For Public Comment
June 4–July 10, 2026

Comments due 11:59 p.m. ET
July 10, 2026

Overview of New Program:

Advanced Primary Care

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Advanced Primary Care:
Overview of New Program

NCQA's Mission: Improve the Quality of Health Care

For almost 40 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-Accredited health plans. Today, over 180 million Americans are enrolled in an NCQA-Accredited health plan.

The NCQA Advantage

Advanced Primary Care Accreditation is designed to define and advance high-quality, coordinated primary care in today's evolving care environment. It aligns standards and measurement with emerging payment models, stakeholder expectations and data-driven care delivery. The NCQA Accreditation seal signals that organizations meet rigorous, forward-thinking standards and are prepared to succeed in advanced primary care and value-based models.

Stakeholders Participating in Public Comment

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

Background

Advanced Primary Care Accreditation was developed in response to evolving expectations for how primary care is delivered, financed and evaluated across the health care landscape. It reinforces the shift toward payment models that reward longitudinal, coordinated, team-based care management.

The program builds on the foundation of NCQA's Patient-Centered Medical Home (PCMH) Recognition, and reflects enhanced capabilities, accountability and infrastructure. It advances organization-level accountability and supports emerging payment and delivery models by incorporating modern capabilities, such as integrated care coordination, data-driven performance management and alignment with advanced payment models. The program also responds to growing demand for more enhanced, measurable quality performance metrics.

The program is supported by national policy and payment trends that emphasize coordinated, activity-based primary care and accountability at the organizational level.

Development of this new program was informed by extensive market engagement and through advisory groups that helped refine its focus and design.

Advanced Primary Care Accreditation supports organization-level accreditation for entities such as health systems, ACOs, CINs and FQHC networks, and ties Accreditation to outcome-driven measurement, including electronic and digital clinical quality measures (eCQM/dQM).

The program will be released in November 2026, with survey availability beginning July 2027.

A Guide to the New Program

Advanced Primary Care Design

NCQA developed the Advanced Primary Care Accreditation program to evaluate how care delivery organizations build and sustain the core capabilities needed to deliver accessible, coordinated, person-centered primary care. The program defines accountability at the organization level, the network level or the highest level responsible for data, infrastructure and enterprisewide processes that enable care delivery, rather than at an individual practice site.

The program includes standards focused on key domains, including population health management, coordinated team-based care, patient safety and experience, behavioral health, and clinical quality, as well as data management and exchange. Measures are grounded in the HEDIS® measure set and align with established national programs, including eCQMs used in the CMS Merit-based Incentive Payment System (MIPS), Core Sets and the Universal Foundation.

Survey Process and Status Length

Advanced Primary Care Accreditation follows the standard NCQA survey process, which includes submitting documentation through the Interactive Review Tool (IRT) and an offsite review by NCQA surveyors. NCQA finalizes scoring, determines the organization's Accreditation status and issues a final report. Once Accredited, the organization maintains its status until the Accreditation anniversary aligned with the 3-year cycle decision date.

Eligibility

Organizations that provide and oversee primary care services are eligible for this program. Organizations include, but are not limited to:

- Coordinated practice networks of clinicians who share responsibility for delivering services to a defined patient population.
- CINs with active and ongoing programs to monitor and help ensure quality of care delivered to a defined patient population.
- Health systems and their employed or contracted clinicians functioning under a unified governance and accountability structure.

Advanced Primary Care Pilot Program

NCQA tested proposed program standards and measures through a pilot program that gathered feedback across diverse primary care delivery models. Pilot participants partnered with NCQA staff to assess the value, feasibility and clarity of proposed content and to provide practical examples of how the requirements function in real-world settings.

The pilot was conducted from January–April 2026 using a two-phase approach. The learning phase focused on building understanding of the program through discussions and group office hours. The

testing phase emphasized operational validation: Organizations worked through requirements using a pilot survey, shared sample evidence and discussed workflows with NCQA evaluators. Feedback from both phases directly informed refinements to the proposed standards and measures.

Advanced Primary Care Standards

Program standards proposed for public comment are organized into six domains. They balance core operational processes and measurable outcomes. Consistent with NCQA's current Accreditation framework, standards use a hierarchy of standards, elements and factors. Some elements are designated as "must-pass"; some give organizations the flexibility to pursue select elements to demonstrate their capabilities.

Draft standards build on existing NCQA programs and national frameworks, and introduce new and expanded expectations tailored to NCQA's definition of advanced primary care.

Refer to Attachment: *2027 APC Program Proposed Standards*

For a full list of standards and elements, refer to Table 3.

Advanced Primary Care Measures

The Advanced Primary Care measure strategy uses two complementary measure types:

1. Established eCQMs.
2. New dQMs built with the Fast Healthcare Interoperability Resources (FHIR®) data standard.

This two-part approach balances near-term feasibility with long-term innovation. Established eCQMs (which many organizations already collect and report) are used to assess current performance, while a limited set of FHIR-enabled dQMs is introduced to foster future-ready, interoperable data capabilities.

Organizations are not required to implement FHIR-based capabilities at this time; including FHIR dQMs is intended to provide transparency into future expectations and to offer organizations a clear roadmap for advancing their digital quality reporting capabilities over time. Leveraging the FHIR standard enables data from multiple sources (such as EHRs, HIEs and administrative systems) to be shared and aggregated consistently, supporting more automated and efficient quality reporting as capabilities evolve.

The eCQMs anchor the program with measures for quality improvement, and are drawn from NCQA's HEDIS measure set. Measures align with NCQA's Health Plan Accreditation requirements and overlap with those used in federal programs, as stated above. This alignment allows organizations to leverage measures with which they are already familiar, which reduces administrative burden.

Measure selection was informed by extensive stakeholder input. Twenty-two organizations—including health plans, state agencies, delivery systems and measurement experts—reviewed an initial list of 39 candidate measures and provided feedback on priorities. The measure list was refined by the 4 pilot sites during testing.

NCQA narrowed the set to 11 high-priority eCQMs that form the core measure set for the program's Clinical Quality domain. These measures (Table 1) focus on critical aspects of primary care quality (preventive care, chronic condition management, access, outcomes), and will be used to evaluate and benchmark program performance.

Table 1. eCQM Strategy

Product Launch 2026	Tentative Inclusion for 2028
1. Breast Cancer Screening (CMS125v13) 2. Cervical Cancer Screening (CMS124v13) 3. Colorectal Cancer Screening (CMS130v13) 4. Screening for Falls (CMS139v13) 5. Use of High-Risk Medication in Older Adults (CMS156v13) 6. Appropriate Treatment for Upper Respiratory Infection (CMS154v13) 7. Glycemic Status Assessment Greater than 9% (CMS122v13) 8. Controlling High Blood Pressure (CMS165v13) 9. Screening for Depression and Follow-Up Plan (CMS2v14) 10. Childhood Immunizations (CMS117v13) 11. Follow-up Care for Children Prescribed ADHD Medication (CMS136v14)	Kidney Health Evaluation (eCQM from NKF) Depression Remission at 12 Months (eCQM from MN Community Measurement) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (needs to be re-evaluated)

NCQA also piloted three FHIR-based dQMs through a qualitative evaluation with pilot sites, designed to assess organizations' interoperability readiness and to identify implementation challenges in extracting and sharing standardized data for the measures. The initial FHIR dQMs are adaptations of existing evidence-based measure concepts presented in a FHIR format; they are not entirely new measure concepts.

Because these measures are being introduced primarily to build and test data exchange capabilities, they will not be scored or used for performance assessment at this stage.

Note: *In APC, the FHIR dQMs carry a "CD" suffix in their measure identifiers to denote they are care delivery-level measures, distinct from health plan-level HEDIS measures. Refer to* Attachment: 2027 Advanced Primary Care Program_dQM Specifications.

Insights from the pilot informed expectations for digital quality reporting, and guided a graduated roadmap for expanding FHIR-based measures in the program. As primary care organizations strengthen their internal data structures and data exchange capabilities, NCQA will gradually broaden the digital measure portfolio beyond the initial three FHIR measures. Additional FHIR dQMs will be introduced over time (Table 2) to address key primary care priorities (e.g., social needs screening, preventive care, health care utilization, care coordination).

Table 2. Proposed FHIR dQM Roadmap

Product Launch 2026	2028 Update	2030 Update	2032 Update
Appropriate Treatment for Upper Respiratory Infection (URI-CD)	Social Needs Screening and Intervention	Follow-Up After Acute and Urgent Care Visits for Asthma	Transitions in Care
Blood Pressure Control for Patients with Hypertension (BPC-CD)	Kidney Health Evaluation	Immunization Status	Follow-Up After ED Visit for People With Chronic Conditions
Colorectal Cancer Screening (COL-CD)	Depression Screening and Follow-up	Breast Cancer Screening	Depression Remission at 12 Months
	Continuity Measure (Adapt from ABFM)	Emergency Department Utilization	Tobacco Screening and Intervention
	Adults Access to Preventative Health Care Services	Blood Pressure Control for Patients with Diabetes	Follow-up for Colorectal Cancer Screening
	Child and Adolescents Well-Care Visits	Glycemic Status Assessment	

Table 3. Advanced Primary Care Standards Summary Table

Standard	Elements	Pilot Feedback	Standard Intent Statement
Population Health Management			
PHM 1: PHM Program Oversight	A: PHM Governance Structure B: Annual PHM Plan C: Communication about PHM Programs D: Annual PHM Evaluation	NA—Recently added	The organization establishes oversight for its population health management (PHM) program to guide strategy, execution and quality improvement.
PHM 2: Population Identification	A: Population Assessment B: Targeting, Segmentation and Bias Evaluation	Strong support for assessing population needs and methodology biases, but organizations flagged overly detailed factor lists in pilot draft standards. Feedback consistently favored streamlined, high-level expectations and flexibility in data sources relevant to organization priorities.	The organization systematically collects, integrates and assesses patient data to inform the needs of its population.
PHM 3: Complex Care Management	A: Access to Care Management B: Care Management Process	Organizations recognized the value of care management access, but highlighted wide variation in feasibility by organization type, especially for ACOs and networks. Feedback emphasized focusing on identification and referral capability, not on completion or outcomes outside primary care control. Organizations supported reducing factor burden and focusing on core assessment domains, not on exhaustive care management requirements.	The organization coordinates services for its highest risk patients with complex conditions and helps them access needed resources.

Standard	Elements	Pilot Feedback	Standard Intent Statement
PHM 4: Self-Management Tools	A: Topics of Tools	Strong support for inclusion. Topics resonated with organizations.	The organization has evidence-based self-management tools available to help patients manage their health
Coordinated, Team-Based Care			
CTC 1: Team-Based Care Strategy	A: CTC Strategy	Feedback emphasized clarifying internal vs. external coordination and reducing prescriptiveness to better reflect real-world structures.	The organization outlines its team-based care strategy to promote efficient, consistent, coordinated care.
CTC 2: Care Coordination	A: Referral Management B: Transitions of Care C: Reporting on Readmissions D: Reporting on Acute Care Utilization	Feedback consistently highlighted that while closing the referral loop and addressing utilization are important goals, they are often constrained by limited data access, unclear ownership beyond primary care and lack of control over external entities. Element D was recently added.	The organization optimizes care coordination processes to minimize gaps in care.
CTC 3: Staff Culture and Experience	A: Assessment of Staff Experience B: Staff Burnout Monitoring and Mitigation	Feedback highlighted that assessing staff experience and clinician burnout is important, but challenged by inconsistent tools, unclear evidence expectations and limited control over underlying drivers. Organizations supported greater flexibility in evidence options, allowing a range of approaches (including broader staff scope), and avoiding overly prescriptive requirements that may be difficult to standardize or implement.	The organization assesses staff experience to support a quality-driven environment.

Standard	Elements	Pilot Feedback	Standard Intent Statement
CTC 4: Alternative Payment Arrangements	A: Alternative Payment Arrangement Participation B: Risk Absorption Capacity C: Primary Care Reinvestment for Risk-Critical Capabilities	Strong cross-organizational support for capturing participation in value-based or alternative payment models, particularly from PCMH organizations, where these criteria exist. Element C generated feasibility concerns, though the concept was seen was valuable.	The organization aims to move beyond traditional fee-for-service models by promoting risk-sharing, transparency and reinvestment
Patient Safety and Experience			
PSE 1: Access to Services	A: Access to Care Team B: Enhanced Communication Opportunities C: Demonstrating Appointment Availability	Feedback consistently affirmed that 24/7 access is foundational. Organizations emphasized defining clear minimum expectations, allowing flexible coverage models and ensuring practical measurement approaches favoring streamlined reporting, clear definitions and avoiding overly granular appointment metrics while still supporting assessment of access and turnaround time.	The organization focuses on achieving person-centered care through technology-supported approach that prioritizes accessible services
PSE 2: Medication Management	A: Medication Reconciliation B: Medication Response and Adherence C: Prescribing Patterns	Medication-related activities were viewed as foundational, but should emphasize clear, flexible, process-based approaches. Organizations supported defining scope, leveraging multidisciplinary teams, and documenting workflows, while noting adherence tracking is often outside primary care control. For safety, feedback called for clearer expectations, flexibility, and avoiding overly narrow or duplicative requirements.	The organization collects medication and prescribing data to identify patterns and improve health outcomes in patients.
PSE 3: Patient-Centered Experience	A: Assessment of Patient Experience	Patient experience measurement was supported, with emphasis on flexibility in survey tools and administration and recognition of continuity as a key domain.	The organization assesses patient experience to monitor and improve activities that support engagement, well-being and quality care.

Standard	Elements	Pilot Feedback	Standard Intent Statement
	B: Demonstrating Improvement on Patient Experience	Feedback favored a simplified approach, such as requiring use of data and at least one improvement action, rather than formal planning structures.	
Behavioral Health			
BH 1: Access and Integration	A: Demonstrating Access to Behavioral Health Services B: Behavioral Health Referrals C: Integrated Services	Behavioral health capability and integration were supported, but should emphasize flexible, practical evidence over formal processes. Referrals should focus on pathways and follow-up, not completion, with expectations that account for data, privacy and varying integration maturity.	The organization helps ensure that patients have timely access to behavioral health services, and promotes integration of behavioral care into medical care.
BH 2: Behavioral Health Screenings	A: Routine Behavioral Health Screenings B: Clinically Indicated Screenings	Routine screening for depression and anxiety was supported, with flexibility for additional conditions based on capacity. Feedback emphasized clear minimum expectations and limiting screening to clinically appropriate cases.	The organization conducts routine behavioral health screenings and assessments using validated tools integrated into standard care workflows.
BH 3: Evidence-Based Care	A: Providing Brief Interventions B: Monitoring Patients Over Time	Brief interventions and harm reduction were widely supported, but should be clearly scoped to primary care and avoid expectations for specialty-level treatment, given feasibility challenges regarding data and care fragmentation. Feedback favored focusing on documented monitoring or escalation processes, with more advanced tracking as optional.	The organization provides interventions consistent with evidence-based guidelines when clinically appropriate for patients with behavioral health conditions.

Standard	Elements	Pilot Feedback	Standard Intent Statement
Clinical Quality			
CQ 1: Quality Performance Measurement	A: Clinical Measurement Reporting B: Demonstrating Clinical Measurement Performance—50th Percentile C: Demonstrating Clinical Measurement Performance—80th Percentile D: Improving Disparity Gaps	Organizations supported a core measure set, but raised concerns about burden, feasibility and relevance across populations. Feedback emphasized the importance of flexible implementation, appropriate peer grouping and risk adjustment, and caution in interpreting small performance differences. Organizations also called for clarity on whether the focus is disparities, service gaps, or both, and supported flexible, higher-level analysis over unstable subgroup reporting.	The organization reports clinical quality measures, demonstrates performance and improves identified gaps.
Data Management and Exchange			
DME 1: Data Integration and Exchange	A: Core Data Integration B: Advanced Data Integration C: Bidirectional External Exchange of Information	NA—Recently added.	The organization integrates core or advanced sources of data to support an understanding of patient care and inform care delivery and coordination activities.
DME 2: Use of Fast Healthcare Interoperability Resources	A: FHIR Data Integration Capability B: FHIR Data Production and Validation C: FHIR Digital Quality Measure Reporting	Elements A and B were recently added. Support for digital measure reporting in principle, but organizations highlighted readiness gaps and data completeness issues. Feedback emphasized flexibility and alignment with existing reporting capabilities. Some organizations expressed the ability to do this through their EHR vendor or due to UDS reporting.	The organization uses FHIR data and reports digital quality measures.

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. Do you support the order and organization of standards?
2. Are there activities in this program that do not add value or are out of scope for primary care organizations?
3. Will the proposed updates help your organization meet its objectives? Why or why not?
4. Are there key expectations not addressed in the proposed requirements?
5. How should AI be reflected, if at all, in the APC standards given current primary care maturity?
6. What AI-related activities should standards address?
7. What observable value is AI delivering in primary care?
8. Is your organization leveraging AI for FHIR mapping or readiness?
9. Will proposed updates assist your organization in meeting its objectives? If so, how? If not, why not?
10. Are there key expectations not addressed in the proposed requirements?

Documents

Find the complete list of questions at: *2027 APC Program - Public Comment Questions*

Find the draft standards rationales at: *2027 APC Program - Proposed Standards*

Find the proposed digital quality measures specifications at: *2027 APC Program - dQM Specifications*

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 https://my.ncqa.org/.
2. Once logged in, click to select **Public Comments**.
3. Click **Add Comment**.
4. Select the name of the organization you are submitting comments for.
5. Click the **Instructions** link to view public comment materials, including instructions and proposed measure specifications.
6. Click **Take Survey**.
7. Review the process instructions and click the **Begin** button.
8. Answer the questions you would like to provide feedback on; required questions will be marked with a red asterisk.

a. Select your support option (e.g., Support with no proposed changes, Support if the following change is made, Do Not Support.

Note: *If you chose* **Do Not Support,** *include the reason in the text box. If you chose* **Support if the following change is made,** *enter the suggested modifications in the text box.*

b. Enter comments in the **Comments** box.

Note: *Comments allow up to 50,000 characters.*

9. Click **Next** at the bottom of the page. Repeat **step 8** for each page.

   Note: *Use the* ***Back*** *button if you would like to change a response.*

10. On the final page, click **Submit**.

All comments must be entered by 11:59 ET on July 10, 2026.

Next Steps

The final Standards and Guidelines for Advanced Primary Care Accreditation will be released in late 2026, following approval by the NCQA Evaluation Programs Committee and the Board of Directors.

Requirements for all programs will take effect for surveys starting July 2027.