The Future of Patient-Centered Medical Homes
Foundation for a Better Health Care System

Patient-Centered Medical Homes (PCMHs) are transforming primary care practices into what patients want, focusing on patients themselves and all of their healthcare needs. They also are foundations for a healthcare system that gives more value by achieving the 'triple aim' of better quality, experience and cost. This white paper lays out our vision for achieving that goal by chronicling PCMH evolution to date, challenges before us, potential solutions underway and those yet to be developed.

More than 10 percent of U.S. primary care practices, approaching 7000 altogether, are recognized as PCMHs by the National Committee for Quality Assurance (NCQA), which has the nation's largest PCMH program. To earn NCQA recognition, practices must meet rigorous standards for addressing patient needs. That means offering access afterhours and online so patients get care where and when they need it. PCMHs get to know patients in long-term partnerships, rather than hurried, sporadic visits. They make treatment decisions together with patients based on individual preferences. They help patients become better engaged in their own healthy behaviors and healthcare. Everyone in the practice – from clinicians to front desk staff – works as a team to coordinate care from other providers and community resources. This maximizes efficiency by ensuring that highly-trained clinicians are not doing tasks lower level staff can do. They also avoid costly and preventable complications and emergencies by focusing on prevention and managing chronic conditions.

A growing body of evidence documents PCMHs' many benefits, including better quality, patient experience, continuity, prevention and disease management. Studies also show lower costs from reduced emergency department visits and hospital admissions. [i ii iii iv v vi vii viii ix x xi xii xiii xiv xv] Other studies show reduced income-based disparities in care and provider burnout. [xvi xvii] Yet some have equivocal results.[xviii]

PCMHs' power in improving the quality, cost and experience of primary care, however, only begins the broad change our health care system needs. Other providers and facilities must build on PCMH foundations to establish patient-centered care throughout all of healthcare. This is beginning in Patient-Centered Specialty Practices (PCSPs), which help specialists become part of medical neighborhoods to improve quality and access. Adoption of patient-centered strategies also is underway in many emerging Accountable Care Organizations (ACOs). ACOs build on a solid PCMH foundation to coordinate doctors, hospitals, pharmacies, other providers and community resources and make sure people get all the care they need. They share savings from reduced waste and inefficiency if they also improve quality.

Key Facets of Patient-Centered Medical Homes
• *Enhanced Access After Hours & On-Line*
• *Long-term Patient & Provider Relationships*
• *Shared Decision Making*
• *Patient Engagement on Health & Healthcare*
• *Team-Based Care*
• *Better Quality & Experience of Care*
• *Lower Cost from Reduced Emergency Department & Hospital Use*

But this still is only a start. Most providers today are not yet in PCMHs, PCSPs or ACOs. Those who are may be on steep learning curves, or lack the capabilities, commitment and resources to sustain transformation. PCMH transformation is not easy and requires a long-term commitment from every team member and a significant financial investment. Practices may face technological or legal challenges with electronic access privacy and liability. Coordination with community services, public health, dental, post-acute and other settings is minimal. Linking with behavioral care is particularly challenging yet critical because many with chronic illness also have behavioral co-morbidities. Payments and other supports vary widely among insurers and may not be sufficient, especially for non-face-to-face and team-based services not traditionally covered. Also, most patients are unaware of PCMHs. Focus groups with PCMH patients show they are aware of better access and coordination, but not the PCMH name. Those not in PCMHs often doubt such care is even possible.

We are making steady progress in addressing many of these challenges. For example, Medicare is moving to support PCMHs with both performance-based and non-face-to-face chronic care management payments. Interest in PCSPs and ACOs is growing, and patients, providers and payers with PCMH experience agree this is the future we all want. This journey to get better healthcare value by focusing on patients will succeed.

Goals for PCMH and Beyond

We have several goals for the Patient-Centered Medical Home:

- Primary care clinicians will improve quality, patient experience, coordination and value through better prevention and access to reduce emergency department and hospital care.
- Primary care will be the foundation of a high-value health care system that provides whole person care at the first contact. Everyone in primary care practices – from physicians and advanced practice nurses to medical assistants and frontline staff – should practice to the highest level of their training and license in teams to support better access, help with self-care, and coordination.
- PCMHs will show the entire health care system what patient-centered care looks like. Patient-centered care is "respectful of and responsive to individual patient preferences, needs, and values, and ensures that patient values guide all clinical decisions."[xix] Individuals and families get help to be actively engaged in their own healthy behaviors, health care, and in decisions about and their care.
- PCMHs will revitalize the "joy of practice" in primary care, making it more attractive and satisfying.

This vision is becoming reality in many parts of the country. For example in Vermont, NCQA-recognized PCMHs are being widely adopted as the foundation for the state's "Blueprint for Health." Purchasers and policymakers there are now engaging a broader set of providers – specialists, hospital systems and community providers of social and long-term services and supports – to align incentives for better value.

The Medical Neighborhood – While primary care is the foundation for delivery system transformation, PCMHs alone cannot change the entire system. Data sharing among primary care, specialists, hospitals, and other providers is needed to maximize coordination and management. Our current payment system drives greater use of services, especially high-volume services for hospitals and many specialists. Primary care spending is low and a small share compared to other providers, which limits access to capital for information technology and other systems to support outreach, patient engagement and analysis. Other parts of the system must also have strong incentives to change if we are to realize better outcomes.

Patient-Centered Specialty Practices: Specialty care clinicians provide many services and many patients seek specialists' care directly without primary care consults. For patients with certain chronic conditions, specialists serve as primary care providers for extended periods of time. Creating better ways for information to flow effectively among primary care clinicians and specialists is critical for care coordination and reducing duplicative care. In 2013, NCQA launched the Patient-Centered Specialty Practice (PCSP) program to recognize specialists that use systems and processes needed to support patient-centered care, including strong communication with other providers.

Accountable Care Organizations: ACOs are bringing communities of doctors, hospitals and other providers together to improve outcomes and lower costs. They share in any savings if they can show improved quality. Medicare and many other insurers now support these "shared savings" opportunities. PCMHs provide the solid foundation ACOs must build to assure quality, patient-centered care. ACOs also can help build and redistribute funding to primary care to develop critically important PCMH infrastructure.

Behavioral Health: This is a key focus for better integration, particularly in Medicaid where many high-cost enrollees have behavioral conditions. Integrating behavioral health poses additional challenges from heightened privacy concerns, culture differences, and patients' tendency to avoid primary care. Unaddressed behavioral health conditions can exacerbate physical health conditions, which increases disability and cost. Medicaid "health home" initiatives are now working to address this by either bringing primary care into behavioral health practices or providing behavioral health expertise in primary care settings. Some states use NCQA's PCMH and PCSP standards to define health home capabilities.

Public Health: Bringing complementary strengths of public health and primary care together has great potential. Some public health providers –school-based, HIV and community health centers –provide primary care and can be PCMHs. The Health Resources and Services Administration is helping community health centers become PCMHs. North Carolina is using public health staff to visit at-risk pregnant women in their homes to help primary care providers engage these patients and get them better prenatal care. Vermont also is connecting its PCMHs and providers of long-term services and supports to provide much needed information and coordination to support patients' full set of needs and circumstances. Helping all PCMHs connect with community resources that can also improve health will be critical going forward.

Worksite, Retails Clinics and Pharmacies: Other settings receiving increased interest include worksites, retail clinics and pharmacies. Worksite clinics are increasingly serving as employees' main primary care setting. Retail clinics that treat minor problems in drug stores and other convenient settings are expanding to address wellness, health promotion, and chronic care management. Many refer patients back to community primary care clinicians for needed follow up. Pharmacies also are taking on new roles with immunizations, health and wellness screenings, adherence and other medication management services. As these options gain in popularity and scope, it becomes increasingly important to share information between them and PCMHs.

NCQA PCMH Evolution to Date

The American Academy of Pediatrics introduced the medical home concept in 1967. A generation later, in 2004 the specialty of family medicine called for all patients to have a "personal medical home."[xx] In 2003 NCQA launched Physician Practice Connections, a PCMH precursor program. In 2007, leading primary care associations released Joint PCMH Principles.[xxi] In 2008, NCQA launched the first PCMH Recognition program, with updates to raise the bar in 2011 and 2014. NCQA's PCMH program is the largest, with over 34,600 clinicians at 6,800 sites – about 10 percent of all primary care clinicians.

Year	Version	Elements of the Program
2003	Physician Practice Connections	PCMH precursor recognized use of systematic processes and health IT to: - Know and use patient histories - Follow up with patients and other providers - Manage patient populations and use evidence –based care - Employ electronic tools to prevent medical errors
2008	PPC- PCMH	First PCMH model implemented the Joint Principles , emphasizing: - Ongoing relationship with personal physician - Team-based care - Whole-person orientation - Care coordination and integration - Focus on quality, safety and enhanced access
2011	PCMH 2011	- Incorporated health information technology meaningful use criteria - Added content and examples for pediatric practices on parental decision-making, age-appropriate immunizations, teen privacy, etc. - Added voluntary distinction if the practice participates in NCQA's standardized survey of patient experience - Added content and examples for behavioral health
2014	PCMH 2014	- Further integrate behavioral health - Additional emphasis on team-based care - Care management for high-need populations - Encourage involvement of patients and families in practice management - Alignment of Quality Improvement activities with the "triple aim" of improved quality, cost and experience of care - Alignment with health information technology Meaningful Use Stage 2

Broad Support: Many public and private sector initiatives support PCMH transformation. The Department of Defense is working to transform all of its primary care practices into NCQA PCMHs. The Department of Health and Human Services is helping hundreds of community health centers and Federally Qualified Health Centers to also become PCMHs. The Office of the National Coordinator for Health Information Technology's Regional Extension Centers provide technical assistance to practices. Congress is advancing legislation to move Medicare beyond demonstration programs in selected states to support PCMHs nationwide with new payments to reward value and non-face-to-face chronic care management services. In addition, states and private insurers have programs in place to support PCMHs in more than three dozen states.

Practices of all sizes earn NCQA recognition. Most have fewer than 8 clinicians, and over one third have only one or two, even though larger practices with more staff and other resources can more readily make the transformation.[xxii] More than 75 percent of NCQA PCMHs have achieved Level 3 Recognition, representing the most advanced capabilities. Level 1 Recognition is for practices beginning to achieve meaningful transformation.

PCMH penetration is greatest in states that provide the most technical and financial support in making this powerful transformation. In New York State, for example, one quarter of all primary care practitioners are in NCQA-recognized PCMHs.[xxiii] Some states and initiatives use other medical home programs.

37 States* Have Public and Private Patient-Centered Medical Home (PCMH) Initiatives That Use NCQA Recognition

Private (13)
Public (7)
Both – Including Multi-Payer (17)
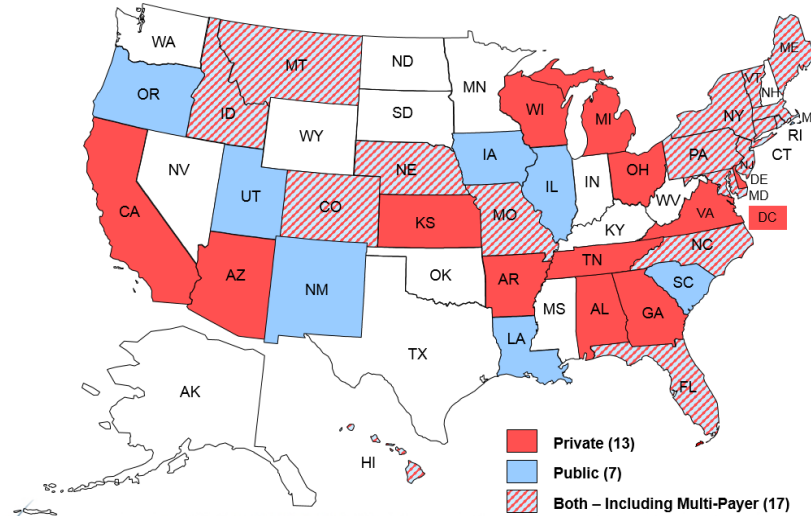
*Sources: states, plan website, PCPCC, NASHP and peer-reviewed research.

Attributes for Success: There are many paths to becoming successful PCMHs – they do not all look alike and generally take local circumstances and preferences into account. NCQA has identified several key attributes that contribute to PCMH success:

- Most successful practices have received financial or technical assistance, or both, to transform.[xxiv] They particularly value practical examples and support for meeting requirements, and worry about maintaining their financial sustainability.
- Organization leadership, a team-based approach, health information technology and delegating self-management education to non-physician team members are also features of most successful practices.
- Involving patients and families in practice improvement efforts through advisory committees, ombudsmen or navigators, is a hallmark of some of the best PCMHs.
- They take a systems approach and, as result, have data, standard measurements, technical assistance, leadership and personnel.
- Having quality improvement systems in place, further distinguishes high performers.

Challenges and Concerns

Despite the successes of PCMHs and the NCQA approach, feedback shows that not everyone embraces the program. Some concerns are specific to NCQA, others relate to broader challenges.

Concerns about the NCQA Approach: Despite its popularity, NCQA's process is criticized for focusing on practice structure rather than outcomes, its cost and frequency. NCQA recognition involves a detailed assessment of practice capabilities and processes because evidence suggests structure and process drive outcomes. A multi-stakeholder committee – expert in primary care and representing clinicians, payers, consumers and others – convenes to define key expectations. The public also is invited to comment. The key elements are expressed as written standards, or a series of statements that describe the expectations. The standards provide a clear roadmap to what practices need to have in place to be successful as PCMHs.

NCQA evaluates how well practices meet expectations. Some are "must pass" and practices failing them cannot get NCQA recognition, regardless of how well they do otherwise. Practices that pass all "must pass" requirements and achieve a minimum number of points are then recognized as PCMHs for three years. The number of points also determines their Recognition level, with Level 3 Recognition for the highest scores.

Using NCQA's Interactive Survey System, practices upload documentation, such as screen shots and reports, to show how they meet expected capabilities and processes. NCQA reviews the documentation off-site. Some stakeholders contend that on-site review is more effective but there is no evidence to support this extra cost. Compiling documentation itself requires significant administrative effort.

Structure vs. Outcomes – NCQA assesses the structural capabilities and processes needed to be PCMHs. Practices must demonstrate continuous quality improvement on at least two clinical, patient experience, or cost/utilization measures, but NCQA does not evaluate overall outcomes. Some PCMH initiatives do measure outcomes if they have claims and other information. But practices themselves often lack data on hospital admissions, emergency room visits and other care provided outside the practices. Also, practices are diverse and often lack enough of any particular type of patient to support robust case sampling. Working toward measuring outcomes in PCMHs is a top NCQA priority, and our ultimate goal is a balance of structural and performance measures, as we have for NCQA Health Plan Accreditation. However, structural measures are the best option until we have consensus and good data sources on the best outcome measures for PCMH evaluation. Further, structural measures are useful as a roadmap that tells practices what they need to do to become PCMHs.

NCQA has developed an approach to measuring PCMH patient experience, which moves towards outcomes, but it involves additional costs and uptake is slow. By doing this we have learned that:

- *Patient Experience is Another Powerful Improvement Tool:* Measuring patient experience provides critical feedback that that practices can use to identify and address areas for further improvement.
- *Choice of Measures is Critical:* The Consumer Assessment of Healthcare Providers & Systems Clinician and Group (CG-CAHPS) survey now includes PCMH-specific questions, such as on after-hours access. Initial feedback suggests that these measures are sound, distinct from traditional core measures and distinguish successful PCMHs. Sponsors using them, such as the Veterans Administration, want to continue using them. There is a version control problem, with different versions of the CG-CAHPS being used for different quality reporting programs. Also, the survey is long and work must continue to further refine it.
- *Alignment Also Matters:* Agreement on a core set of measures is necessary for establishing benchmarks and minimizing burden. However, some related initiatives, including ACO pilots, are requiring or considering different CG-CAHPS survey versions focusing on different reporting levels (individual clinician, practice, ACO, etc.). This discourages PCMHs in those initiatives from also reporting the PCMH version and thus hinders development of needed benchmarks.
- *On-site Patient Surveys are Problematic:* Some vendors promote patient surveys when they get care and contend that this supports faster analysis and improvement. However, it also creates opportunities for gaming by coaching patient responses. Ensuring fair results and comparisons is essential if such measures get more weight, particularly if they are used as criteria for financial incentives.

Cost of Recognition—NCQA PCMH Recognition fees range from $210 to under $150 per clinician per year, and almost all practices receive some type of discount. (Please see Appendix A for a full price chart.) For example, practices get a 20 percent discount when sponsored by payers and 10-20 percent if they are part of a multi-site group. Cost concerns are more common in smaller practices and those hiring consultants or staff to support recognition.

Greater concerns exist on related costs, such as for electronic health records that are needed to achieve Level 3 recognition, despite federal electronic health record "meaningful use" financial incentives. Enhanced revenue available to many PCMHs should also be considered in considering costs. This includes direct support from payers plus benefits of NCQA PCMH alignment with health IT meaningful use and other incentive programs for which NCQA recognized practices are directly prepared.

Three-Year Recognition—NCQA requires practices to be re-evaluated every three years. Many practices fully commit to ongoing practice transformation through development of care teams, integrating more advanced data exchange and tracking and developing more strategies to engage patients. However, some revert to "business as usual" after achieving NCQA recognition. Some stakeholders wonder if PCMH performance should be monitored more frequently to make sure practices meet expectations. Others suggest that payment should evolve from per-member-per-month fees to reward PCMHs' actual performance on outcomes, which requires consensus on and data sources.

Concerns about Financial and Practice Support – PCMHs often are supported by sponsors or initiatives with financial incentives for participation. Many practices say recognition renewal is highly dependent on continuing financial support. Support varies, but per-member per-month coordination fees are common, as are across the board fee schedule increases. Practices also may receive bonus payments for high performance on clinical quality and resource use measures. Some sponsors and initiatives pay for NCQA survey-related fees and training. Others go further and support care coordinators that practices may share (as in Vermont), integrated health information technology and connections to behavioral health and long-term services and supports resources.

To strengthen this financial support, some suggest weighting per-member per-month payments for complex patients. There also is interest in building advanced measurement reporting systems for more streamlined benchmarking, larger incentives and eventually shared savings. This offers another way to prevent PCMHs from reverting to business as usual.

Multi-payer initiatives, such as those sponsored by Medicare, Medicaid and commercial plans together, furnish the strongest incentive for practices to participate, especially when they use similar standards and payments. Practices have less reason to invest in PCMH transformation if they have:

- Uneven or inadequate financial support. Sponsors must pay enough to cover ongoing PCMH costs either in direct incentive payments or other types of support.
- Fragmentation among payers. If different sponsors use different incentives or standards, practices may be less sure about whether or where to participate.
- Payers who are concerned about legal challenges for aligning payment strategies. States like Montana have enacted statutory antitrust protections for PCMH initiatives to address this.

Broader concerns – Excellent primary care embodied in the PCMH is fundamental to better health care. Yet it is unrealistic to expect primary care to be the only locus for delivery system reform when so much health care (and health care spending) is driven by specialty providers.

- *How to bring in specialists?* – NCQA is working to create better connections among clinicians in the PCSP program. This program contains similar standards as PCMH with specific expectations for specialty and primary care clinician communication and agreement on how to work together to better coordinate patient care. However, other steps also are needed to create better incentives for specialists to collaborate and focus on value, for example through payment strategies.

- *Population health and "that's not my patient"* – Many initiatives build on a traditional fee-for-service foundation, where payments and quality measurement determinations are based on patients who seek care in PCMHs. Sponsors often pay PCMHs for patients assigned to them (common in Medicaid and HMOs) or based on attribution algorithms (common in PPOs and Medicare) that match patients to providers they see. However, disagreements sometimes exist about which patients are which providers' responsibility (patients seeing multiple primary care providers may most need PCMH coordination efforts). There also is increasing interest in finding ways to help practices reach and engage broader populations, including those who do not seek care.
- *What about the Small Practice?* Regions with many small, traditionally organized practices also tend to have shortages of providers and resources, such as high-speed internet access, which may make advanced primary care more challenging. However, we must support practices of all type and places. And we must do so while we continue to push for greater accountability from practices with greater resources and in more integrated environments. That is why consistent, meaningful support from all payers for practices to transform into and maintain themselves as PCMHs is so critically important.
- *How to better address pediatric concerns?* – NCQA added standards in 2011 to better address pediatricians concerns, such as parental decision-making, age-appropriate immunizations and teen privacy. However, we continue to explore how we might better support pediatricians' efforts in other areas, such as well-child care.
- *How to build patient demand for PCMHs?* – Most people choose health care providers through word-of-mouth references from friends and family. Yet efforts to build on that by educating patients about PCMH benefits and help them seek them out for care are only beginning. *Consumer Reports* has featured PCMHs in its highly-regarded pages and a few other press accounts are appearing. Some payers are promoting PCMHs through patient education, featuring recognized practices in provider directories, and placing PCMHs into tiers with lower cost sharing. Much more must be done, though, for PCMH recognition status to become a key factor in patients' choice of new primary care providers.
- *How to incorporate medication management?* Medications are involved in 80 percent of all treatments, yet lack of coordination across providers leads to poor outcomes. Improving medication management can be a critical element of both PCMHs and ACOs.

Potential Solutions

All of these challenges can and must be addressed. Potential strategies include better practice supports, making the transformation process more efficient, aligning policies to better support this movement, building up from PCMHs to medical neighborhoods and ACOs, and other steps.

Supporting Practices – To provide better support to practices working to transform into PCMHs, NCQA has a certification program for the growing numbers of consultants that offer to help practices prepare for PCMH evaluation. These Certified Content Experts must complete two rigorous PCMH education seminars and pass a comprehensive exam validating their knowledge of NCQA standards and guidelines, application procedures, survey processes and documentation requirements. Less than 80 percent of applicants pass. Certification helps practices gauge how well consultants understand NCQA's program requirements. NCQA also has a pre-validation program that evaluates electronic health records, registries, population health management tools and related software's alignment with PCMH requirements. NCQA verifies that pre-validated products completely meet one or more PCMH requirements and gives practices automatic credit for them, which reduces documentation needs.

Several states are also working to help practices transform and maintain status as PCMHs. Vermont stands out for its initiative, which supports care coordinators that practices can share and connects PCMHs to providers of long-term services and supports to enhance care coordination. In some states, public-private partnerships provide practice transformation support, such as HealthTeamWorks in Colorado. Other states, like Pennsylvania, hope to use federal State Innovation Model grants to expand PCMHs throughout their states by providing technical support to more practices, especially rural, urban and smaller ones. There is growing recognition that all payers – federal, state and commercial alike – must increase primary care payment rates and align PCMH standards and payment policies to ease the burden.

There also continues to be great interest in advancing information exchange needed for good care coordination and measurement through better health information technology. Even sophisticated electronic medical records have only limited ability to help analyze data needed to maximize improvement. PCMHs ability to improve the health of broad populations simply cannot happen without advanced informatics capabilities that few health IT vendors now provide.

Building from PCMH – Extending patient-centeredness beyond primary care also is crucial, both for supporting PCMHs themselves and improving quality, cost and experience throughout the health care system. PCMHs can provide the best care coordination only when all other providers also understand the importance and are committed to sharing information and working together to meet patient need.

The Patient-Centered Specialty Practice – The standards and expectations in NCQA's PCSP program directly build on what we have learned with PCMHs. Moreover, the goal of the PCSP program is to provide more support to PCMHs by enhancing coordination among clinicians in different practices. There is today often a serious disconnect between primary care providers and the specialists to whom they refer patients. The typical primary care provider coordinates with 229 physicians in 117 practices.[xxv] But coordination between primary care and specialty providers is often lacking. In fact, up to half of referring physicians did not know if patients had seen the specialist to whom they had been referred. [xxvi] There is solid scientific research on the need for better specialty-primary care coordination.[xxvii] Some suggests that a standard structure and guidelines for specialty-primary care coordination could have as much or more return-on-investment as better clinical care.[xxviii] [xxix]

To fill this gap NCQA developed the PCSP program based on the "medical neighborhood" concept, developed by the American College of Physicians and Agency for Healthcare Research & Quality.[xxx] [xxxi] It builds on the PCMH program to improve communication and care coordination with:

- Written referral agreements on specialists' roles and responsibilities and expectations for sharing information and coordinating care;
- Standards for timely access to care and clinical advice based on patient need;
- A systematic approach to track patients and coordinate care;
- Measuring performance to identify and act on needed improvements; and
- Three Recognition levels to support pay-for-performance programs.

PCSPs have great potential to improve quality, cost and patient experience. After launching in 2013, over 70 practices in 17 specialties stepped forward as "early adopters;" 30 have submitted applications.

Accountable Care Organizations – ACOs also build on a solid PCMH foundation to bring patient-centered care to entire health care communities. ACOs coordinate doctors, hospitals and other health professionals to make sure people get all the care they need, while eliminating waste and inefficiency. Payments to ACOs reward efficiency rather than the volume of services they provide, if they can show improved quality.

NCQA's ACO accreditation program assesses how well an ACO is likely to provide high quality, efficient care. We specifically evaluate whether an ACO:

- Ensures access to and availability of care;
- Protects patient rights, including privacy;
- Has a solid foundation of patient-centered primary care;
- Has the necessary care management and coordination capabilities;
- Monitors practice patterns and uses performance data to improve quality;
- Uses decision supports to help patients and providers identify the best care; and
- Has necessary stakeholder participation, structure, contracting and payment arrangements.

Additional Approaches – Additional avenues for building on and strengthening PCMHs include:

- Incorporating patient-centered care and PCMH principles into physician, nurse and other training, as some schools are beginning to do.
- Exploring how to tailor Scope of Practice policies for non-physician professionals to help the workforce best prepare for these changes to the delivery system.
- Consider other types of oversight between the 3-year Recognition cycles to ensure that practices continue to meet expectations and identify and address gaps.
- Developing better data sharing among payers and providers and more consolidated reporting systems to facilitate care management and benchmarking for quality improvement purposes.
- Have PCMHs report performance measures to establish benchmarks to identify and address gaps and support more advanced payment models. There are important challenges to meeting this goal, however, particularly with small practices that may not have the financial and/or technical resources, or enough patients for statistically valid results.
- Have successful recognized PCMHs review and provide feedback to practices beginning the PCMH transformation.
- Getting more and better patient feedback on how they perceive PCMH practices and what they think needs to improve. Some practices are beginning to do this already by collecting patient experience surveys, establishing patient advisory councils or having some patients themselves serve as navigators to help others and get feedback from them.

Conclusion

PCMHs are making substantial improvements in the quality, cost and experience of care. We have the momentum to leverage these gains and expand patient-centered approaches throughout our health care system. The challenges are significant but surmountable, and dwarfed by the increasing evidence and broad consensus among stakeholders that this is the direction in which we must and all want to go. The progress, goals, challenges and potential solutions discussed in this paper should help clarify where we are and what we must still do. But there will surely be more challenges and potential solutions that we need to identify and address. We look forward to continuing to work with all stakeholders to further this amazing journey to transform health care by focusing on what patients themselves truly need and want.

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Appendix A

NCQA PCMH Recognition Pricing*

Number of Clinicians	Survey Tool License Fee	Standard Three-Year Application	Sponsored Three-year Application*	Total Standard Cost per Year / per Clinician	Total Sponsored Cost per Year / per Clinician
1	$80	$550	$440	$210	$173
2	$80	$1,100	$880	$393 / $197	$320 / $160
3	$80	$1,650	$1320	$576 / $192	$467 / $156
4	$80	$2,200	$1760	$760 / $190	$613 / $153
5	$80	$2,750	$2200	$943 / $189	$760 / $152
6	$80	$3,300	$2640	$1127 / $188	$907 / $151
7	$80	$3,850	$3080	$1310 / $187	$1050 / $150
8	$80	$4,400	$3520	$1493 / $187	$1200 / $150
9	$80	$4,950	$3960	$1677 / $186	$1347 / $150
10	$80	$5,500	$4400	$1860 / $186	$1493 / $149
11	$80	$6,050	$4840	$2043 / $186	$1640 / $149
12	$80	$6,600	$5280	$2227 / $186	$1787 / $149
<50	$80	$6,600 + $10/ # >50	$5280 + $8/ # >50	$2227 + $3.34/ # >50	$1787 + $2.67 $/ # >50

* As of February, 2014.