NCQA Patient-Centered Medical Home (PCMH) Recognition

A tool to improve quality outcomes, lower utilization rates, and drive savings

Program Description

NCQA PCMH is the most widely-used program for transforming primary care practices into medical homes. To achieve recognition, practices must meet all core criteria and earn 25 credits in elective criteria across 5 of 6 concept areas.

PCMH 2017 includes a streamlined application process and an annual check-in. We've also added the flexibility to emphasize state-specific priorities, such as behavioral health integration.

20% of all primary care clinicians are NCQA PCMH Recognized, including 70,000+ clinicians across 15,000+ practices.

Value to States

- ***Provides*** standardized model of care
- ***Improves*** outcomes, lowers utilization
- ***Aligns*** with MACRA/MIPS and CPC+
- ***Builds*** provider capacity/increases access
- ***Supports*** Value-Based Payment initiatives
- ***Enhances*** state quality improvement efforts
- ***Foundation*** for building ACO's/CIN'S
- ***Drives*** savings

NCQA PCMH Recognition in Action

Medicaid Managed Care contract incentive (PMPM for NCQA PCMH recognition)	Metric for measuring network quality (track % of providers that are NCQA recognized)	Participation requirement for DSRIP, SIM or Health Home initiatives	Auto-credit for NCQA recognition to participants in state initiative
South Carolina Provider Quality Incentive Program	Georgia (CMO Contract)	Tennessee (SIM) New York (DSRIP) Iowa (Health Home)	Oregon (PCPCH)

Additional State Examples

Twenty-nine public sector initiatives across 24 states require or use NCQA PCMH including: CA, CT, DC, FL, HI, LA, MA, ME, MI, MO, NM, ID, RI, TX, VT, WY.

To learn more, contact our State Affairs Team at publicpolicy@ncqa.org.