The Value of the Patient Centered Medical Home (PCMH)

June 3, 2025

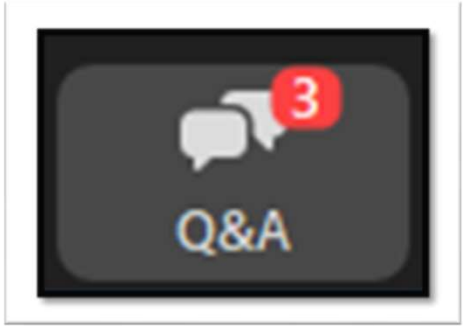
The Webinar Will Begin Momentarily

Today's Presenters

Bri Clifford
AD, Recognition Policy

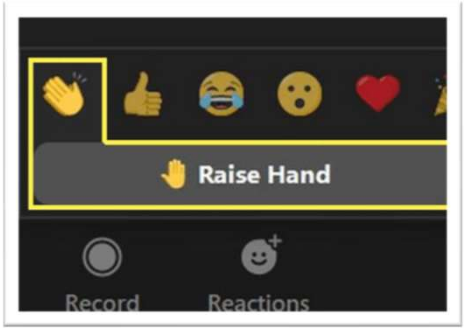
Jeff Sitko
AVP, Product Management

Housekeeping



Ask Now

Enter your questions in the Q&A function in Zoom



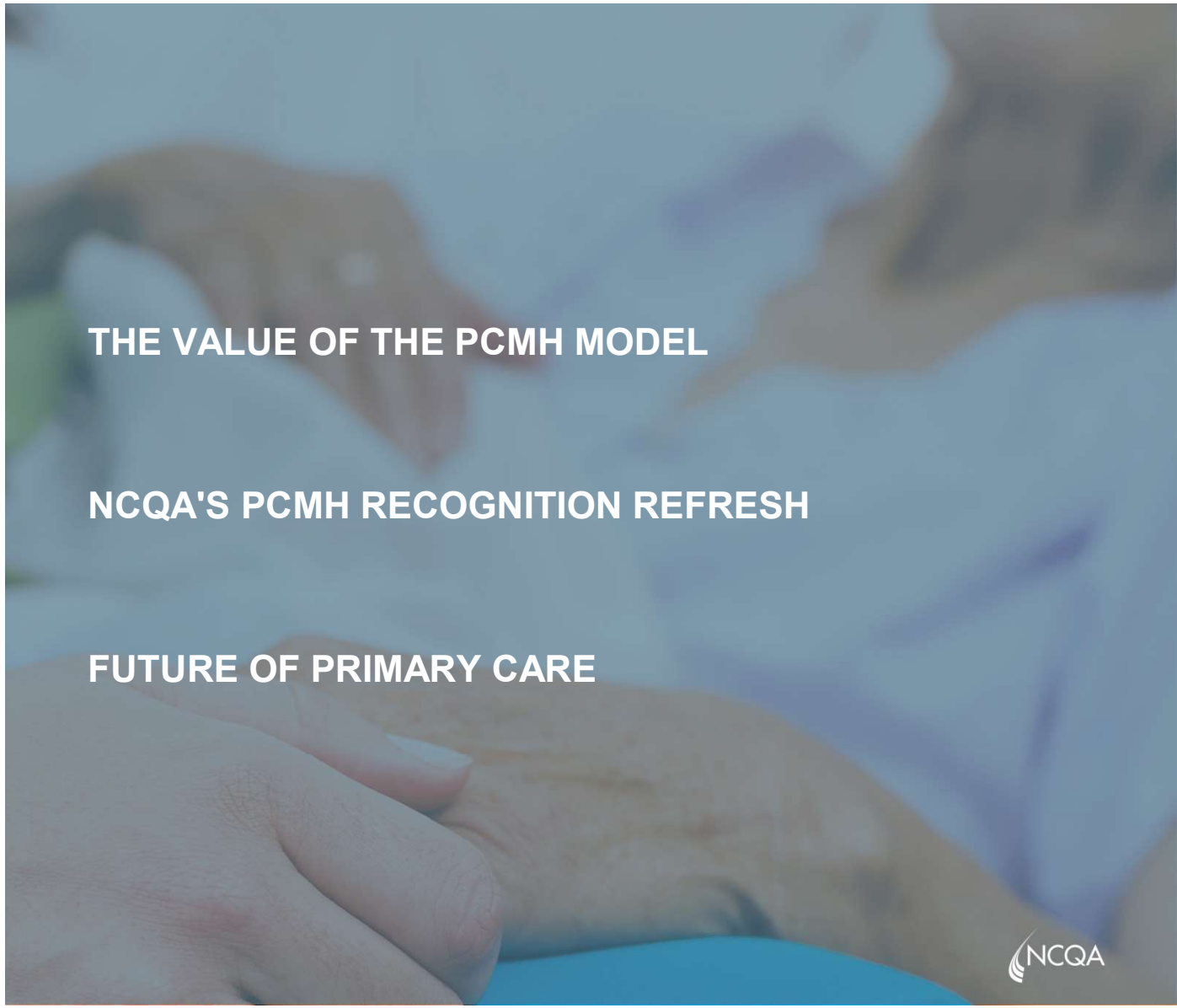
Join In

To ask questions verbally, click on Zoom's "Raise Your Hand," and our team will unmute you.

Engage After

A recording of the event and slides/supporting materials will be sent to attendees.

Agenda



Polling Question #1

Which best represents your organization type?

A. Hospital/Health System
B. Physician Practice
C. Health Plan
D. ACO
E. Community Based Organization
F. FQHC (health center)
G. Other (please share in the Q&A)

Basis for High-Value Primary Care

Standardizing Team-Based Quality Improvement

- Provides **blueprint** for strong primary care infrastructure
- Drives actionable **data** use
  - *Improves **quality** outcomes*
  - *Lowers total **cost** of care*
- Supports success in quality-linked **payment** models
- Enhances patient **experience** and trust

Patient-Centered Care

Increased Screenings

9% increase in **cervical cancer** screenings[1]

Up to **6.8%** more **breast cancer** screenings[1]

7% increase in **colorectal cancer** screenings. [1]

1. Hu, R., Shi, L., Sripipatana, A., Liang, H., Sharma, R., Nair, S. … Lee, D. (2018). The association of patient centered medical home designation with quality of care of HRSA-funded health centers: A longitudinal analysis of 2012-2015. Medical Care, 56 (2018), pp. 130-138.

Patient-Centered Care

Making Better Use of Health Care Dollars

NCQA PCMHs lower costs through better chronic care management, preventive medicine, and coordination across care settings and transitions.

$482.40

Lower per capita spending for patients in NCQA PCMH[1]

$5M

Annual savings for 100,000 patients in NCQA PCMH pilot[2]

[1] - Department of Vermont Health Access / Vermont Blueprint for Health

[2] - Rosenthal MB, et al. (2016). A Difference-in-Difference Analysis of Changes in Quality, Utilization and Cost Following the Colorado Multi-Payer Patient-Centered Medical Home Pilot. *Journal of General Internal Medicine*.

Polling Question #2

Is your organization currently NCQA PCMH Recognized?

A. Yes

B. We are PCMH Recognized through a different organization.

C. Not currently but have been in the past.

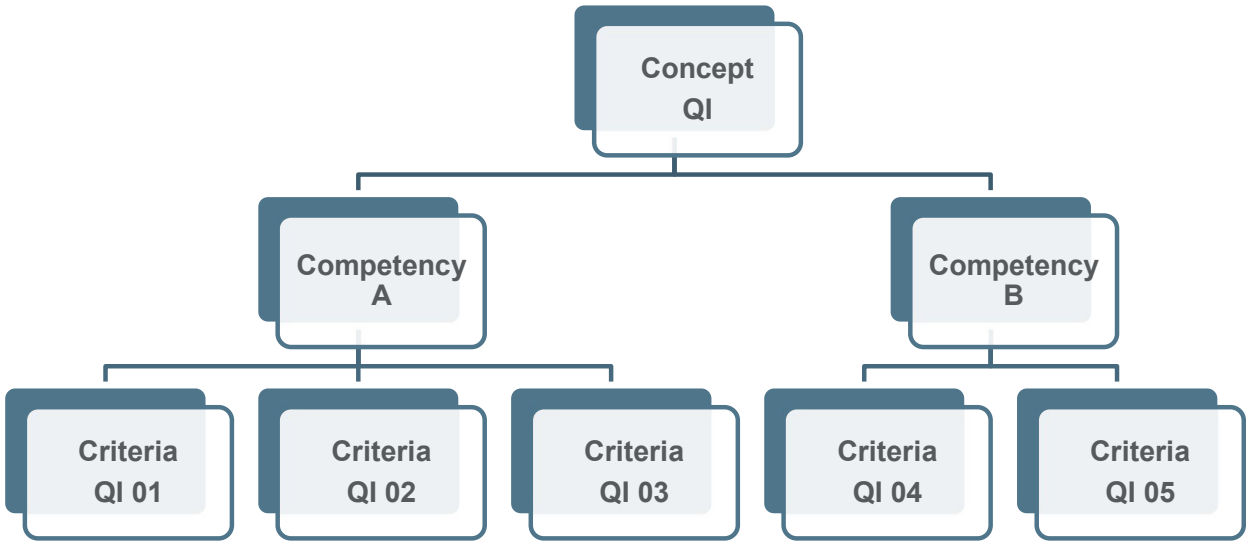
D. Not currently and have not been recognized by NCQA before.

Patient-Centered Medical Home

NCQA PCMH Refresh

NCQA PCMH

Terminology



PCMH Standards

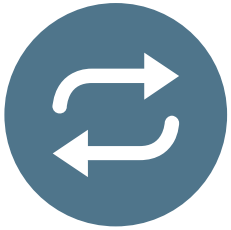
Concepts

Team-Based Care and Practice Organization (TC)

Knowing and Managing Your Patients (KM)

Patient-Centered Access and Continuity (AC)

Care Management and Support (CM)



Care Coordination and Care Transitions (CC)

Performance Measurement & Quality Improvement (QI)

Summary of PCMH Refresh—2026

- Frequencies to Transforming criteria.
- Documented process for standardized measurement.
- Updating the threshold for KM 14.
- Alignment with Virtual Care Delivery criteria.
- Retirement of criteria.
- Alignment with Health Plan Accreditation.

Addition of Frequency Thresholds to Guidance

Ensures fidelity in the medical records

Key Points:

- Thresholds added to 46 criteria.
- Threshold is a minimum.

Examples:

- **KM 02:** Completes a comprehensive health assessment ***at least annually***.
- **CM 04:** The practice reviews the care plan ***at least twice a year***.

Documented Process for Standardized Measurement

Addresses consistency for practices in generating measure reports

Key Points:

- Added for QI 01: Clinical Quality Measures.
- Added for QI 02: Resource Stewardship Measures.
- Can address data validation.

Evidence:

- **Documented Process**

AND

- Report *or*
- Quality Improvement Workbook

NCQA

KM 14: Medication Reconciliation

New threshold update

Key Points:

- Review and reconcile medications.
- 80% to **90%**.
- At least annually.

Evidence:

- Report of how many patients had their medications reviewed and reconciled at transitions of care OR at least annually.

Alignment with Virtual Care Delivery Criteria

Addresses current landscape in health care

Key Points:

- **9** new criteria added.
- All are **elective**.
- For all PCMH practices, not specific to virtual care only sites.

Examples:

- **TC:** The organization requests patient consent to treatment through virtual modalities.
- **AC:** The organization has a process for determining that virtual care is appropriate for the patient.
- **QI:** Assesses clinician and care team experience for delivering care and sets goals and actions for improvement.

Retirement of Criteria

Addresses changes in health care practices

Key Points:

- Retirement of **8** criteria.
- Criteria no longer adding value to PCMH Recognition.

Examples:

- KM 18: Controlled Substance Review.
- QI 18: Electronic Submission of Measures.

Alignment with Health Plan Accreditation

Addresses changes for collaboration

Key Points:

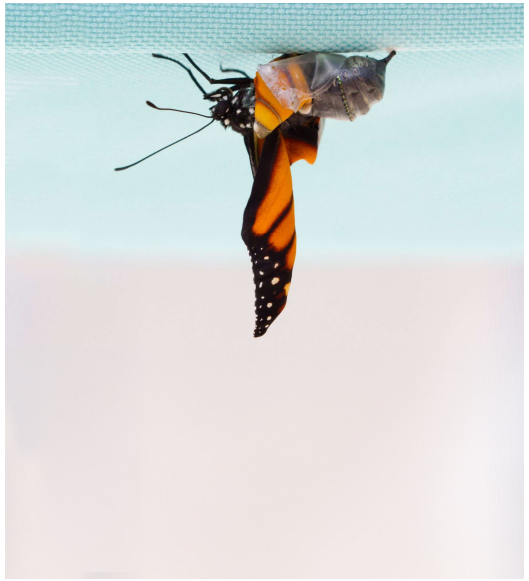
- Affects **2** criteria.
- Improves collaboration between primary care and payers.
- **Addition of "payers" as a source is optional.**

Examples:

- KM 26: Community (Resource) Lists
- CC 21: External Electronic Exchange of Information

Next Steps in PCMH's Life Cycle

An Outcomes-Driven Focus



- How will NCQA's approach to PCMH evolve?
- Build on original intent of PCMH
  - *Value of **standardization***
- Meet practices where they are (capability **differences**)
- Measure **what matters**
  - *Narrow, impactful, outcomes-focus*
- Align with quality-linked **incentives**

Polling Question #3

Are you interested in a speaking to a member of the NCQA team to discuss PCMH Recognition?

A. Yes.
B. No.

Are you interested in learning more about the evolution of NCQA primary care programs?

A. Yes.
B. No.

Questions

you're invited!

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THIS IS QUALITY

NCQA Upcoming Events- Register Now!

Featured Guest...

President of The Commonwealth Fund, ***Joseph R. Betancourt***

June 4, 1-2pm EST

Register Here


NCQA
Thank you