Background Questions

1. Which of the following best describes your organization?
    - Physician-owned medical group
    - Hospital or health system-affiliated medical group
    - Accountable care organization
    - Health plan
    - Vendor
    - Employer or purchaser
    - Patient advocacy or community organization
    - State or federal agency
    - Other (fill in the blank)
2. Is your organization currently PCMH Recognized?
3. Approximately how many patients, members or individuals does your organization serve each year?

Global Questions

4. On a scale of 1–5, how valuable would Advanced Primary Care Accreditation be to your organization? Please explain the factors that contribute to your scoring.
5. Do you support the order and organization of the program's standards?
6. Does the program include activities that don't add value or are out of scope for primary care organizations?
7. How should AI be reflected, if at all, in program standards, given where primary care organizations are today?
8. What AI activities should standards address?
9. What observable value does AI deliver in primary care?
10. Does your organization leverage AI for FHIR® mapping/readiness?
11. Based on your organization's experience, what other problems could a quality measurement program for advanced primary care organizations help address?
12. Are there specific areas of the standards where submitting the required data sources may be challenging?
13. Will the proposed standards help your organization meet objectives? If so, how? If not, why not?
14. Are key expectations not addressed in the proposed requirements?

Scoring

15. Do you support the scoring structure of each element (Met, Partially Met, Not Met)?
16. Do you support tiered Accreditation statuses?
17. Do you have concerns about scoring of specific standards or elements?
18. Would you like to leave feedback on this topic for NCQA's consideration?

Standards

PHM 1: PHM Program Oversight

Element A: PHM Governance Structure

19. Does this element apply to care delivery organizations?

Element B: Annual PHM Plan

20. Do you support inclusion of this element?
21. Does your organization currently have and maintain a population health management plan or strategy?

Element C: Communication About PHM Programs

22. Do you support inclusion of this element?

Element D: Annual PHM Evaluation

23. Do you support inclusion of this element?
24. Is this element feasible for care delivery organizations?

PHM 2: Population Identification

Element A: Population Assessment

25. Do you support factors listed?

Element B: Targeting, Segmentation and Bias Evaluation

26. Do you support inclusion of this element?
27. Is this element feasible for your organization?

PHM 3: Complex Care Management

Element A: Access to Care Management

28. Is this element feasible for care delivery organizations?
29. How does your organization define “care management”? What activities are included?
30. Is care management a responsibility of primary care? Why or why not?

Element B: Care Management Process

31. Is this element feasible for care delivery organizations?
32. If applicable, what does your organization’s care management process include? Does the process align with the factors in this element?

PHM 4: Self-Management Tools

Element A: Topics of Tools

33. Do you support inclusion of this element?

CTC 1: Team-Based Care Strategy

Element A: CTC Strategy

34. Does this element add value to the program? Why or why not?

CTC 2: Care Coordination

Element A: Referral Management

35. Are the referral expectations in this element feasible for primary care organizations? Why or why not?

Element B: Transitions of Care

36. Do you support inclusion of this element?

Element C: Reporting on Readmissions

37. Do you support inclusion of this element?
38. What readmission type (all-cause, potentially preventable, clinically related, other) may be feasible for primary care organizations?

CTC 3: Staff Culture and Experience

Element A: Assessment of Staff Experience

39. How does your organization assess staff experience?
40. Do you support the proposed factors to assess staff experience?

Element B: Care Team Burnout Monitoring and Mitigation

41. Do you support inclusion of this element?
42. How does your organization currently assess staff burnout?

CTC 4: Alternative Payment Arrangements

Element A: Alternative Payment Arrangement Participation

43. Do you support inclusion of this element?

Element B: Risk Absorption Capacity

44. Do you support inclusion of this element?
45. Does this element add value to the program? Why or why not?
46. Is this element feasible?

Element C: Primary Care Reinvestment for Risk-Critical Capabilities

47. Do you support inclusion of this element?
48. Does the value-based terminology in this element resonate?
49. Would this element be valuable to your organization? Why or why not?
50. Is this element feasible?

PSE 1: Access to Services

Element A: Access to Care Team

51. Should NCQA require use of an EMR with two-way communication for 24/7 access (rather than phone-only access)?
52. Do you support inclusion of this element?

Element B: Enhanced Communication Opportunities

53. Are the requirements in this element considered “enhanced”?

Element C: Demonstrating Appointment Availability

54. Do you support evaluating appointment turnaround time?
55. Should NCQA use other metrics to assess appointment availability?

PSE 2: Medication Management

Element A: Medication Reconciliation

56. Do you support inclusion of this element?

Element B: Medication Response and Adherence

57. Are reports a feasible data source for this element?
58. Do you support inclusion of this element?

Element C: Prescribing Patterns

59. What should NCQA assess with regard to prescribing patterns or medication tracking?

PSE 3: Patient-Centered Experience

Element A: Assessment of Patient Experience

60. Do you support the list of domain areas as factors, or should NCQA require a specific patient experience tool/survey?
61. How does your organization currently evaluate patient experience?

Element B: Demonstrating Improvement on Patient Experience

62. Do you support inclusion of this element?

BH 1: Access and Integration

Element A: Demonstrating Access to Behavioral Health Services

63. Do you support inclusion of this element?
64. Do you believe this element adds value to the program?
65. What is the minimum behavioral health access needed for an advanced primary care organization?

Element B: Behavioral Health Referrals

66. What data sources are feasible and appropriate for this element?

Element C: Integrated Services

67. What does behavioral health integration look like for your organization?
68. Do you support this element's factors?
69. Should NCQA reference a specific model of behavioral health integration for the program?

BH 2: Behavioral Health Screenings

Element A: Routine Behavioral Health Screenings

70. Should anxiety screening remain a required factor?
71. Do you support screening for suicide risk/ideation?
72. Do you support combining depression and suicide screening factors?
73. Should NCQA include a cadence for routine screenings (e.g., at least annually)?

Element B: Clinically Indicated Screenings

74. Do you support the listed screenings? If not, are other screenings more appropriate for primary care?
75. How feasible is PTSD screening in the primary care setting?

BH 3: Evidence-Based Care

Element A: Providing Brief Interventions

76. Do you agree with the proposed factors? If not, why not?

Element B: Monitoring Patients Over Time

77. Is this element feasible for your organization type?
78. Do you believe the requirements fall within the scope of primary care?

CQ 1: Quality Performance Measurement

Element A: Clinical Measurement Reporting

79. Do you support the use of the following quality measures to assess clinical performance? If not, please describe recommended changes and your rationale (feasibility for reporting in primary care, relevance to clinical practice).
80. Given the existence of a separate behavioral health standard, do the measures in Clinical Quality sufficiently capture behavioral health performance in primary care? Are there key gaps? Should any behavioral health measures be added or removed?

Element B: Demonstrating Clinical Measurement Performance—50th Percentile

81. When demonstrating clinical measurement performance relative to the national distribution (e.g., 50th percentile), would it be helpful to benchmark network/ACO performance against CMS MIPS benchmark decile distributions for comparable measures (by the same collection type, where available)?
82. If not, do you recommend an alternative benchmarking approach?
83. Do you support requiring a specific number of measures to meet this benchmark?

Element C: Demonstrating Clinical Measurement Performance—80th Percentile

84. When demonstrating clinical measurement performance relative to the national distribution (e.g., 80th percentile), would it be helpful to benchmark network/ACO performance against CMS MIPS benchmark decile distributions for comparable measures (by the same collection type, where available)?
85. If not, do you recommend an alternative benchmarking approach?
86. Do you support requiring a specific number of measures to meet this benchmark?

Element D: Improving Disparity Gaps

87. Do you support inclusion of this element?
88. Do you agree with the listed factors? If not, why not?
89. Does the explanation for this element resonate?

DME 1: Data Integration and Exchange

Element A: Core Data Integration

90. Do you support this element's data integration sources?
91. What sources does your organization currently integrate?
92. Does the explanation for this element resonate?

Element B: Advanced Data Integration

93. Do you support this element's data integration sources?
94. What sources does your organization currently integrate?
95. Does the explanation for this element resonate?

Element C: Bidirectional External Exchange of Information

96. Do you support inclusion of this element?
97. Which external data sources/types (claims, eligibility/rosters, HIE feeds, external labs, imaging, pharmacy/PBM, IIS, registries) are the most challenging to obtain and integrate into your systems, data tools/platforms for quality reporting/gap closure, attribution workflows, etc.? Please explain.
98. What limitations, constraints or costs affect your ability to access or receive FHIR data, or to transform data into FHIR?

DME 2: Use of Fast Healthcare Interoperability Resources

Element A: FHIR Data Integration Capability

99. Which dQM inputs require external data sharing (claims, eligibility/rosters, HIE feeds, external labs, imaging, pharmacy/PBM, IIS, registries), and which are the most difficult to obtain and integrate reliably?
100. Are the evidence requirements (e.g., screenshots, sample outputs) clear and feasible?
101. Does this element appropriately account for variation in vendor capabilities and system configurations?

Element B: FHIR Data Production and Validation

102. Are the required FHIR bundle components appropriate?
103. Is the requirement for validation against implementation guides clear?
104. Is the level of effort required to generate and validate FHIR datasets reasonable?
105. Are evidence and submission requirements (e.g., JSON file, validation outputs) clear and feasible?
106. Does this element appropriately reflect progression from Element A?

Element C: FHIR Digital Quality Measure Reporting

107. In the provided materials, three measure specifications—COL CD, URI CD, BPC CD—assess an organization's technical capability to submit data using FHIR. After reviewing the measure specifications, do you have questions or comments about their readability, clarity or interpretability (e.g., structure, terminology, logic, implementation guidance)?
108. Which of the following best reflects how your organization defines patient attribution?

    All patients within a specific payer

    All patients covered under a particular contract

    Patients segmented by clinical or diagnostic risk

    Patients segmented by socio-economic risk

    Patients segmented by disease or disorder

    Patients segmented by level of engagement (e.g., patients with an Annual Wellness Visit vs. those who are not engaged)

109. How challenging would it be for your organization to report the three measures using one attribution (network/ACO) approach, while continuing to report similar measures to health plans using a different, plan-defined attribution?
110. What limitations, constraints or costs are there for accessing/reporting required data elements (vendor fees, separate data feeds, siloed systems)? Which are specific to FHIR dQMs vs. eCQMs, and what mitigations should NCQA consider?
111. Beyond addressing barriers, what enablers would most help your organization successfully report FHIR-based quality measures? Please share additional feedback about becoming FHIR-ready.
112. Does your organization have a roadmap or implementation plan for incorporating FHIR-based digital dQMs into your systems?

Additional Measures

113. How relevant, feasible and valuable are continuity of care measures such as the American Board of Family Medicine Continuity Measure?
114. How relevant, feasible and valuable are primary care experience and delivery measures such as the Person-Centered Primary Care Measure?
115. How relevant, feasible and valuable are patient-reported outcome measures such as self-reported overall health status, pain interference or pain intensity measures like the PROMIS® Pain Interference or the PEG scale?

116. What considerations or challenges should NCQA consider in implementing program measures, particularly with respect to data collection, reporting burden, workflow integration, equity and digital readiness?