification (from the measure steward) as documentation, as well as the implemented version. NCQA compares the specification documents and determines whether the measure specifications are standardized.

NCQA recognizes that some specifications issued by measure owners may require additional specifications for implementation. The organization may supplement endorsed specifications if it follows the specifications, and if it does not alter the measure's intended numerator, denominator and exclusion criteria.

HEDIS measures may only be adjusted according to NCQA's Rules for Allowable Adjustments of HEDIS (the "Rules")~~. Effective with surveys starting on or after January 1, 2021, HEDIS measures must be un-adjusted or follow the Rules~~ to be considered standardized measures.

Changes in endorsement status

If a measure receives or loses endorsement during an organization's survey period, the organization may use the measure if it was endorsed for at least half the measurement period.

Third-party commercial software

The organization may use commercial software to calculate measure results. The organization must demonstrate that the specifications employed by the software match the standardized specifications for the measures used, and must make this information available to NCQA for evaluation as part of the survey process.

Patient-experience measures

Patient-experience measures are considered measures of quality. The organization should use items or composites from the CAHPS-CG survey or

other patient experience instruments endorsed by the ~~NQF~~PQM, or developed by national accreditors or government agencies or specialty societies.

Specialty board measurement initiatives

Board certification does not count as a standardized measure.

Medical specialty boards belonging to the ABMS or the AOA have measurement initiatives in place as part of the requirements for achieving or maintaining certification. These measurement initiatives often produce results that reflect the breadth of a physician's practice and draw from data on a broader scope of patients than an individual organization may capture through its measurement. Relying on these initiatives can reduce physician burden resulting from external organizations' various measures or methodologies, and because they are created by the physician community, they enjoy broad physician support.

Completing a performance practice assessment within the last two years—whether as part of an ABMS Maintenance of Certification (MOC) (ABMS MOC Part IV) or an AOA Osteopathic Continuous Certification (OCC) Component 4,—is considered a standardized quality measure for meeting this element. One performance practice assessment counts as one standardized measure.

To receive credit for using ABMS MOC Part IV or AOA OCC Component 4, the organization must list in the Survey Tool's Element A Measure Worksheet:

- The ABMS MOC Part IV and AOA OCC Component 4 activities on which it bases the action.
- The source of the measures as specialty medical boards.
- A direct link to the board where the activity and its measures can be found.

The organization must verify that a physician has completed an ABMS MOC Part IV or AOA OCC Component 4 activity within the last two years.

Use of Performance-Based Designation Programs

There are a variety of nationally recognized performance-based designation programs for physician measurement. Organizations may incorporate physician participation in these programs as a quality measure in their own physician measurement programs. The organization's program methodology must specify how it makes use of the programs, including the time frame during which a physician is recognized by or otherwise participates in the program. That period is considered the "measurement year" for the purposes of this requirement.

For example, "For ABC Health Plan's ~~2021~~ 2026 Star Network, credit is given if a physician is NCQA PCMH-Recognized any time from January 1–

December 31, ~~2019~~2024." In this case, the measurement year (MY) is ~~2019~~2024.

Because the number of standardized quality measures in each program is known, organizations do not need to provide documentation of measurement specifications. Organizations must complete the measure workbook and indicate how they use the designation to take action.

The composition of the performance-based designation programs changes periodically; NCQA will update Appendix 4 as needed and will include effective and expiration dates of performance-based designation programs based on the measurement year for which they may be used.

If an organization uses a program for more than one measurement year, and the number of measures changed during the interval, the organization receives credit for the program one time for the version that has the greater number of standardized measures. Organizations enter only that single program in the worksheet.

Element B: Measuring Cost

The organization measures cost, resource use or utilization of physicians, practices or medical groups:

1. **Across the physician's total patient population.**
2. **Specific to at least one clinical condition.**

Summary of changes

Clarifications

- Converted scoring to Met, Partially Met, Not Met.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets both factors~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization does not meet either factor~~

Met	Partially Met	Not Met
The organization meets 2 factors	No scoring option	The organization meets 0 factors

Data source Documented process

Scope of review NCQA scores this element once for the program.

Measures included: NCQA evaluates the cost, resource use or utilization measures the organization uses to measure physician performance.

Look-back period

For Initial and Renewal Surveys: NCQA looks for evidence that the required activities were completed in conjunction with the most recent version or cycle of actions included in the scope of review.

Explanation

Documentation

NCQA reviews the organization's documented processes or materials, including program descriptions and measure specifications demonstrating the organization's approach to cost of care, resources use or utilization measurement; how the approach is used; and the clinical categories, if any, being measured for physicians, practices and medical groups.

Cost, resource use or utilization measures

The organization measures cost, resource use or utilization to understand and address areas of overuse, underuse and misuse.

Cost of care considers the mix and frequency of services, and is determined using actual unit price per service or unit prices found on a standardized fee schedule. Examples of cost of care measurement include:

- Dollars per episode, overall or by type of service.
- Dollars per member, per month (PMPM), overall or by type of service.
- Dollars per procedure.

Because price can vary among physicians, practices or medical groups—even within an organization's network—measures using both actual unit prices and standardized prices may be needed to gain a full understanding of differences among physicians.

Utilization is an unweighted count of services (e.g., inpatient discharges, inpatient days, office visits, prescriptions).

Resource use differs from utilization by considering the relative intensity or cost of services in addition to the count of services across the spectrum of care, such as the difference in intensity between a major surgery and a 15-minute office visit.

This element further distinguishes measures for an entire patient population (factor 1), regardless of specific conditions, and measures for specific clinical conditions (factor 2). For cost, resource use and utilization, the organization must apply risk adjustment (Element C).

Current methods of evaluating physicians' relative cost, resource use or utilization are often designed around a risk- or case-mix system that classifies patients with similar conditions into groups with similar utilization patterns. The central feature is how the methods classify diseases and the cost, resource use and utilization metrics to be used in evaluating cost of care.

Some methods focus on a patient population where the person is the unit of analysis; these are known as **population-based approaches**. The resulting

measure is a risk-adjusted total cost, resource use or utilization for a panel of patients across diagnoses.

Some methods focus on specific homogenous episodes of care as the unit of analysis; these are known as **episode-based approaches**. An episode can be defined by a specific acute illness or event (e.g., cardiac bypass surgery) or a specific time period, for patients with a chronic condition (e.g., care for a diabetic during a year).

Exception

This element is NA if the organization does not include cost, resource use or utilization measures in the program for which it is seeking certification.

Examples

Population-based measures

- Total cost, resource use or utilization of a patient panel over a defined time period (not grouped by disease or clinical condition).

Element C: Define Methodology

The organization's methodology addresses:

1. **The physicians measured, including which specialties and geographic areas.**
2. **The specifications used to calculate each performance measure.**
3. **How the organization attributes patients to physicians, practices or medical groups.**
4. ***For quality only*: the minimum number of observations for each measure for assessment of physicians, practices or medical groups.**
5. **How the organization considers measurement error in reporting actual performance differences among physicians, practices or medical groups.**
6. **The peer groups used for comparison.**
7. **How the organization employed or considered risk adjustment to make fair comparisons.**
8. ***For cost, resource use or utilization only*: how the organization uses risk adjustment to make fair comparison.**
9. ***For cost, resource use or utilization only*: how the organization handles measurement outliers.**

Summary of changes

Clarifications

- Converted scoring to Met, Partially Met, Not Met.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization~~	~~The organization~~	~~The organization~~	~~The organization~~	~~The organization~~

~~addresses 8-9 factors~~	~~addresses 7 factors~~	~~addresses 6 factors~~	~~addresses 4-5 factors~~	~~addresses 0-3 factors~~

Met	Partially Met	Not Met
The organization meets 6-9 factors	No scoring option	The organization meets 0-5 factors

Data source Documented process

Scope of review NCQA scores this element once for the program.

Look-back period *For Initial and Renewal Surveys*: NCQA looks for evidence that the required activities were completed in conjunction with the most recent version or cycle of actions included in the scope of review.

Explanation **THIS IS A MUST-PASS ELEMENT.**

~~The organization must earn a score of 50% or higher in order to achieve certification.~~

Documentation

NCQA reviews the organization's documented processes, including program descriptions, methodology documentation and measure specifications.

Specifications

For each measure, the organization specifies the criteria for inclusion and exclusion in numerators and denominators, including requirements for:

- Diagnostic and procedure codes.
- Data source (e.g., claims, pharmacy, laboratory data, medical record, registry, as applicable).
- Age and sex of patients included in attribution.
- The physician peer group (e.g., family vs. all primary care physicians).
- Definition of episodes of care, if applicable.
- The time period covered by the measure, as applicable.

In addition, for each cost, resource use or utilization measure, the organization should specify:

- The types of cost included (e.g., total costs or outpatient only).
- How comparison is made (average vs. nominal).

Attribution methods

The organization's methodology clearly defines how it attributes specific patient services to specific physicians, practices or medical groups. The organization may attribute a patient to one or more physicians, practices or medical groups.

Organizations may use different methodologies for attributing care to physicians for cost, resource use or utilization analyses and for quality analyses. For quality of care attribution, as well as cost attribution, methods may differ for primary care physicians (PCP) and specialists. If there are multiple attribution methods, the organization must specify the method of attribution for each.

Time period

To achieve larger denominators, the organization may use more than 12 months of data for measurement (e.g., rolling measurement periods).

Measurement error

The organization demonstrates how it distinguishes between the performance of one physician (or practice or medical group) and the performance of peers, thresholds or benchmarks. This process requires statistical determinations. For this element, NCQA reviews whether the organization defined its statistical methods in its methodology documentation. Element D requires specified levels for statistical determinations. Statistical determinations may include any of the following:

1. **Minimum observations.** As applicable, the organization specifies whether there is a minimum number of observations or a minimum denominator for each measure. If the organization includes patients or members from all product lines (commercial, Medicaid, Medicare) and from multiple organizations in the denominators, its methodology must specify how it addresses case-mix adjustment. Denominators may be composed of observations, and individual patients may account for more than one observation. If an organization relies solely on confidence levels or intervals of reliability in lieu of minimum observations, its methodology must clearly disclose this, thereby addressing how it handles minimum observations.

2. **Confidence levels and intervals.** The confidence level gives an indication of how much uncertainty there is about a performance estimate and is used to calculate an interval around the performance estimate. By statistical definition, a 90 percent confidence interval calculated for a performance estimate indicates that if many samples were drawn and interval estimates calculated on each performance estimate, in the long run, 90 percent of these confidence intervals will include the true rate. In practical terms, the confidence interval gives a margin of error around the estimate. Its size is influenced by sample size and by the standard deviation—larger samples decrease the confidence interval and more variation increases the confidence interval.

3. **Reliability of a measure.** The ability to distinguish between the performance of one physician (or practice, or medical group) and the performance of other physicians (or practices, or medical groups). **Reliability** is the ratio of the variance between physicians to the variance

within one physician, plus the variance between physicians. Two factors are necessary to determine reliability:

- Understanding observations eligible for the measure.
- Performance variation among physicians on the measure. The greater the number of observations, the more precise the estimate of a physician's performance. Where performance does not vary across physicians, it is harder to distinguish individual performance. Requiring a minimum number of observations per measure helps to ensure that comparisons across measures are fair, but even large numbers of observations per measure may not be enough to ensure reliable comparisons when there is not much variation among physicians.

4. For quality measures, the organization specifies the minimum number of observations or a minimum denominator for each measure. When using a confidence interval or reliability level to determine the minimum observations for each measure and physician, instead of setting a discrete number for the minimum observations, the methodology specifies the confidence interval or reliability level and the type of test used to determine it.

Risk adjustment

Case-mix adjustment accounts for variations in the health of patient populations, often defined by age and gender. **Severity** is a patient's degree of illness for a specific mix of conditions (e.g., cancer stages), morbidity or comorbidity. Together, case mix and severity are often called **risk**. Risk can be either the risk for needing a mix of medical services (utilization and associated costs) or the patient's likelihood of achieving some level of quality-related outcome.

For **quality measures**, NCQA requires the organization to address risk adjustment in its methodology. To meet the requirement, the methodology documentation must:

- Describe the explicit methodology used, if the organization adjusts measures for case-mix or severity, ***or***
- Document that the organization has considered risk adjusting measures and has an explicit rationale for not risk adjusting if it determined that case-mix and severity adjustment do not apply to a quality measure.

5. For cost, resource use or utilization measures, the organization must use an adjustment methodology to account for variation in the characteristics of physicians' patient populations. This includes consideration of case-mix, severity and outlier episodes.

Outliers, which should be rare, are extreme data values that are likely to be inaccurate or not represent general patterns. Outliers can create statistical (estimation of the mean) problems, either because an outlier is a case-mix problem (the case was a true clinical aberration) or is a data or coding error.

The organization's methodology addresses how it handles outliers when calculating results.

If the organization uses commercial software to calculate cost, resource use or utilization results, it demonstrates that the software includes—and the organization makes use of—risk and outlier adjustment methodologies. The organization must be transparent about the method it employs.

Summary measures

If the organization uses multiple measures to arrive at an overall rating—such as a star (public reporting display); tiering or inclusion in network; or performance-based payment—it must have clear methodological documentation for the overall rating, as well as for the individual measures addressing all applicable factors.

Episodes of care represent clinically meaningful units of analysis for measuring care and encompass all care received by clinically homogenous patient groups between specific start and end dates.

Exceptions

Factors 8 and 9 are NA if the organization does not use cost, resource use or utilization measures in the program under review.

Examples

Attribution methods

Common methods include assigning patients to physicians, practices or medical groups based on:

- Primary care physician assignment, if applicable, ***or***
- Visit-based algorithms (e.g., any visit, most recent visit or a specified percentage of visits), ***or***
- Cost-based algorithms (e.g., percentage of costs per episode or per year).

Risk adjustment

- *Case-mix adjustment:* Considering the inherent variation (e.g., race, ethnicity, socioeconomic status, age, gender) in the populations served by physicians being measured.
- *Severity adjustment*: Including stage of illness and comorbidities.
- *Outliers:* Excluding rare or extreme data values that can disproportionately influence statistical results, such as values beyond an expected range.

Element D: Adhere to Key Principles

The organization uses results of physician measurement in accordance with the following principles.

1. **Comparisons of performance on quality measures are based on a minimum number of 30 observations or a confidence interval of 90% or measure reliability of at least 0.70.**
2. **Comparisons of performance on cost, resource use or utilization measures are based on a confidence interval of 90% or measure reliability of at least 0.70.**
3. **Taking action on cost, resource use or utilization results only in conjunction with quality results.**

Summary of changes

Clarifications

- Converted scoring to Met, Partially Met, Not Met.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets all 3 factors~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization meets 0-2 factors~~

Met	Partially Met	Not Met
The organization meets 3 factors	No scoring option	The organization meets 0-2 factors

Data source Documented process, Reports

Scope of review NCQA scores this element once for the program.

Look-back period *For Initial and Renewal Surveys*: NCQA looks for evidence that the required activities were completed in conjunction with the most recent version or cycle of actions included in the scope of review.

Explanation **THIS IS A MUST-PASS ELEMENT.**

~~The organization must earn a score of 50% or higher in order to achieve certification.~~

Documentation

NCQA reviews the organization's reports and documented processes, including program descriptions and measure specifications describing the organization's process and measurement results.

Results include results of individual measures or composite scores (e.g., stars or tiers).

Minimum observations, reliability and confidence interval

Factors 1 and 2 are NCQA's minimum requirements for the precision of data on which organizations act. If consumers and purchasers use measure results to help them choose physicians, it is important that the measures accurately reflect physician performance. Although the science of measurement is evolving rapidly, at present there is limited published information that can help develop consensus about necessary levels of precision.

Attaining appropriate precision

Two strategies for measurement may help the organization attain appropriate precision. First, using composite measures and scoring usually results in substantially higher calculated reliability and confidence; this is the technique used in NCQA Recognition programs. Second, increasing the sample size by either reporting data over multiple years or reporting at an aggregate level (practice or medical group) leads to lower standard errors and higher reliability.

The organization may include patients from all product lines (commercial, Exchange, Medicaid, Medicare) in the denominators. In this case, its methodology must specify how case-mix adjustment is addressed.

Taking action on quality measures

Acting on quality measures requires one of the following three criteria to be met:

- The calculated reliability of the measure is 0.70 or higher (Element C). Reliability equals the ratio of the variance between physicians to the variance within one physician, plus the variance between physicians.
- A confidence level of 90 percent is used to compare performance among physicians or with a benchmark. The organization must calculate a confidence interval around measurement results based on a 90 percent confidence level, and must distinguish among physicians, accounting for the confidence interval. Performance rates with confidence intervals that span two or more performance categories should always be considered to meet the more desirable performance level.
- The minimum number of observations is 30.

Taking action on cost, resource use or utilization measures

Measures of cost, resource use and utilization usually have skewed distributions, so statistics such as those for quality measures, based on the assumptions of a normal distribution, are less appropriate. For this reason, NCQA does not accept a minimum sample size of 30 as meeting this element for cost, resource use or utilization measurement.

The organization may only act on cost, resource use or utilization measures that meet one of the following criteria (factor 2):

- The calculated statistical reliability is 0.70 or higher and equals the ratio of the variance between physicians to the variance within one physician, plus the variance between physicians (Element C).

- A confidence level of 90 percent is used to compare performance among physicians or with a benchmark. The organization must calculate a confidence interval around measurement results based on a 90 percent confidence level, and must distinguish among physicians, accounting for the confidence interval. Performance rates with confidence intervals that span two or more performance categories should always be considered to meet the more desirable performance level.

Using quality and cost, resource use or utilization measures together (factor 3)
The organization's program may not be designed to take action based solely on cost, resource use or utilization.

For the purposes of meeting this factor, NCQA counts only those quality measures that meet the definition of a quality measure as defined by these standards that the organization is using to measure physicians. These are the measures that are in the denominator of Element A. If NCQA determines that the organization is using a criterion or metric that is not a quality measure as defined by these standards and it is not counted in the denominator of Element A, that criterion or metric would not be counted as a quality measure for Element D.

The organization's program must consider quality in conjunction with cost, resource use or utilization when taking action. However, if the organization is unable to identify standardized measures of quality for a particular specialty or if there is insufficient data on an individual physician, practice or group the organization can act on cost performance when quality performance is not known. This is allowed in order to maximize the availability of performance information but must be handled in a fully transparent manner so that it is very clear when a physician is designated as high value and when they are purely designated as low cost. In order to meet the expectations of this factor in such instances, the organization must:

- Identify for NCQA and clearly indicate in methodology documents and communications with customers and physicians the specialties for which quality measures cannot be obtained.
- Identify for NCQA and clearly indicate in methodology documents and communications with customers and physicians how insufficient data is defined and how these circumstances are handled within the program.
- Identify for NCQA the total number of physicians by specialty subject to the measurement program and of those the number that do not have quality performance included 1) where there are applicable quality measures but insufficient data (e.g. observations) to calculate measure results and 2) where there is an absence of applicable quality measures for the specialty, including Maintenance of Certification or other accepted performance designation programs. The including of physicians in these two groups should be mutually exclusive by definition.
- Prominently indicate for any individual physician that quality performance is not known wherever cost performance is acted on alone. This requires that, for example, public report cards on the internet specifically denote each physician who has insufficient information to report on quality in the same place where cost performance is displayed. A generic note on a public report card is not sufficient.

The above documentation must be submitted as documentation for this Element and factor even though some of this documentation has been provided for other Elements.

Exception

Factor 2 is NA if the organization does not take action on results of cost, resource use or utilization measurement. In this case, factor 3 is scored ”Met.”

Examples

Element E: Frequency

The organization uses measure results that reflect recent physician performance by measuring at least every two years.

Summary of changes

Clarifications

- Converted scoring to Met, Partially Met, Not Met.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization measures physician performance at least every 2 years~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization measures physician performance less frequently than every 2 years~~

Met	Partially Met	Not Met
The organization measures physician performance at least every 2 years	No scoring option	The organization measures physician performance less frequently than every 2 years

Data source Documented process, Reports

Scope of review NCQA scores this element once for the program.

Look-back period *For Initial and Renewal Surveys*: NCQA looks for evidence that the required activities were completed in conjunction with the most recent version or cycle of the actions included in the scope of review.

Explanation **Documentation of the measurement period**

The organization measures the performance of its individual physicians, practices or medical groups at least every 2 years (every 24 months, with a two-month grace period).

- *For Initial Surveys*, NCQA evaluates the organization's documented process for its planned measurement cycle.
- *For Renewal Surveys*, NCQA evaluates reports demonstrating the time between the current and previous measurement cycles.

Examples

Attribution methods

Common methods include assigning patients to physicians, practices or medical groups based on:

- Primary care physician assignment, if applicable, ***or***
- Visit-based algorithms (e.g., any visit, most recent visit or a specified percentage of visits), ***or***
- Cost-based algorithms (e.g., percentage of costs per episode or per year).

Risk adjustment

- *Case-mix adjustment:* Considering the inherent variation (e.g., race, ethnicity, socioeconomic status, age, gender) in the populations served by physicians being measured.
- *Severity adjustment*: Including stage of illness and comorbidities.
- *Outliers:* Excluding rare or extreme data values that can disproportionately influence statistical results, such as values beyond an expected range.

Element F: Verifying Accuracy

The organization employs a process that includes the following to verify that its measurement methodology is accurately applied when it conducts measurement.

1. **How the organization verifies or audits the measurement process, including the accuracy of the application of specifications and data completeness across those being measured.**
2. **Who verifies the measurement process.**
3. **How the organization corrects errors.**
4. **How the organization updates any measure results it makes available to physicians or customers.**

Summary of changes

Clarifications

- Converted scoring to Met, Partially Met, Not Met.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~

~~The organization employs a process that includes all 4 factors~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization employs a process that includes 0-3 factors.~~

Met	Partially Met	Not Met
The organization meets 4 factors	No scoring option	The organization meets 0-3 factors

Data source Documented process, Reports

Scope of review NCQA scores this element once for the program.

Look-back period *For Initial and Renewal Surveys*: NCQA looks for evidence that the required activities were completed in conjunction with the most recent version or cycle of actions included in the scope of review.

Explanation

Documentation

NCQA reviews the organization's documented process for verifying that the specifications outlined in Element C were followed, and reviews reports (including corrections and notifications to physicians) to determine that the organization followed its process.

Vendors

The organization may use a vendor to produce measure results, but the survey must include documentation demonstrating how to meet the element.

Notice of available information

If the organization makes any information available upon request only, it must provide written or Web-based notice to customers that the information is available, with instructions on how to obtain it.

External audit

The organization may use external auditors to verify its methodology, but is not required to do so.

Examples

Data completeness

- Do data systems capture lab results for a high percentage of patients with a diagnosis that would call for lab tests?

Element G: Results Reflect Data Beyond a Single Payer

To make data more representative and to reduce redundant measurement, the organization uses data from other sources that are representative of a physician's performance or participates in a multi-payer collaborative for quality or cost, resource use or utilization measurement.

1. **The organization participates in a multi-payer measurement collaborative**
2. **The organization uses physician performance data from other sources**

Summary of changes

Clarifications

- Converted scoring to Met, Partially Met, Not Met.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets both factors~~	~~No scoring option~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~The organization does not meet either factor~~

Met	Partially Met	Not Met
The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Materials

Scope of review NCQA scores this element once for the program.

Look-back period *For Initial and Renewal Surveys*: NCQA looks for evidence that the required activities were completed in conjunction with the most recent version or cycle of actions included in the scope of review.

Explanation

Documentation

For factor 1, NCQA reviews materials published by the collaborative to verify that the organization is a participant.

For factor 2, NCQA reviews the organization's documented process for incorporating data from other sources into its measurement.

Collaboratives

Collaboratives are measurement initiatives that involve multiple payers or other participants to whom the organization actively contributes data. Because participation in such initiatives is not always within an organization's control, NCQA allows an NA response for this factor, although organizations are strongly

encouraged to seek or initiate collaborative measurement initiatives in the communities where they operate.

Data from other sources

Measurement activities that draw on data across the totality of a physician's practice—as opposed to what can be measured by a single organization—can produce a more complete and robust data set and more accurate results. Such activities can also:

- Reduce redundancy in measurement efforts.
- Increase consistency of information shared with consumers and purchasers.

NCQA recognizes that physician organizations can initiate measurement activities, including specialty board activities, registries and state measurement and reporting initiatives. NCQA supports such efforts to measure physician performance.

The organization demonstrates its use of results from these activities by:

- Addressing the use of measures in its methodology.
- Reporting results from such measures.

Exception

Factor 1 is NA if the organization does not participate in a collaborative. NCQA may score this factor for all organizations in a future version of these standards.

Examples

Multi-payer measurement collaboratives

- California's Integrated Healthcare Association Pay-for-Performance program.
- Minnesota Measurement.

Data from other sources

- Data collected by the Pennsylvania Health Care Cost Containment Commission.
- Data collected by the New York State Department of Health on cardiovascular disease data and statistics procedures.
- ABMS or AOA board maintenance of certification activities that involve performance measurement.
- Performance-based designation programs (e.g., NCQA Recognition~~, BTE~~).

PQ 2: Working with Physicians

The organization is transparent about the details of its physician measurement program and works with physicians to respond to requests for corrections or changes.

Intent

Physicians have an opportunity to understand the program including its measures, methods and actions and contribute data to help make their own results as accurate as possible.

Element A: Transparency of Measures and Methods

The organization shares information about measurement activities with its physicians, practices or medical groups.

1. **At the time of initial contracting, providing its chosen measures, measurement methodology and information on how it uses results.**
2. **At least 45 days prior to acting on measure results, providing its chosen measures and the measurement methodology.**
3. **At least 45 days prior to acting on measure results, providing information on how it uses the results.**

Summary of changes

Clarifications

- Converted scoring to Met, Partially Met, Not Met.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets all 3 factors~~	~~No scoring option~~	~~No scoring option~~	~~The organization meets 2 factors~~	~~The organization meets 0-1 factors~~

Met	Partially Met	Not Met
The organization meets 3 factors	No scoring option	The organization meets 0-2 factors

Data source Materials

Scope of review NCQA scores this element once for the program.

Look-back period *For Initial and Renewal Surveys*: NCQA looks for evidence that the required activities were completed in conjunction with the most recent version or cycle of actions included in the scope of review.

Explanation **THIS IS A MUST-PASS ELEMENT.**

~~Because this standard has no scoring option for 50% or 80%, the organization must earn a score of 100% in order to achieve certification.~~

Documentation

NCQA reviews materials (e.g., letters) that reflect the information that the organization shares with physicians.

Periodicity

The organization works with physicians each time measure results or actions have the potential to change, including each cycle of measurement (e.g., annual or biannual calculation of results) and any aspect of methodology or process (e.g., the process to manage requests for corrections or changes).

If the organization's methodology involves ongoing (continuous) measurement and reporting (e.g., ongoing patient survey results), it must fully apprise physicians of the process and methodology. The organization may continue to report while responding to a request for information.

Providing information

The organization may use the following methods to provide information to physicians, practices or medical groups:

- In writing.
- In person, at meetings.
- On the Web, if it notifies physicians, practices or medical groups that the information is available.

Notification must be specific to the measurement and actions taken, and must be directed to each physician, practice or medical group. Individual notification may be through a mailed letter, fax or e-mail, but not through general communication such as a newsletter. Notification need not be personalized (e.g., with the physician's name and specific results), but must explain how and where to obtain personalized information (e.g., on a secure Web site).

Notice of available information

If the organization makes any information available upon request only (e.g., provides a summary of its methodology and offers an opportunity to receive a more complete description), it must provide written or e-mail notification that the specific information is available, with instructions on how to obtain it. The notification must be directed to each physician, practice or medical group, as described above.

Providing measures and methodology

As part of each measurement cycle, the organization provides physicians, practices and medical groups with information about the measures and methodology, including all factors of the methodology addressed in PQ 1, Element C, and information related to the factors in PQ 1, Element D.

To allow physicians who may be affected by measurement programs in the future to make informed decisions about network participation, the organization also provides this information before initially contracting with physicians, practices or medical groups. If the organization did not contract with any physicians, practices or medical

groups during the look-back period, it must provide sample communication or contracts that would be used to communicate the information.

The organization must provide, or make available upon request, all information necessary for physicians to understand how it arrived at the measurement results. The organization may make this information available on an individual basis, rather than publicly.

Timing of information

As part of each measurement cycle, the organization provides the information required in factors 2 and 3 to physicians, practices or medical groups at least 45 calendar days before it acts on measure results. The 45-calendar-day notice period applies to each cycle of measurement and action, regardless of scheduled recurrence (e.g., biannual, annual, semiannual, quarterly).

Exceptions

The following are exceptions to the 45-day-notice requirement:

- If an organization recalculates results (e.g., as part of annual remeasurement for a public report) without changing its methodology or measures, it does not need to provide the information required for factor 2 again, as long as it supplies instructions for obtaining the information and makes the information available upon request.
- If the action is a pay-for-performance activity that is not publicly reported (e.g., an action that is only between the organization and the physician). In this instance, the organization may provide the results and methodology concurrent with an additional or bonus payment. The organization must still provide a process for the physician to request corrections or changes (Element B).

Examples

Element B: Opportunity to Correct

The organization provides its physicians, practices or medical groups the opportunity to request corrections or changes and receive a timely response, including:

1. **Providing results and estimates of statistical reliability for comparative information at least 45 days prior to acting on measure results.**
2. **Providing the opportunity to obtain a full explanation of their individual results before they are used**
3. **Communicating the organization's ongoing process by which additional information or data can be provided to request corrections or changes.**
4. **Specifying as part of that process a timeframe of no less than 21 days in which requests for corrections or changes can be submitted in order to be resolved prior to acting on measure results.**

5. **Specifying how requests are investigated including who will participate in the resolution.**
6. **Specifying a timeframe for responding to requests.**
7. **Having a process for communicating the outcome and specific reasons for the decision.**

Summary of changes

Clarifications

- Converted scoring to Met, Partially Met, Not Met.
- Removed outdated examples.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets all 7 factors~~	~~No scoring option~~	~~No scoring option~~	~~The organization meets 4-6 factors~~	~~The organization meets 0-3 factors~~

Met	Partially Met	Not Met
The organization meets 7 factors	No scoring option	The organization meets 0-6 factors

Data source Documented process, Reports, Materials

Scope of review NCQA scores this element once for the program.

Look-back period *For Initial and Renewal Surveys*: NCQA looks for evidence that the required activities were completed in conjunction with the most recent version or cycle of actions included in the scope of review.

Explanation **THIS IS A MUST-PASS ELEMENT.**

~~Because there is no scoring option for 50% or 80%, the organization must earn a score of 100% in order to achieve certification.~~

Documentation

NCQA reviews the organization's documented processes for providing information and for handling requests for correction or change, as well as sample reports or materials that the organization uses to communicate results and the opportunity to receive a full explanation and request corrections or changes to physicians.

Requests for corrections or changes

The intent of this process is to ensure that measure results are as accurate as possible. The physician, practice or medical group may have additional data or documentation that could contribute to the accuracy of the measurement process. The organization has established a process for physicians, practices or medical groups to provide written or electronic comments, additional data or documents for

consideration if corrections or changes to results are necessary. The process may include requirements that comments or requests be made in writing or electronically (i.e., not verbally) and must specify a time frame of not less than 21 calendar days for providing information in order for the organization to respond before it takes action. The process must include:

- How the request will be investigated and the organization staff who will participate in the resolution.
- A time frame for resolving the request and for responding to the physician, practice or medical group.
- A process for communicating the outcome and the specific reason for the decision to the physician, practice or medical group.

If the organization receives a request for a correction or change within the specified time frame, it must either resolve and respond to the request before taking action on the physician's measure results or it must delay acting until it can do so. If the organization receives the request after the specified time frame, it may proceed with the planned action, but must resolve and respond to the request within 30 days and in accordance with its process.

Providing a complete explanation

The organization gives physicians an opportunity to obtain all information necessary for them to understand how the organization arrived at their results. This includes, but is not limited to, methodological information and specific information about patients in numerators and denominators.

Exceptions

The following are exceptions to the 45-day-notice requirement:

- If an organization recalculates results (e.g., as part of annual remeasurement for a public report) without changing its methodology or measures, it does not need to provide the information required for factor 1 again, as long as it supplies instructions for obtaining the information and makes the information available upon request.
- If the action is a pay-for-performance activity that is not publicly reported (e.g., an action that is only between the organization and the physician). In this instance, the organization may provide the results and methodology concurrent with an additional or bonus payment. The organization must still provide a process for the physician to request corrections or changes.

~~**Examples**~~ ~~**Report format**~~

~~There are several nationally recognized and widely accepted sources of guidance on developing reports to physicians:~~

- ~~In 2012, the AMA, in consultation with many physicians, Federation of Medicine staff, national health insurers, accreditation bodies and others, created the Guidelines for Reporting Physician Data. The reporting~~

~~guidelines are intended to be aspirational goals that will encourage health plans and other reporting bodies to standardize the format used for physician data reporting and provide physicians with patient-level detail to enhance the utility of data reports.~~

- ~~In 2008, the Consumer-Purchaser Disclosure Project released the Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs, which includes guidance for physician reports. The Patient Charter is supported by leading consumer, labor and employer organizations.~~
- ~~In 2006, the AQA, through its Reporting Workgroup, issued the AQA Principles for Reporting to Clinicians and Hospitals, which acknowledge the importance of ensuring that clinicians receive valid, reliable and useful information so they can assess and improve their performance and meet or exceed agreed-upon targets.~~

Element C: Requests for Corrections or Changes

The organization's responses to physician requests for corrections or changes contain the following information:

1. **Documentation of the substance of the request.**
2. **Investigation of the request.**
3. **Notification of the specific reasons for the final decision.**
4. **Timely notification of the outcome.**

Summary of changes

Clarifications

- Converted scoring to Met, Partially Met, Not Met.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review for all 4 factors~~	~~High (90-100%) on file review for at least 3 factors; medium (60-89%) on file review for no more than 1 factor~~	~~High (90-100%) on file review for 1-2 factors; medium (60-89%) on 1-2 factors and low on no more that 1 factor (0-59%)~~	~~Medium (60-89%) on file review for at least 3 factors; low (0-59%) on file review for no more than 1 factor~~	~~Low (0-59%) on file review for 2 or more factors~~

Met	Partially Met	Not Met
High (90-100%) on file review	Medium (60-89%) on file review	Low (0-59%) on file review

Data source Records or files

Scope of review

NCQA scores this element once for the program.

Look-back period

For *Initial Surveys*: NCQA reviews a sample of files for complaints received by the organization within 6 months prior to the survey date.

For *Renewal Surveys*: NCQA reviews a sample of files for complaints received by the organization within 24 months prior to the survey date.

~~**Note:** The revised look-back periods are effective beginning January 1, 2016.~~

Explanation

Documentation

NCQA reviews a sample of physician files to evaluate the organization's performance against this element.

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team should contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed after the onsite survey is complete.

This element evaluates whether the organization handles requests for corrections or changes in accordance with the processes specified and evaluated in Element B.

Physician requests for corrections or changes

The intent of this process is to assure physicians that measure results are as accurate as possible.

A **request for correction or change** is a request by a physician, practice or medical group to reconsider results because of the existence of additional data or documentation that could improve the accuracy of the measurement.

This standard applies to all requests submitted by a physician before or after action is taken.

Although the organization may use other terms for these requests, such as "appeals," "complaints," "grievances" or "concerns," for the purpose of this review, NCQA refers to all requests to reconsider results and proposed actions as "requests for corrections or changes" and considers them to be within the scope of this standard.

Review and investigation of the request

The organization must fully investigate the content of the request and document its findings in accordance with the process specified in Element B.

The process may include requirements that comments or requests be made in writing or electronically (i.e., not verbally) and must specify a time frame for

providing information that allows the organization to respond before it takes action. The process must include the following:

- How the request will be investigated.
- The organization staff who will participate in the resolution.
- A time frame for resolving the request and for communicating the resolution to the physician, practice or medical group.

If the organization receives a request for a correction or change within the specified time frame, it must either resolve and respond to the request before acting on the physician's measure results or it must delay acting until it can do so. If the organization receives the request after the specified time frame, it may proceed with the planned action, but must resolve and respond to the request within 30 days and in accordance with its process, including resolution within the specified time frame.

Examples **Requests for correction or change**

The specifications define a measure's denominator as "all patients of a certain age and sex seen in the past 12 months." The organization gives the practice a list of patients included in the denominator. The practice's records indicate that it did not see one listed patient during the specified period. The practice contacts the plan and provides documentation (i.e., medical or billing records) that indicate when the patient was seen. The organization considers the documentation and, prior to taking action, notifies the practice about whether it will remove the patient from the denominator, the revised measure result and the rationale.

PQ 3: Working with Customers

The organization is transparent with customers (i.e., consumers and purchasers) about the details of its physician measurement program, and works with consumers to address complaints.

Intent

The organization makes materials available to customers so they can understand how it measures physicians.

Element A: Transparency of Measures and Methods

The organization prominently places key information in clear, understandable language near information it publishes on physicians, including:

1. **Which physicians, practices or medical groups, including which specialties and geographic areas, are included in the measurement program.**
2. **Whether the organization measures and takes action for individual physicians, practices or medical groups and why it has chosen that unit of measure.**
3. **Where consumers can find physician, practice or medical group performance ratings.**
4. **A statement that physician performance ratings are a guide to choosing a physician, practice or medical group and that because ratings have a risk of error, they should not**

be the sole basis for selecting a doctor; and that patients should confer with their existing physicians before making a decision.

5. **How the customer may register a complaint about the organization's physician, practice or medical group rating system with the organization.**
6. **How customers can obtain information on the percentage of the organization's total aggregate payments to physicians, practices and medical groups based on performance.**
7. **Information on how the organization uses performance results.**

Summary of changes

Clarifications

- Converted scoring to Met, Partially Met, Not Met.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets all 7 factors~~	~~The organization meets 6 factors~~	~~The organization meets 4-5 factors~~	~~The organization meets 1-3 factors~~	~~The organization meets no factors~~

Met	Partially Met	Not Met
The organization meets 6-7 factors	The organization meets 4-5 factors	The organization meets 0-3 factors

Data source Documented process, Reports, Materials

Scope of review NCQA scores this element once for the program.

Look-back period *For Initial and Renewal Surveys:* NCQA looks for evidence that the required activities were completed in conjunction with the most recent version or cycle of actions included in the scope of review.

For Interim Initial Surveys: NCQA looks for evidence that the organization has policies and procedures and planned communication activities.

For Interim Follow-Up Surveys: NCQA looks for evidence that the organization carried out its planned communication activity.

Explanation NCQA reviews the organization's documented processes and materials demonstrating to whom, and how, the organization communicates the information. The organization publicly reports information on the percentage of total payments based on performance. Information on physician payment is placed in proximity to the information the organization publishes on physician performance. If no payment is based on performance, the organization discloses this publicly, even if the program under review by NCQA is not a pay-for-performance program.

For factor 4, the organization uses language that addresses the material intent of the factor. If the organization is required by a third party to post specific language, it may

use that language. If the language does not address the material intent of the factor fully, the organization supplements the disclosure, unless prohibited by a regulatory requirement or other legal requirement

Information about physicians

Consumers and purchasers can benefit from detailed information that helps them understand how the organization uses performance measurement. This information includes the numbers of physicians measured by specialty and geographic area.

Unit of measure

The organization may measure performance and may take action at the individual physician, practice or medical group level.

Consumers are most interested in information about their physician. Because small numbers of observations and care are sometimes provided interchangeably by physicians at the same practice, it can be difficult to measure the performance of an individual physician. In addition, integrated practices can enhance continuity of care; as a result, there may be reasons to consider measuring practice sites or medical groups.

It is important that consumers and purchasers have information about whether the organization measures and takes action for individual physicians, practices or medical groups, as well as the organization's rationale for this.

The organization may measure at an aggregate level (e.g., the medical group or practice) and act at a discrete level (e.g., publicly report or reward each physician based on the performance of the practice or group as a whole), or the opposite. It must disclose whether it measures and takes action for different levels. The unit of measure may be different from the unit with which the organization contracts.

A **medical group** is a group of physicians that comprises more than one practice site. The term also refers to a **physician organization**.

Exceptions

Factors 3–5 are NA if the program being reviewed focuses solely on pay-for-performance (there is no visible information to consumers).

Factors 3-5 are NA if the organization does not display physician performance information for its pay-for-performance program.

Examples

Paper or Web-based documentation

- Materials providing a list of all measures the organization uses, with information on the number or percentage of physicians measured
- Materials with information about pay-for-performance.

- Materials demonstrating how the organization notifies customers that information is available, where the information is and how customers can obtain it.

Publicly reporting information on the percentage of total payments based on performance

- NYSAG Settlement Agreements read, "... [the organization] shall disclose to consumers: ... (2) that physician performance ratings are only a guide to choosing a physician, that consumers should confer with their existing physicians before making a decision, and that such ratings have a risk of error and should not be the sole basis for selecting a doctor"

Element B: Transparency with Customers

The organization makes measurement methodology available to the following customer groups:

1. **Current consumers.**
2. **Current purchasers.**
3. **Prospective consumers.**
4. **Prospective purchasers.**

Summary of changes

Clarifications

- Converted scoring to Met, Partially Met, Not Met.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization makes methodology available to all 4 customer groups~~	~~The organization makes methodology available to 3 customer groups~~	~~No scoring option~~	~~The organization makes methodology available to 1-2 customer groups~~	~~The organization does not make methodology available to customer groups~~

Met	Partially Met	Not Met
The organization meets 3-4 factors	No scoring option	The organization meets 0-2 factors

Data source Materials

Scope of review NCQA scores this element once for the program.

Look-back period

For Initial and Renewal Surveys: NCQA looks for evidence that the required activities were completed in conjunction with the most recent version or cycle of actions included in the scope of review.

For Interim Initial Surveys: NCQA looks for evidence that the organization has policies and procedures and planned communication activities.

For Interim Follow-Up Surveys: NCQA looks for evidence that the organization carried out its planned communication activity.

Explanation

Documentation

NCQA reviews the organization's documented processes for making its methodology available to customers, as well as representative materials the organization provides to customers when it shares its methodology.

Making methodology available

The organization may make the measurement methodology available in a paper document or electronically (Web based).

Notice of available information

If the organization makes any information available upon request only, it must provide written or Web-based notice to customers that the information is available, with instructions on how to obtain it.

Aspects of methodology

Upon request, the organization discloses all information (but not patient-specific information) necessary for customers to understand how it arrived at the measurement results, including all factors of the methodology addressed in PQ 1, Element C, and the principles addressed in PQ 1, Element D. The organization may make summary information available and provide details of the methodology, upon request. If it does this, it must provide notice of the specific additional details available, in accordance with PQ 1, Element C (e.g., detailed measurement specifications or full details on how outliers are handled).

Exception

This element is NA if the organization does not display physician performance information for its pay-for-performance program.

Examples

Element C: Policies and Procedures for Complaints

The organization has a process for registering and responding to oral and written consumer complaints about its physician measurement activities that includes:

1. Documentation of the substance of complaints and actions taken.

2. **Investigation of the substance of complaints.**
3. **Notification to consumers of the disposition of complaints and the right to appeal, as appropriate.**
4. **Standards for timeliness.**

Summary of changes

Clarifications

- Converted scoring to Met, Partially Met, Not Met.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets all 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~The organization meets 1 factor~~	~~The organization meets no factors~~

Met	Partially Met	Not Met
The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source Documented process

Scope of review NCQA scores this element once for the program.

Look-back period *For Initial and Renewal Surveys*: NCQA looks for evidence that the required activities were completed in conjunction with the most recent version or cycle of actions included in the scope of review.

Explanation

Documentation

NCQA reviews the organization's documented process for evidence of ongoing monitoring and investigation of consumer complaints related to physician measurement activities.

A formal complaint system provides consumers with a method for addressing dissatisfaction with the organization.

A **complaint** is an oral or written expression of dissatisfaction. The organization may use other terms for this level of interaction with consumers, such as "grievance" or "concern." NCQA refers to consumers' initial expressions of dissatisfaction as "complaints." For this element, a complaint covers anything related to the organization's program of measurement and action.

Automatic credit

Organizations that are accredited under NCQA's MCO, PPO or health plan Accreditation standards receive full credit for this element if they manage consumer

complaints related to these activities using the same complaint process that is in place for other complaints. The organization must document that the scope of its policies includes consumer complaints.

Referring issues for resolution

There must be a process to refer issues for resolution beyond the Member or Customer Services Department. If consumer complaints and appeals are handled by the organization and by another entity (e.g., an employer), written policies and procedures must be in place explaining the circumstances under which complaints are forwarded to the other entity.

Investigation

The organization must research and document all issues relevant to a complaint.

Consumer notification

The organization must notify consumers in a timely manner when an issue is resolved, and must inform them of their right to appeal the decision. The organization may notify consumers by telephone, as long as a staff person records this notification electronically or in writing.

If the organization cannot resolve a complaint immediately or cannot inform members of the final disposition, it must, at a minimum, notify members that the complaint was received and investigated.

Appeal rights

Appeal rights may be NA for some complaints if the complaint does not involve the organization making a decision.

An **appeal** is a request to change a previous decision made by the organization. A formal appeal system provides members with a method for addressing any adverse decision made by the organization, including the outcome of a complaint, if appropriate.

“Appeal” refers to appeals arising out of complaints to the organization, not to appeals of coverage decisions.

The organization may use other terms for this level of interaction with members, such as "grievance" or "concern."

Timeliness

The organization must determine its own timeliness standards.

Examples

Information in complaint policies and procedures

- How the organization receives consumer complaints (e.g., telephone, mail, fax, onsite visit).

- How complaints are logged into the system, including documentation of the consumer's demographic information, the nature of the complaint and its resolution.
- How the organization resolves complaints, including triage to the appropriate department (e.g., initial contact, follow-up).
- How the organization categorizes different types of complaints (e.g., routine inquiries or dissatisfaction).
- The turnaround time for resolving different types of complaints.
- Consumer notification of the resolution and any applicable appeal process.

Complaints not subject to appeal

- A consumer complains that physician measurement methodology information is difficult to understand. In this case, there is no adverse decision to appeal, even though the organization follows up with the consumer.

Complaints where an appeal may apply

- A health plan member complains that he cannot afford to see a physician because the organization's measurement activities have placed the physician in a lower tier. The health plan investigates and responds to the member. If the plan decides that a member may not see the physician and the member still wants to do so, it is an adverse decision and is therefore subject to appeal.

~~Element D: Handling Complaints~~

~~**The organization follows its process for registering and responding to oral and written consumer complaints about its physician measurement activities, including:**~~

1. ~~**Documentation of the substance of complaints and actions taken.**~~
2. ~~**Investigation of the substance of complaints.**~~
3. ~~**Notification to consumers of the disposition of complaints and the right to appeal, as appropriate.**~~
4. ~~**Standards for timeliness.**~~

Summary of changes

Clarifications

- NCQA proposes to retire this element.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~High (90-100%) on file review for all 4 factors~~	~~High (90-100%) on file review for at least 3 factors;~~	~~High (90-100%) on file review for 1-2 factors, medium (60-~~	~~Medium (60-89%) on file review for at least 3 factors; low~~	~~Low (0-59%) on file review for 2 or more factors~~

	~~medium (60-89%) on file review for no more that 1 factor~~	~~89%) on 1-2 factors and low on no more that 1 factor (0-59%)~~	~~(0-59%) on file review for no more than 1 factor~~	

~~Data source~~

~~Records or files~~

~~Scope of review~~

~~*Files included*: NCQA reviews and scores this element once based on a sample of randomly selected files that are related to the most recent cycle of the program~~

~~Look-back period~~

~~For *Initial Surveys*: NCQA reviews a sample of files for complaints received by the organization within 6 months prior to the survey date.~~

~~For *Renewal Surveys*: NCQA reviews a sample of files for complaints received by the organization within 24 months prior to the survey date.~~

~~**Note:** The revised look-back periods are effective beginning January 1, 2016.~~

~~Explanation~~

~~NCQA reviews a sample of consumer complaint files to evaluate the organization's performance against this element.~~

~~NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team should contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.~~

~~This element evaluates actual handling of complaints about its physician measurement activities according to the policies evaluated in PQ 3, Element C.~~

~~Exceptions~~

~~This element is NA in the following circumstances:~~

- ~~Under the Interim PQ Certification Survey.~~
- ~~The organization did not have any complaints during the look-back period.~~
- ~~If the organization does not display physician performance information for its pay-for-performance program.~~

PQ 4: Program Input & Improvement

The organization seeks input and feedback on the design of its physician measurement program and on its reporting process, to improve the program's value to physicians and customers.

Intent

The organization uses input from various stakeholders to develop and improve its physician measurement program.

Element A: Seeking Input During Development

The organization seeks input into the development of its physician measurement and reporting activities, including measure selection, methodology for reporting differences in performance and reporting format, from the following groups:

1. **Consumer representatives.**
2. **Physicians, practices or medical groups or their representatives.**
3. **Purchasers.**

Summary of changes

Clarifications

- Converted scoring to Met, Partially Met, Not Met.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets all 3 factors~~	~~No scoring option~~	~~The organization meets 2 factors~~	~~The organization meets 1 factor~~	~~The organization meets no factors~~

Met	Partially Met	Not Met
The organization meets 2-3 factors	No scoring option	The organization meets 0-1 factors

Data source Documented process, Reports, Materials

Scope of review NCQA scores this element once for the program.

Look-back period *For Initial and Renewal Surveys*: NCQA looks for evidence that the required activities were completed in conjunction with the most recent version or cycle of actions included in the scope of review.

Explanation **THIS IS A MUST-PASS ELEMENT.**

~~The organization must earn a score of 50% or higher in order to achieve certification.~~

Documentation

NCQA reviews documentation demonstrating how the organization seeks feedback from customers. Documentation may include a documented process describing how

the organization obtains customer input; reports showing the results or summary of input obtained; and materials the organization used to solicit input.

Levels of performance difference

Organizations may report physician performance in a number of ways (e.g., actual results; summary ratings, such as stars). Consumers must understand what the results mean and how to compare performance among physicians, practices or medical groups. Because differences in performance can be very small and can rely on statistical methods (e.g., confidence intervals) unfamiliar to consumers, it is important that those being measured and those using the measurement results have input into the definition of "meaningful" differences, to improve the usefulness of the results.

Soliciting consumer input on measure selection

The organization solicits input from consumers or consumer representatives about the development of measures or measurement activities that the organization may be able to use in its physician measurement program. The solicitation addresses at a minimum measures to include in the program and how information about physicians should be reported to help understand what is useful and understandable to consumers. The organization may solicit input from several individual consumers or consumer groups. The organization may communicate with consumers or consumer groups through face-to-face meetings, conference calls or through surveys or direct mail. A **consumer** is defined as a non-health care professional who has or would utilize health care services. A **consumer group** is defined as an organization that advocates for people who are actual or potential users of healthcare services.

Soliciting physician input on measure selection

The organization solicits input from physicians or physician representatives about measures or measurement activities that the organization may be able to use in its physician measurement program. The organization may use advisory committees or physician organizations to solicit input.

Examples

Consumer groups

- American Association of Retired People.
- Consumers Union.
- National Partnership for Women & Families.
- Child Welfare League of America.

Soliciting feedback

- Paper or Web-based survey.
- Advisory committees.
- Focus group.

Element B: Feedback on Reports

With the goal of improving its physician reports, with each measurement cycle, the organization:

1. **Seeks feedback from current consumers on the usefulness of public reports.**
2. **Seeks feedback from current purchasers on the usefulness of public reports.**
3. **Seeks feedback on the validity and usefulness of individual and public reports from physicians, practices or medical groups.**
4. **Makes information about its process for obtaining and using feedback available to physicians and current customers.**
5. **Analyzes the feedback and identifies opportunities for improvement, if applicable.**
6. **Implements changes based on identified opportunities for improvement, if applicable.**

Summary of changes

Clarifications

- Converted scoring to Met, Partially Met, Not Met.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets all 6 factors~~	~~The organization meets 4-5 factors~~	~~The organization meets 2-3 factors~~	~~The organization meets 1 factor~~	~~The organization meets no factors~~

Met	Partially Met	Not Met
The organization meets 4-6 factors	The organization meets 2-3 factors	The organization meets 0-1 factors

Data source Documented process, Reports, Materials

Scope of review NCQA scores this element once for the program.

Look-back period *For Initial and Renewal Surveys*: NCQA looks for evidence that the required activities were completed in conjunction with the most recent version or cycle of actions included in the scope of review.

For Interim Initial Surveys: NCQA looks for evidence that the organization has policies and procedures and planned communication activities.

For Interim Follow-Up Surveys: NCQA looks for evidence that the organization carried out its planned communication activity.

Explanation

Documentation

NCQA reviews documentation demonstrating how the organization seeks feedback from customers.

Feedback methods

The organization actively seeks feedback from physicians, consumers and purchasers using paper or Web-based surveys, focus groups or solicitations for feedback and comments included with reports.

Feedback time frame

The organization seeks feedback at least every measurement cycle. Notice of available information If the organization makes any information available upon request only, it must provide written or Web-based notice to customers that the information is available, with instructions on how to obtain it.

Analyzing results and identifying opportunities

The organization analyzes feedback to identify and prioritize opportunities for improving the usefulness of reports. Analysis considers quantitative and qualitative data to identify feedback patterns. Opportunities may be different each time the organization measures and analyzes data.

Exceptions

Factor 1 and the customer portion of factor 4 are NA if the organization does not display physician performance information for its pay-for-performance program.

Examples

Feedback methods

- Surveys, including “pop-up” surveys on the organization’s Web site.
- Solicit feedback on reports.
- Focus groups

Element C: Program Impact

To maximize the impact of its physician measurement program, the organization annually assesses the program by:

1. **Identifying areas for improvement.**
2. **Implementing changes in areas identified for improvement.**

Summary of changes

Clarifications

- Converted scoring to Met, Partially Met, Not Met.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets both factors~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~No scoring option~~	~~The organization does not meet either factor~~

Met	Partially Met	Not Met
The organization meets 1-2 factors	No scoring option	The organization meets 0 factors

Data source Reports

Scope of review NCQA scores this element once for the program.

Look-back period *For Initial and Renewal Surveys*: NCQA looks for evidence that the required activities were completed in conjunction with the most recent version or cycle of actions included in the scope of review.

Explanation

Documentation

NCQA reviews documentation about the information the organization gathers to evaluate the physician measurement program and how it seeks feedback on the program, as well as the processes the organization uses to assess and maximize program impact.

Assessing impact

At least once per measurement cycle, the organization identifies the purpose of its physician measurement program and the program's desired results (e.g., patient volume shifts to higher-performing physicians; improved physician performance). The organization creates and executes an evaluation strategy to determine if its program is having the desired results and, if it is not, explores opportunities for improvement. If the organization has a two-year measurement cycle, it may meet factors 1 and 2 by identifying areas for improvement and implementing changes in those areas every two years.

Hospital Quality

HQ 1: Hospital Performance

Using all-payer data on hospitals, the organization provides consumers with information and resources to inform decision making.

Intent

The organization provides consumers and purchasers with information about how hospitals perform to help them make decisions based on quality and cost.

Element A: Hospital Performance Data

The organization reports to customers current all-payer quality and cost information from the following sources.

1. **Hospital Compare or Quality Check® (Joint Commission)**
2. **The Leapfrog Group**
3. **Cost results based on MEDPAR, state-mandated, state hospital association or other all-payer sources**
4. **Quality results from state-mandated, state hospital association or other all-payer sources, if applicable**

Summary of changes

Clarifications

- Converted scoring to Met, Partially Met, Not Met.
- Removed outdated references in the Look-back period and Explanation sections.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization reports data from 3 or more sources~~	~~The organization reports data from 2 sources~~	~~The organization reports data from 1 source~~	~~No scoring option~~	~~The organization does not report data from any sources~~

Met	Partially Met	Not Met
The organization meets 1-3 factors	No scoring option	The organization meets 0 factors

Data source Materials

Scope of review

Measures: NCQA uses the measures for which the organization receives credit in this element to score subsequent elements as outlined in the Scope of Review for those elements.

Products/product lines included: NCQA reviews and scores this element once for all product lines/products brought forward by the certifiable entity.

NCQA reserves the right to score each product separately if the organization applies different resulting actions to different products or in other ways administers products differently.

Look-back period

~~The survey of an organization that previously achieved "Distinction" under the 2006 Quality Plus Physician and Hospital Quality Standards and has not previously undergone a survey under the PHQ 2008 Standards is considered a Renewal Survey for this element.~~

For Initial Surveys: NCQA looks for evidence that the organization has performed the required activities prior to the start of the survey and continues to perform them at the time of the survey. NCQA does not require the organization to demonstrate compliance for a minimum period of time.

For Renewal Surveys: NCQA looks for evidence that the organization has performed the required activities throughout the 12-month period prior to the survey.

Explanation

THIS IS A MUST-PASS ELEMENT.

~~This is a must-pass element for Hospital Quality Certification (HQ 1 alone). The organization must achieve a score of 50% or higher on this element in order to achieve Hospital Quality Certification. This must-pass requirement does not apply to organizations seeking full Physician and Hospital Quality Certification.~~

Documentation

NCQA reviews documentation demonstrating the data types the organization incorporates into reports to customers.

Customers, consumers and purchasers

Customers include both **consumers** (individuals) and **purchasers** (organizations). **Consumers** are the individuals who use the information resulting from measurement to aid in their choice of a health plan or hospital. The organization being certified, depending on its type, may also refer to consumers as **patients** or **members**. Consumers' relationship to the organization may be **indirect** and through a purchaser (e.g., a health plan) or **direct** (e.g., an information provider that makes information publicly available on a Web site). **Purchasers** are other organizations that directly contract with the organization being certified to display or otherwise use the results of measurement and action. Purchasers may be employers, states or even health plans.

Prospective purchasers and consumers can benefit from having Information on quality and cost, resource use or utilization of hospitals to inform their choice of a health plan or hospital. Prospective purchasers are purchasers with whom the organization is in sales discussions. Prospective consumers are individuals who may have the option to choose the organization or choose hospitals from the organization's list.

Requirements regarding **prospective consumers** are not applicable (NA) for organizations that do not enroll consumers.

The organization may share data with prospective purchasers and members upon request and in a restricted manner (e.g., time-limited access to a Web report).

Notice of available information

If the organization makes any information available upon request only, it must provide written or Web-based notice to customers that the information is available and how to obtain it.

Measure sources

The organization uses current all-payer data sources to report on hospital quality and cost. By making use of existing data sources, the organization does not duplicate existing measurement activities and reduces burden to hospitals, and all-payer data produces more robust measurement results. The data sources listed in this element are **primary data sources**.

State or other all-payer data sources

The organization includes quality results from state-mandated, state hospital association or other all-payer sources applicable to any state or region it covers. During the survey, the organization presents documentation of which sources it includes. If it serves a state that does not have data available, the organization presents documentation demonstrating this.

Cost results

The organization includes information on hospital cost that is based on all-payer data sources. The organization may present cost data that incorporates price using standardized pricing (e.g. based on Medicare), its actual prices or averages based on local norms. The organization includes an explanation of which pricing is used in its reports.

Patient experience results

The organization may include results from the HCAHPS® survey when such results are available through Hospital Compare. Organizations may also use results from standardized hospital surveys administered at the state or local level.

Third-party software or tools

The organization may report results to customers using commercial software products or tools developed by and licensed from third parties that collect and aggregate data from the primary source. NCQA reviews evidence provided by the organization that demonstrates how the tools comply with this element.

Sharing results

The organization may share measure results in writing (obtained through Member Services) or electronically (Web based). The organization may report information using restricted portals on its Web site, including its hospital directory.

Periodicity

The organization updates quality measures for its network hospitals at least annually, using current data.

Examples

Documentation

- Tools or materials (screen shots, mailings, newsletters) that include the required data and sources

Element B: Decision Support Tools

The organization's hospital reports support informed decision-making.

Summary of changes

Clarifications

- Converted scoring to Met, Partially Met, Not Met.
- Removed outdated references in the Look-back period and Explanation sections.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization provides interactive, Web-based tools that integrate multiple results~~	~~The organization integrates multiple results in a static report~~	~~The organization provides results separately by data source~~	~~No scoring option~~	~~Reports are not available~~

Met	Partially Met	Not Met
The organization provides integrated results in a report, or provides results separately by data source	No scoring option	Reports are not available

Data source Materials

Scope of review *Measures included:* NCQA scores this element based on the quality and cost results for which the organization received credit in *HQ 1, Element A—Hospital Performance Data*.

Products/product lines included: NCQA reviews and scores this element once for all product lines/products brought forward by the certifiable entity. NCQA reserves the

right to score each product separately if the organization applies different resulting actions to different products or in other ways administers products differently.

Look-back period

~~The survey of an organization that previously achieved "Distinction" under the 2006 Quality Plus Physician and Hospital Quality Standards and has not previously undergone a survey under the PHQ 2008 Standards is considered a Renewal Survey for this element.~~

For Initial Surveys: NCQA looks for evidence that the organization has performed the required activities prior to the start of the survey and continues to perform them at the time of the survey. NCQA does not require the organization to demonstrate compliance for a minimum period of time.

For Renewal Surveys: NCQA looks for evidence that the organization has performed the required activities throughout the 12-month period prior to the survey.

Explanation

THIS IS A MUST-PASS ELEMENT.

~~This is a must-pass element for Hospital Quality Certification (HQ 1 alone). The organization must achieve a score of 50% or higher on this element in order to achieve Hospital Quality Certification. This must-pass requirement does not apply to organizations seeking full Physician and Hospital Quality Certification.~~

Documentation

NCQA reviews the tools or materials the organization makes available to customers.

Decision support

By presenting information in an integrated, interactive manner, the organization ensures that customers can more easily use the information to inform their decisions about where to seek care.

Customers, consumers and purchasers

Customers include both **consumers** (individuals) and **purchasers** (organizations). **Consumers** are the individuals who use the information resulting from measurement to aid in their choice of a health plan or hospital. The organization being certified, depending on its type, may also refer to consumers as **patients** or **members**. Consumers' relationship to the organization may be **indirect** and through a purchaser (e.g., a health plan) or **direct** (e.g., an information provider that makes information publicly available on a Web site). **Purchasers** are other organizations that directly contract with the organization being certified to display or otherwise use the results of measurement and action. Purchasers may be employers, states or even health plans.

Prospective purchasers and consumers can benefit from having Information on quality and cost, resource use or utilization of hospitals to inform their choice of a health plan or hospital. Prospective purchasers are purchasers with whom the organization is in sales discussions. Prospective consumers are individuals who

may have the option to choose the organization or choose hospitals from the organization's list.

The organization may share data with prospective purchasers and members upon request and in a restricted manner (e.g., time-limited access to a Web report).

Notice of available information

If the organization makes any information available upon request only, it must provide written or Web-based notice to customers that the information is available and how to obtain it.

Sharing results

The organization may share measure results in writing (obtained through Member Services) or electronically (Web-based). The organization may report information using restricted portals on its Web site, including its hospital directory.

Integrated results

Integrated results provide data from multiple sources in a single report that allows the customer to view information about a hospital from multiple sources at the same time (e.g., on a single Web page or on a single page in a paper report). Integrated results do not require customers to navigate among multiple sources to view various data and obtain a more robust picture of hospital performance. Separate, Web-based links to primary data sources are not integrated. **Primary data sources** include Hospital Compare, The Leapfrog Group, Quality Check®, MEDPAR and state-mandated or state hospital association databases that collect quality or cost data.

The organization may use products provided by commercial software vendors to provide integrated results, but is not required to do so.

Interactive, Web-based tools

Interactive tools facilitate user input and provide results based on user input about personal preferences.

Explanatory information

Information that helps inform decision making includes an explanation that puts results into context.

- Clarifying results that represent hospital-wide activities (Leapfrog patient safety measures), as opposed to a specific service (procedure-specific mortality rates)
- Providing benchmarks, such as nationwide mortality rates.

Third-party software or tools

The organization may report results to customers using commercial software products or tools developed by and licensed from third parties that collect and aggregate data from the primary source. NCQA reviews evidence provided by the organization that demonstrates how the tools comply with this element.

Exception

Requirements regarding prospective consumers are NA for organizations that do not enroll consumers.

Examples

Documentation

- Tools or materials (screen shots, mailings, newsletters) that demonstrate how data is presented to consumers

Customers

- Current or prospective consumers
- Current or prospective purchasers

Interactive features

- Ability to search based on zip code
- Ability to search results for hospitals that provide a specific service
- Ability to sort results based on different data fields

Element C: Availability of Information to Customers

The organization makes hospital performance information available to the following groups.
1. Current consumers
2. Current purchasers
3. Prospective consumers
4. Prospective purchasers

Summary of changes

Clarifications

- Converted scoring to Met, Partially Met, Not Met.
- Removed outdated references in the Look-back period and Explanation sections.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization makes performance information available to all 4 customer groups~~	~~The organization makes performance information available to 3 customer group~~	~~The organization makes performance information available to 2 customer groups~~	~~The organization makes performance information available to 1 customer groups~~	~~The organization does not makes performance information available to any customer groups~~

Met	Partially Met	Not Met
The organization meets 2-4 factors	No scoring option	The organization meets 0-1 factors

Data source Materials

Scope of review *Measures included:* NCQA scores this element based on the quality and cost results for which the organization received credit in *HQ 1, Element A—Hospital Performance Data*.

Products/product lines included: NCQA reviews and scores this element once for all product lines/products brought forward by the certifiable entity.

NCQA reserves the right to score each product separately if the organization applies different resulting actions to different products or in other ways administers products differently.

Look-back period ~~The survey of an organization that previously achieved "Distinction" under the 2006 Quality Plus Physician and Hospital Quality Standards and has not previously undergone a survey under the PHQ 2008 Standards is considered a Renewal Survey for this element.~~

For Initial Surveys: NCQA looks for evidence that the organization has performed the required activities prior to the start of the survey and continues to perform them at the time of the survey. NCQA does not require the organization to demonstrate compliance for a minimum period of time.

For Renewal Surveys: NCQA looks for evidence that the organization has performed the required activities throughout the 12-month period prior to the survey.

Explanation **THIS IS A MUST-PASS ELEMENT.**

~~This is a must-pass element for Hospital Quality Certification (HQ 1 alone). The organization must achieve a score of 50% or higher on this element in order to achieve Hospital Quality Certification. This must-pass requirement does not apply to organizations seeking full Physician and Hospital Quality Certification.~~

Documentation

NCQA reviews tools or materials the organization makes available to consumers or purchasers.

Customers, consumers and purchasers

Customers include both **consumers** (individuals) and **purchasers** (organizations). Consumers are the individuals who use the information resulting from measurement to aid in their choice of a health plan or hospital. The organization being certified, depending on its type, may also refer to consumers as **patients** or **members**. Consumers' relationship to the organization may be **indirect** and through a purchaser (e.g., a health plan) or **direct** (e.g., an information provider that makes

information publicly available on a Web site). **Purchasers** are other organizations that directly contract with the organization being certified to display or otherwise use the results of measurement and action. Purchasers may be employers, states or even health plans.

Prospective purchasers and consumers can benefit from having Information on quality and cost, resource use or utilization of hospitals to inform their choice of a health plan or hospital. Prospective purchasers are purchasers with whom the organization is in sales discussions. Prospective consumers are individuals who may have the option to choose the organization or choose hospitals from the organization's list.

The organization may share data with prospective purchasers and members upon request and in a restricted manner (e.g., time-limited access to a Web report).

Notice of available information

If the organization makes any information available upon request only, it must provide written or Web-based notice to customers that the information is available and how to obtain it.

Sharing results

The organization may share measure results in writing (obtained through Member Services) or electronically (Web-based). The organization may report information using restricted portals on its Web site, including its hospital directory.

Third-party software or tools

The organization may report results to customers using commercial software products or tools developed by and licensed from third parties that collect and aggregate data from the primary source. NCQA reviews evidence provided by the organization that demonstrates how the tools comply with this element.

Exception

Factor 3 is NA for organizations that do not enroll consumers.

Examples

Documentation

- Materials (screen shots, mailings, newsletters) provided to consumers or purchasers that demonstrate how the organization makes information available to each customer group
- Documented process for prospective consumers and purchasers

Element D: Scope of Hospitals

The organization reports performance information on its network hospitals.

Summary of changes

Clarifications

- Converted scoring to Met, Partially Met, Not Met.
- Removed outdated references in the Look-back period and Explanation sections.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization reports on all network hospitals for which the primary all-payer data source has data~~	~~The organization reports on some of its network hospitals based on specified services or a defined set of high-volume hospitals~~	~~No scoring option~~	~~No scoring option~~	~~The organization does not have a defined reporting scope~~

Met	Partially Met	Not Met
The organization reports on some or all network hospitals for which the primary all-payer data source has data	No scoring option	The organization does not have a defined reporting scope

Data source Documented process, Reports

Scope of review

Measures included: NCQA scores this element based on the quality and cost results for which the organization received credit in *HQ 1, Element A—Hospital Performance Data*.

Products/product lines included: NCQA reviews and scores this element once for all product lines/products brought forward by the certifiable entity.

NCQA reserves the right to score each product separately if the organization applies different resulting actions to different products or in other ways administers products differently.

Look-back period

~~The survey of an organization that previously achieved "Distinction" under the 2006 Quality Plus Physician and Hospital Quality Standards and has not previously undergone a survey under the PHQ 2008 Standards is considered a Renewal Survey for this element.~~

For Initial Surveys: NCQA looks for evidence that the organization has performed the required activities prior to the start of the survey and continues to perform them at the time of the survey. NCQA does not require the organization to demonstrate compliance for a minimum period of time.

For Renewal Surveys: NCQA looks for evidence that the organization has performed the required activities throughout the 12-month period prior to the survey.

Explanation **THIS IS A MUST-PASS ELEMENT.**

~~This is a must-pass element for Hospital Quality Certification (HQ 1 alone). The organization must achieve a score of 50% or higher on this element in order to achieve Hospital Quality Certification. Since there is no scoring option for 50%, the organization must achieve a score of 80% for Certification. This must-pass requirement does not apply to organizations seeking full Physician and Hospital Quality Certification.~~

Documentation

NCQA reviews documentation that identifies hospitals for which the organization reports data.

Reporting scope

The organization reports results on as broad a portion of its network as possible; including all hospitals for which there is data. Other approaches to reporting are:

- All hospitals in the network that have provided a defined set of clinical services that the organization specifies
- All hospitals in the network that meet the organization's specified criteria for high-volume.

The organization may report results on hospitals that are not in its networks; if it does so, the reports must indicate which hospitals are in and out of the network.

Primary data sources include Hospital Compare, The Leapfrog Group, Quality Check®, MEDPAR and state-mandated or state hospital association databases that collect quality or cost data.

Third-party software or tools

The organization may report results to customers using commercial software products or tools developed by and licensed from third parties that collect and aggregate data from the primary source. NCQA reviews evidence provided by the organization that demonstrates how the tools comply with this element.

Examples **Documentation**

- Documents that identify hospitals for which the organization reports results
- Materials (screen shots, mailings, newsletters) provided to consumers that specify hospitals for which the organization reports results

Element E: Working With Hospitals on Reporting

As part of annual measurement activities, the organization works with its network hospital on its reporting activities, including:

1. Providing hospitals the opportunity to review reports if the organization reports results to customers in a format different from the primary data source

2. Providing hospitals the opportunity to obtain a full explanation of how the organization arrived at the modified version of results before using them
3. Providing information on how the organization uses results
4. Obtaining feedback from hospitals on the validity and usefulness of reports

Summary of changes

Clarifications

- Converted scoring to Met, Partially Met, Not Met.
- Removed outdated references in the Look-back period and Explanation sections.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets all 4 factors~~	~~The organization meets 3 factors~~	~~The organization meets 2 factors~~	~~The organization meets 1 factor~~	~~The organization does not meet any factors~~

Met	Partially Met	Not Met
The organization meets 2-4 factors	No scoring option	The organization meets 0-1 factors

Data source Reports, Materials

Scope of review

Measures included: NCQA scores this element based on the quality and cost results for which the organization received credit in *HQ 1, Element A—Hospital Performance Data*.

Products/product lines included: NCQA reviews and scores this element once for all product lines/products brought forward by the certifiable entity.

NCQA reserves the right to score each product separately if the organization applies different resulting actions to different products or in other ways administers products differently.

Look-back period

~~The survey of an organization that previously achieved "Distinction" under the 2006 Quality Plus Physician and Hospital Quality Standards and has not previously undergone a survey under the PHQ 2008 Standards is considered a Renewal Survey for this element.~~

For Initial Surveys: NCQA looks for evidence that the organization has performed the required activities prior to the start of the survey and continues to perform them at the time of the survey. NCQA does not require the organization to demonstrate compliance for a minimum period of time.

For Renewal Surveys: NCQA looks for evidence that the organization has performed the required activities throughout the 12-month period prior to the survey.

Explanation **THIS IS A MUST-PASS ELEMENT.**

~~This is a must-pass element for Hospital Quality Certification (HQ 1 alone). The organization must achieve a score of 50% or higher on this element in order to achieve Hospital Quality Certification. This must-pass requirement does not apply to organizations seeking full Physician and Hospital Quality Certification.~~

Documentation

NCQA reviews documentation about information the organization shares with hospitals and how it obtains feedback.

Providing information

The organization may provide the information addressed by this element to hospitals:

- In writing
- In person at meetings
- On the Web, if it notifies hospitals that the information is available.

Notification must be specific to the measurement and actions taken and directed to each hospital. Individual notification may be through a mailed letter, fax or e-mail, but not through general communication such as a newsletter because newsletters contain diverse content. Notification need not be personalized (e.g., with the hospital's name and specific results) if it explains how to obtain personalized information, such as on a secure Web site where results are available.

Notice of available information

If the organization makes any information available upon request only, it must provide written or e-mail notice that the specific information required by this element is available and how to obtain it. The notification must be directed to each physician, practice or medical group as described above.

Format changes

An organization that makes results available in a format that differs from the primary data source must share the reports prior to using the results. Primary data sources include Hospital Compare, Quality Check®, The Leapfrog Group, MEDPAR and state or state hospital association databases.

Changes in format include:

- Interactive tools that allow customers to weight different results
- Aggregating individual measures into summary results, including stars or tiers
- Presenting numeric results graphically.

Third-party software or tools

The organization may report results to customers using commercial software products or tools developed by and licensed from third parties that collect and

aggregate data from the primary source. NCQA reviews evidence provided by the organization that demonstrates how the tools comply with this element.

Such commercial software systems are not primary data sources. If the organization reports results using a commercial software product that modifies the original format from the primary source, the organization must meet these factors.

The vendor may perform the functions required by this element on behalf of the organization for hospitals in the organization's network. The organization must provide documentation about the vendor's activities to meet the element.

Full explanation of results

The organization may make summary information available and provide details upon request; if it does this, it must provide notice that the information is available. At a hospital's request, the organization must provide all information about how it arrived at the measurement results. The organization may make this information available on an individual basis, to respect the intellectual property rights of any third party.

Disclosing use

The organization provides information to hospitals about how it uses results, including whether it uses them for quality or cost improvement or for product design or payment strategies. If the organization's uses are limited to public reporting, it need only disclose that; however, the factor is still applicable.

Time frame for disseminating information

The organization must share information before it releases reports to customers.

Examples

Documentation

- Reports to hospitals, with measurement results
- Materials for hospitals describing how the organization reformatted measure results
- Materials soliciting hospital feedback
- Reports summarizing hospital feedback

Element F: Information About Measurement

The organization makes available to hospitals and customers information on the percentage of its total payments in aggregate to hospitals based on performance.

Summary of changes

Clarifications

- Converted scoring to Met, Partially Met, Not Met.
- Removed outdated references in the Look-back period and Explanation sections.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~

~~The organization makes information on the percentage of its total performance-based payments available to hospitals and customers~~	~~No scoring option~~	~~No scoring option~~	~~No scoring option~~	~~The organization does not make information on the percentage of its total performance-based payments available to hospitals and customers~~

Met	Partially Met	Not Met
The organization makes information on the percentage of its total performance-based payments available to hospitals and customers	No scoring option	The organization does not make information on the percentage of its total performance-based payments available to hospitals and customers

Data source Documented process, Reports, Materials

Scope of review

Measures included: NCQA scores this element based on the quality and cost results for which the organization received credit in *HQ 1, Element A—Hospital Performance Data*.

Products/product lines included: NCQA reviews and scores this element once for all product lines/products brought forward by the certifiable entity.

NCQA reserves the right to score each product separately if the organization applies different resulting actions to different products or in other ways administers products differently.

Look-back period

~~The survey of an organization that previously achieved "Distinction" under the 2006 Quality Plus Physician and Hospital Quality Standards and has not previously undergone a survey under the PHQ 2008 Standards is considered a Renewal Survey for this element.~~

For Initial Surveys: NCQA looks for evidence that the organization has performed the required activities prior to the start of the survey and continues to perform them at the time of the survey. NCQA does not require the organization to demonstrate compliance for a minimum period of time.

For Renewal Surveys: NCQA looks for evidence that the organization has performed the required activities throughout the 12-month period prior to the survey.

Explanation

THIS IS A MUST-PASS ELEMENT.

~~This is a must-pass element for Hospital Quality Certification (HQ 1 alone). The organization must achieve a score of 50% or higher on this element in order to~~

~~achieve Hospital Quality Certification. Since there is no scoring option for either 50% or 80%, the organization must achieve a score of 100% for Certification. This must-pass requirement does not apply to organizations seeking full Physician and Hospital Quality Certification.~~

Documentation

NCQA reviews documentation demonstrating how the organization makes payment information available to hospitals and customers.

Customers, consumers and purchasers

Customers include both **consumers** (individuals) and **purchasers** (organizations). **Consumers** are the individuals who use the information resulting from measurement to aid in their choice of a health plan or hospital. The organization being certified, depending on its type, may also refer to consumers as **patients** or **members**. Consumers' relationship to the organization may be **indirect** and through a purchaser (e.g., a health plan) or **direct** (e.g., an information provider that makes information publicly available on a Web site). **Purchasers** are other organizations that directly contract with the organization being certified to display or otherwise use the results of measurement and action. Purchasers may be employers, states or even health plans.

Prospective purchasers and consumers can benefit from having Information on quality and cost, resource use or utilization of hospitals to inform their choice of a health plan or hospital. Prospective purchasers are purchasers with whom the organization is in sales discussions. Prospective consumers are individuals who may have the option to choose the organization or choose hospitals from the organization's list.

The organization may share data with prospective purchasers and members upon request and in a restricted manner (e.g., time-limited access to a Web report).

Notice of available information

If the organization makes any information available upon request only, it must provide written or Web-based notice to customers that the information is available and how to obtain it.

Information about payment based on performance

Consumers and purchasers can benefit from detailed information that helps them understand how performance effects payment. At a minimum, the organization makes available information about the percentage of its total annual hospital health spending that is based on performance.

Exceptions

This element is NA if the organization does not make payments to hospitals (e.g., an information provider).

Requirements regarding **prospective consumers** are NA for organizations that do not enroll consumers.

Examples

Paper or Web-based documentation:

- Documents showing how the organization provides the information or makes it available

Payment for performance

- Bonus payments
- Differential increases

Element G: Feedback on Customer Reports

With the goal of improving the usefulness of its hospital performance reports, each year the organization:

1. **Seeks feedback from current purchasers**
2. **Seeks feedback from current consumers**
3. **Makes information about its process for seeking and using feedback available to current consumers and purchasers**
4. **Analyzes the feedback and identifies opportunities for improvement, if applicable**

Summary of changes

Clarifications

- Converted scoring to Met, Partially Met, Not Met.
- Removed outdated references in the Look-back period and Explanation sections.

Scoring

~~100%~~	~~80%~~	~~50%~~	~~20%~~	~~0%~~
~~The organization meets 3 or more factors~~	~~The organization meets 2 factors~~	~~The organization meets 1 factor~~	~~No scoring option~~	~~The organization meets no factors~~

Met	Partially Met	Not Met
The organization meets 1-3 factors	No scoring option	The organization meets 0 factors

Data source Documented process, Reports

Scope of review

Measures included: NCQA scores this element based on the quality and cost results for which the organization received credit in *PHQ 2, Element A—Hospital Performance Data*.

Products/product lines included: NCQA reviews and scores this element once for all product lines/products brought forward by the certifiable entity.

NCQA reserves the right to score each product separately if the organization applies different resulting actions to different products or in other ways administers products differently.

Look-back period

~~The survey of an organization that previously achieved "Distinction" under the 2006 Quality Plus Physician and Hospital Quality Standards and has not previously undergone a survey under the PHQ 2008 Standards is considered a Renewal Survey for this element.~~

For Initial Surveys: NCQA looks for evidence that the organization has performed the required activities prior to the start of the survey and continues to perform them at the time of the survey. NCQA does not require the organization to demonstrate compliance for a minimum period of time.

For Renewal Surveys: NCQA looks for evidence that the organization has performed the required activities throughout the 12-month period prior to the survey.

Explanation

THIS IS A MUST-PASS ELEMENT.

~~This is a must-pass element for Hospital Quality Certification (HQ 1 alone). The organization must achieve a score of 50% or higher on this element in order to achieve Hospital Quality Certification. This must-pass requirement does not apply to organizations seeking full Physician and Hospital Quality Certification.~~

Documentation

NCQA reviews documentation demonstrating how the organization obtains feedback from customers.

Customers, consumers and purchasers

Customers include both **consumers** (individuals) and **purchasers** (organizations). **Consumers** are the individuals who use the information resulting from measurement to aid in their choice of a health plan or hospital. The organization being certified, depending on its type, may also refer to consumers as **patients** or **members**. Consumers' relationship to the organization may be **indirect** and through a purchaser (e.g., a health plan) or **direct** (e.g., an information provider that makes information publicly available on a Web site). **Purchasers** are other organizations that directly contract with the organization being certified to display or otherwise use the results of measurement and action. Purchasers may be employers, states or even health plans.

Notice of available information

If the organization makes any information available upon request only, it must provide written or Web-based notice to customers that the information is available and how to obtain it.

Feedback methods

The organization seeks feedback from consumers and purchasers using paper or Web-based surveys, focus groups or solicitations for feedback and comments that are included with reports. The organization must actively solicit feedback.

Analyzing results and identifying opportunities

The organization analyzes feedback to identify opportunities to improve the usefulness of reports. Analysis considers quantitative and qualitative data to identify patterns of feedback. The organization uses analysis to prioritize opportunities to improve. The opportunities may be different each time the organization measures and analyzes data.

Specific feedback

If the organization provides results using a report or tool that is offered to other organizations (e.g. operated at a corporate level for all affiliated organizations), the organization may collect feedback at the corporate level provided the functions and features of the report or tool are the same for all users.

Third-party software or tools

The organization may report results to customers using commercial software products or tools developed by and licensed from third parties that collect and aggregate data from the primary source. The vendor may perform this service on behalf of the organization and may collect feedback across all users, including those of other users of its tool, but it must collect feedback specific to the functions and features the organization has licensed and report this to the organization. NCQA reviews evidence provided by the organization that demonstrates how the vendor complies with this element.

Examples

Feedback methods

- Surveys, including “pop-up” surveys on Web site
- Solicit feedback on reports
- Form focus groups

Documentation

- Summaries of survey results
- Copies of surveys with documentation of implementation
- Results from focus group

Open-ended request

- Solicit feedback about report usefulness on the Web site