For Public Comment
February 25–March 25, 2025
Comments due 11:59 p.m. ET
March 25

Overview of Proposed Updates to 2026 PCMH Recognition

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You can find the public comment questions here 2025 Accreditation and Recognition Public Comment Questions.

NCQA's Mission: Improve the Quality of Health Care

NCQA is dedicated to improving health care quality.

For 35 years, NCQA has driven improvement throughout the health care system, helping to advance the issue of health care quality to the top of the national agenda. NCQA's programs and services reflect a straightforward formula for improvement: measurement, transparency, accountability.

This approach works, as evidenced by the dramatic improvements in clinical quality demonstrated by NCQA-Recognized primary care and specialty practices using both standards and performance results. Today, approximately 130 million Americans are seen by an NCQA-Recognized practice. NCQA is dedicated to improving health care quality.

NCQA's Patient-Centered Medical Home Recognition—2026 Update

PCMH Recognition, released in 2008, recognizes primary care practices that focus on improved communication and coordination in the medical neighborhood. To help ensure both program relevance and integrity, NCQA proposes modifications for the 2026 standards year:

- *Add 9 new elective criteria to the program, centered on virtual care.* These criteria were developed as part of NCQA's virtual care program and identified as best practices. There is also an instance of aligning specific criteria between PCMH and NCQA's virtual care program.
- *Retire 9 criteria from the program.* These criteria no longer drive significant quality improvement and have become basic expectations of primary care practices.
- *Align with Health Plan Accreditation.* NCQA is exploring ways to integrate our program to better facilitate payer–provider collaboration, building on the belief that when care stakeholders are aligned around quality, patients benefit. Initial changes will be implemented primarily in Health Plan Accreditation, although minor, corresponding updates to PCMH also highlight this expectation.
- *Add 46 cadence thresholds.* To promote the integrity of ongoing transformation, NCQA will add expected cadence thresholds to 46 criteria. These will incorporate transformation into the practice model, rather than a one-time expectation.

NCQA seeks feedback on proposed updates to PCMH Standards and Guidelines for release in July 2025, effective for evaluations on or after January 1, 2026.

Stakeholders Participating in Public Comment

NCQA shares updates for public comment to generate thoughtful commentary and constructive suggestions from interested parties. Many comments lead to changes in our standards and policies, and the review process makes our standards stronger for all stakeholders. NCQA asks respondents to consider whether the requirements are feasible as written and are clearly articulated, and to highlight areas that might need clarification.

Global Questions

Public comment is integral to the development of all NCQA standards and measures. NCQA considers all suggestions, and encourages reviewers to provide insights on global issues related to proposed updates:

1. Will the proposed updates help your organization meet its objectives? If so, how? If not, why not?
2. Are some key expectations not addressed in the proposed requirements?
3. Are requirements feasible?
4. Are requirements clearly written and framed in a manner representative of the organizations that perform the activities?
5. Detailed feedback on each individual criteria to be added, removed, or modified: Refer to the question format in each section of this memo.

Best Practices from NCQA's Virtual Primary Care Program to PCMH

The following elective criteria were written during creation of the new Virtual Care program and were found to be best practices that apply to traditional practice models. For this reason, we are adding them to PCMH Recognition as a playbook of quality for all primary care settings.

For each criterion in the table below, please respond with one of the following options and provide comments as needed:

- Support Inclusion
- Support With Modifications
- Do Not Support Inclusion

Concept	Title	Description
Team-Based Care and Practice Organizations (TC)	Patient Consent	The organization requests patient consent to treatment through virtual modalities.
Knowing and Managing Your Patients (KM)	Prescribing Patterns	The organization tracks medication prescribing practices and performs analysis on prescribing patterns.
	Interpreter Services	The organization uses competent interpreter or bilingual services to communicate with individuals in a language other than English.
	Virtual Care Training	The organization provides staff training on relevant clinical and nonclinical topics.
Patient-Centered Access and Continuity (AC)	Appropriate Modality of Care	The organization has a process for determining that virtual care is appropriate for the patient.
	Information for Appeals	The organization provides clinical information in response to appeals of denials based on medical necessity or treatment guidelines.
	Services Covered by Insurance	The organization has a process for informing patients which services are covered by insurance.

Concept	Title	Description
Performance Measurement and Quality Improvement (QI)	Assessment of Clinician and Care Team Experience	The organization assesses clinician and care team experience for delivering care.
	Goals and Actions to Improve Clinician and Care Team Experiences	The organization identifies at least one opportunity to improve the clinician and care team's experience, implements an intervention and measures the intervention's effectiveness.

In addition to the new elective criteria in the table above, there is an opportunity to align and standardize criteria across NCQA Virtual Care Accreditation and NCQA PCMH Recognition. NCQA expects this to reduce customer confusion and reflect best practices. This change affects only one criterion. Please respond with one of the following options and provide comments as needed:

- Support Modification
- Do Not Support Modification

Concept	Title	Description
Knowing and Managing Your Patients (KM)	KM-14 Medication Reconciliation	Increased from "at least 80%" **to "at least 90%"** of patients whose medications are reviewed and reconciled at each visit.

Criteria Retirement

The following criteria no longer serve a substantial purpose or add meaningful value to primary care, leading to their refinement or removal.

For each criterion in the table below, please respond with one of the following options and provide comments as needed:

- Support Retirement
- Support With Modifications
- Do Not Support

Concept	Identification and Title
Team-Based Care and Practice Organizations (TC)	TC 03: External PCMH Collaborations
	TC 09: Medical Home Information
Knowing and Managing Your Patients (KM)	KM 08: Patient Materials
	KM 15: Medication Lists
	KM 18: Controlled Substance Review
	KM 25: School/Intervention Agency Engagement
	KM 28: Case Conferences
Care Coordination and Care Transitions (CC)	CC 12: Co-Management Arrangements

Concept	Identification and Title
Performance Measurement and Quality Improvement (QI)	QI 18: Electronic Submission of Measures

Alignment With Health Plan Accreditation

Workstream element updates to PCMH Recognition align with expectations of Health Plan Accreditation. “Payers” will be added to KM 26 guidance and a new clinical data exchange requirement will be added to CC 21.

For each criterion in the table below, please respond to the following questions and provide comments as needed:

- KM 26: Community Lists. Do you support the inclusion of payer-supported resources in this criterion?
- CC 21: External Electronic Exchange of Information. Do you support the proposed inclusion of payers in the scope of this criterion?

Criteria Title	Excerpt From Guidance
KM 26: Community Lists	The practice maintains a list of resources supported by the community ***and/or payers*** by selecting five topics or service areas of importance to the patient population.
CC 21: External Electronic Exchange of Information	Added: ***D. Clinical data exchange with payers.***

Criteria With Cadence Threshold Added

Cadence thresholds are applied to 46 criteria to ensure practices continuously improve and avoid stagnation in their workflows.

For each criterion in the table below, please respond with one of the following options and provide comments as needed:

- Support Addition of Cadence
- Support With Modification
- Do Not Support

Concept	Title	Excerpt From Guidance
Team-Based Care and Practice Organizations (TC)	TC 06: Individual Patient Care Meetings/ Communication	The practice has a structured communication process or holds regular care-team meetings (such as huddles) ***twice a week*** to share patient information, care needs, concerns of the day and other information that encourages efficient patient care and practice workflow.
	TC 07: Staff Involvement in Quality Improvement	Improving quality outcomes involves all members of the practice staff and care team. ***Annually*** engaging the team in review and evaluation of the practice's performance is important for identifying opportunities for improvement and developing meaningful improvement activities.
Knowing and Managing Your Patients (KM)	KM 02: Comprehensive Health Assessment	A comprehensive patient assessment includes an examination of the patient's social and behavioral influences in addition to a physical health assessment. Comprehensive, current patient data provide a foundation for supporting population needs. The practice ***reviews patients' health assessments annually.***
	KM 03: Depression Screening	The documented process includes the practice's screening process and approach to follow-up on positive screens. The practice reports the screening rate and identifies the standardized screening tool. ***Depression screening is completed annually.***
	KM 04: Behavioral Health Screenings	The documented process includes the practice's screening process and approach to follow-up on positive screens. ***The practice screens patients annually.***
	KM 05: Oral Health Assessment	The practice conducts patient-specific oral health risk assessments ***annually and*** keeps a list of oral health partners (e.g., dentists, endodontists, oral surgeons, periodontists) for referrals.
	KM 06: Predominant Conditions	The practice analyzes diagnosis codes or problem lists ***annually*** to identify its patients' most prevalent and important conditions and concerns.
	KM 07: Social Determinants of Health	***Annual*** collection of data on social determinants of health (as required in KM 02) is an important step, but the real benefit to the population is that the practice uses the information to continuously enhance care systems and community connections to address population needs.
	KM 09: Diversity	Although it is voluntary for individuals to report these aspects of diversity, the practice must attempt to collect this information ***annually.*** The practice may collect it directly, at points of interaction, and through multiple mechanisms, using as many channels as are available.

Concept	Title	Excerpt From Guidance
	KM 11: Population Needs B. Educates practice staff on health literacy and C. Educates practice staff in cultural competence.	B. Health-literate organizations understand that lack of health literacy leads to poorer health outcomes and compromises patient safety, and act to establish processes that address health literacy to improve patient outcomes. ***Education occurs annually.*** C. Builds a culturally competent organization that educates staff on how to interact effectively with people of different cultures and be respectful and responsive to the health beliefs and cultural and linguistic needs of patients. ***Education occurs annually.***
	KM 17: Medication Responses and Barriers	The practice asks patients if they are having difficulty taking a medication, are experiencing side effects and are taking the medication as prescribed ***at all relevant visits (e.g., a new diagnosis with medication).*** If a patient is not taking a medication as prescribed, the practice determines why.
	KM 21: Community Resource Needs	The practice ***annually*** identifies needed resources by assessing collected population information (social determinants of health, predominant conditions, ED use and other health concerns) to prioritize community resources (e.g., food banks, support groups) that support the patient population.
	KM 23: Oral Health Education	The practice provides an example of how it encourages healthy oral health practices by providing patients with educational and other resources pertaining to the importance of oral health and hygiene. ***Oral health education occurs at all relevant visits (e.g., well visits or visits involving oral health).***
	KM 26: Community Resource List	The practice ***annually reviews and updates, as needed,*** a community resource list by selecting five topics or community service areas of importance to the patient population. The list includes services offered outside the practice and its affiliates, and an update/maintenance date.
	KM 27: Community Resource Assessment	The practice ***annually*** assesses the usefulness of resources by requesting and reviewing feedback from patients/families/caregivers about community referrals. Community referrals may be tracked using the same system that tracks clinical referrals.
Patient-Centered Access and Continuity (AC)	AC 01: Access Needs and Preferences	The practice ***annually*** evaluates patient access to appointments from collected data, such as through a survey, to determine if existing access methods are sufficient for its population.

Concept	Title	Excerpt From Guidance
	AC 09: Equity of Access	Knowing whether groups of patients experience differences in access to health care can help practices focus efforts to address the disparity. The practice ***annually*** evaluates whether identified health disparities demonstrate differences in access to care.
	AC 11: Patient Visits with Clinician/Team	The practice establishes a goal for the proportion of visits a patient should have with the primary care provider and care team. The goal should acknowledge that meeting patient preferences for timely appointments will sometimes be at odds with patients' ability to get an appointment with their selected clinician. ***The practice reviews this criterion annually.***
	AC 13: Panel Size Review and Management	The practice has a process ***for annually reviewing*** the number of patients assigned to each clinician and balancing the size of each providers' patient panel.
	AC 14: External Panel Review and Reconciliation	The practice has a process ***for annually reviewing*** reports, and for informing the entities of patients known or not known to be under the care of clinicians.
Care Management and Support (CM)	CM 01: Identifying Patients for Care Management	The practice ***annually*** defines a protocol for identifying patients who may benefit from care management.
	CM 02: Monitoring Patients for Care Management	The practice ***annually*** uses the criteria defined in CM 01 to identify eligible patients.
	CM 03: Comprehensive Risk Stratification	The practice demonstrates that it ***annually*** identifies patients who are at high risk, or likely to be at high risk, and prioritizes their care management to prevent poor outcomes.
	CM 04: Person-Centered Care Plans	***The practice reviews the care plan twice a year.*** The care plan may also address community and/or social services.
	CM 05: Written Care Plans	***Twice a year,*** the care plan is printed and given to the patient, or is made available electronically.
	CM 06: Patient Preferences and Goals	***Twice a year,*** the practice works with patients/families/ caregivers to incorporate patient preferences and functional lifestyle goals in the care plan.
	CM 07: Patient Barriers to Goals	***Twice a year,*** the practice works with patients/families/ caregivers, other providers and community resources to address potential barriers to meeting treatment and functional/lifestyle goals.
	CM 08: Self-Management Plan	***Twice a year,*** the practice works with patients/families/ caregivers to develop self-management instructions to manage day-to-day challenges of a complex condition.

Concept	Title	Excerpt From Guidance
	CM 10: Person-Centered Outcomes Approach	Person-centered outcomes are personalized, structured, measurable outcome goals identified by the patient or caregiver as what matters most to them. ***The practice reviews this criterion twice a year.***
	CM 11: PCO: Monitoring and Follow-Up	The PCO approach aligns patients' personal goals with their health outcomes. ***Twice a year***, the clinician uses either a patient-reported outcome measure (PROM) or goal attainment scaling to document and measure a health outcome goal and document what matters most to the patient (e.g., attend a graduation, participate in a 5K walk), then monitor and track progress over time.
Care Coordination and Care Transitions (CC)	CC 06: Commonly Used Specialists Identification	The practice ***annually*** monitors patient referrals to gain information about the referral specialists and specialty types it uses frequently.
	CC 07: Performance Information for Specialist Referrals	The practice ***annually*** consults available information about the performance of clinicians or practices to which it refers patients.
	CC 14: Identifying Unplanned Hospital and ED Visits	Receiving timely notification of patients with unplanned hospital admissions and ED visits allows practices to provide support and coordinate with the hospital or ED. ***Notification occurs near the time of admission.*** Relying on notification of discharge alone does not meet the intent.
Performance Measurement and Quality Improvement (QI)	QI 03: Appointment Availability Assessment	The practice ***annually*** reviews the availability of major appointment types (e.g., urgent care, new patient, routine exams, follow-up) to ensure that it meets the needs and preferences of its patients, and adjusts appointment availability, if necessary.
	QI 04: Patient Experience Feedback	The practice ***annually*** gathers feedback from patients and provides summarized results to inform quality improvement activities.
	QI 05: Health Disparities Assessment	The practice ***annually*** stratifies performance data by race and ethnicity or by other indicators of vulnerable groups that reflect the practice's population demographics
	QI 07: Vulnerable Patient Feedback	The practice ***annually*** obtains qualitative patient feedback from population representatives to acquire better understanding of disparities and to support quality improvement initiatives to close gaps in care.
	QI 08: Goals and Actions to Improve Clinical Quality Measures	The practice has an ongoing quality improvement strategy and process that includes ***annual*** review of performance data and evaluation of performance against goals or benchmarks.

Concept	Title	Excerpt From Guidance
	QI 09: Goals and Actions to Improve Resource Stewardship	The practice has a quality improvement strategy and process that includes ***annual*** review of performance data and evaluation of performance against goals or benchmarks.
	QI 10: Goals and Actions to Improve Appointment Availability	After assessing performance on the availability of common appointment types in QI 03, the practice ***annually*** sets goals to improve appointment availability and acts to meet the goals.
	QI 11: Goals and Actions to Improve Patient Experience	After assessing performance on one patient experience measure (QI 04), the practice ***annually*** sets goals for improving patients' experience of care and acts to meet the goals.
	QI 13: Goals and Actions to Improve Disparities in Care/ Service	After assessing performance in care or services among vulnerable populations (QI 05), the practice ***annually*** identifies disparities, sets goals and acts to meets the goals.
	QI 15: Reporting Performance Within the Practice	The practice ***annually*** provides individual clinician or practice-level reports to clinicians and practice staff that include: • One clinical quality measure. • One resource stewardship measure. • One patient experience measure.
	QI 16: Reporting Performance Publicly or With Patients	The practice ***annually*** shares individual clinician or practice-level reports with patients and the public that include: • One clinical quality measure. • One resource stewardship measure. • One patient experience measure.
	QI 17: Patient/ Family/Caregiver Involvement in Quality Improvement	The process specifies how patients and families are selected, their role on the quality improvement team and the frequency of team/PFAC meetings and ***is reviewed annually.***
	QI 18: Electronic Submission of Measures	The practice ***annually*** produces and transmits clinical quality measures to an external entity electronically.

Public Comment Instructions

Public Comment Questions

Public comment is integral to the development of all NCQA standards and measures. NCQA considers all suggestions. NCQA encourages reviewers to provide insights on global issues related to the proposed updates including:

1. Will proposed updates assist your organization in meeting its objectives? If so, how? If not, why not?
2. Are there key expectations not addressed in the proposed requirements?

How to Submit Comments

Respond to topic and element-specific questions for each product on NCQA's public comment website. NCQA does not accept comments by mail, email or fax.

1. Go to http://my.ncqa.org and enter your email address and password.
2. Once logged in, scroll down and click **Public Comments**.
3. Click **Add Comment** to open the comment box.
4. Select one or more of the following from the drop-down box:
   - **Updates to PCMH Recognition 2026**
5. Click to select the **Topic** and **Element** (question) on which you would like to comment.
6. Click to select your support option (**Support, Do not support, Support with modifications**).
   a. If you choose **Do not support**, include your rationale in the text box.
   b. If you choose **Support with modifications**, enter the suggested modification in the text box.
7. Enter your comments in the **Comments** box.

   Note: *There is a 2,500-character limit for each comment. We suggest you develop your comments in Word to check your character limit; use the "cut and paste" function to copy your comment into the Comments box.*

8. Use the **Submit** button to submit more than one comment. Use the **Close** button to finish leaving comments; you can view all submitted comments in the **Public Comments** module.

All comments must be entered by 11:59 ET on March 25