Patient-Centered Medical Homes

NCQA’s Patient-Centered Medical Home (PCMH) Recognition program is a powerful tool for transforming primary care into what patients want it to be. It’s a model that puts patients at the forefront of care by building better relationships between patients and the teams who care for them. PCMHs directly address the fragmentation\(^1\) that plagues our health care system by:

- Ensuring patients receive the treatment they need, when they need it.
- Preventing costly, avoidable hospitalizations and emergency department visits – particularly for those with complex chronic conditions.
- Reducing health care disparities for important services like preventive screenings.
- Coordinating the type of personalized, comprehensive, integrated care that patients want.
- Improving staff satisfaction by ensuring practices have the systems and structures to work efficiently.
- Leveraging health information technology (HIT) to enhance access and coordinate and manage care.

PCMH practices meet a set of clear, specific criteria that show clinicians how to organize care around patients and work in teams to coordinate, track and improve care:

This year, NCQA is launching a PCMH Redesign to help clinicians through the recognition process. We are aligning recognition activities with other reporting requirements, leveraging investment HIT to support transformation, and strengthening the link between recognition and practice performance on quality, cost, and patient experience. The Redesign also focuses on helping providers develop relationships with social, community and other non-medical providers to fully integrate care delivery.


©2017 National Committee for Quality Assurance. All rights reserved.
A growing body of evidence documents PCMHs’ many benefits, including better quality, continuity, prevention, disease management and patient engagement. Studies also show lower costs from inpatient admissions, especially for patients with complex chronic conditions.

### Practice & Clinician Benefits
- Align with national health care trends away from volume and toward value-based care.
- Earn auto-credit and perform better in the Merit-Based Incentive Payment System.
- Improve patient care by implementing processes that drive practice efficiency.
- Earn enhanced reimbursements through federal, state and commercial payers for your NCQA recognition.

### Patient Benefits
- Trust their PCMH to deliver the right preventive services to stay healthy.
- Enhanced access and better communication to get needed clinical advice or information.
- Care teams have helpful staff to coordinate care both inside and outside the practice.
- Complex chronic conditions are better managed, preventing acute incidents and costly hospital visits.

### PCMH & MACRA.
Medicare recognized these benefits by offering financial incentives for NCQA PCMH Recognition under the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA). That’s because NCQA PCMH provides a roadmap for making this powerful change to how clinicians provide care.

PCMHs also are a fundamental building block for participating in public and private APMs. APMs are proliferating under the nationwide transition from volume to value-based care, and NCQA’s rigorous standards provide a roadmap for practices to implement the infrastructure necessary to flourish in this new environment. Together with our Patient-Centered Specialty Practice (PCSP) and Patient-Centered Connected Care (PCCC) Recognition, NCQA offers a full suite of programs to recognize an entire medical neighborhood that could potentially form its own APM.

NCQA’s PCMH standards are available free of charge at [https://store.ncqa.org/](https://store.ncqa.org/). NCQA also offers a variety of educational programs about how the program works. For more information, please contact Paul Cotton, NCQA’s Director of Federal Affairs at (202) 955-5162 or cotton@ncqa.org.

---


©2017 National Committee for Quality Assurance. All rights reserved.