BCBSM
Physician Group Incentive Program

Patient-Centered Medical Home

Interpretive Guidelines

March 2026

The Patient-Centered Medical Home (PCMH) is a care delivery model in which patient treatment is coordinated through primary care physicians to ensure patients receive the necessary care when and where they need it, in a manner they can understand.

The goal of the PCMH model is to:

- Strengthen the role of the PCP in the delivery and coordination of health care through a team-based approach
- Support population health management, which uses a variety of individual, organizational and cultural interventions to help improve the illness and injury burden and the healthcare use of defined populations
- Ensure effective communication, coordination and integration among all PCP and specialist practices, including appropriate flow of patient care information, and clear definitions of roles and responsibilities
- Support the quintuple aim (reduce cost, improve appropriate utilization, quality, health outcomes, patient experience, and provider well-being)

The PCMH program was redesigned in 2026, with the goal of developing a set of primary care capabilities that are foundational to the PCMH designation program. All capabilities listed in the Interpretive Guidelines are required to be in place for a practice to earn PCMH Designation. Although the goal is to maintain a consistent PCMH program from year to year, BCBSM reserves the right to make changes to the capabilities as needed. POs will receive notification of any changes.

Physician Organizations are responsible for reporting PCMH capabilities to BCBSM. Capabilities can be reported online at any time, using the PACT Tool. If practices do not have all capabilities in place, they will be at risk of losing their PCMH designation during the next designation cycle. Practices are expected to have all required capabilities in place by the next full PCMH designation/nomination period.

It is not acceptable for a PO to request that practices simply self-report their capabilities. POs must be actively engaging and educating their practices about PCMH and must validate all capabilities before reporting them in place. Any capability reported to BCBSM as “in place” must be fully in place and in use by all appropriate members of the practice unit team on a routine and systematic basis.

Site visits are conducted yearly and are a vital component of BCBSM's PCMH program, and serve to:

- Educate POs and practice staff about the PCMH Interpretive Guidelines and BCBSM expectations.
- Enable the Blue Cross Field Team to gather questions and input to refine, clarify, and enhance the PCMH Interpretive Guidelines.
- Ensure that the PCMH database (PACT) is an accurate source of information to support PCMH Designation.

POs should inform practices that demonstration will be required for certain capabilities. For example, if the practice is asked to show how patient outreach attempts were tracked for communication of abnormal test results, the practice should have patient examples identified ahead of time and be prepared to discuss them during the site visit. Documentation will not be accepted after the site visit.

Health literacy should be considered across all relevant domains. All verbal and written communications with patients must be appropriate to the specific level of understanding and needs of the individual patient.

For any questions, please submit an issue through the PO Collaboration Portal or by emailing valuepartnerships@bcbsm.com.

PCMH Foundation (PCMH)

PCMH-101

Practice unit has developed PCMH-related patient communication tools. An established process is in place to discuss the patient-provider partnership with patients on a regular basis and document this discussion.

Guidelines:

a. Documents and patient education tools are developed that explain PCMH concepts and outline patient and provider roles and responsibilities.
b. Patient communication process must include a conversation between the patient and a member of the practice unit team who is knowledgeable about the key concepts of patient-centered care and the patient-provider partnership.
c. Process is in place to document the discussion of the patient-provider partnership.
d. Practice has an established process for repeating Patient-Provider Partnership discussion on a regular basis. For example, a discussion takes place every 1-3 years or during certain visit types (e.g., Annual Wellness Visits).

PCMH-102

Practice unit staff members receive regular training and have comprehensive knowledge of key concepts and processes related to patient-centered care. Practice maintains a log of training completion dates for all staff.

Guidelines:

a. All staff are trained on the Patient-Centered Medical Home model, the Chronic Care model, and practice transformation concepts.
b. All staff are trained on available community resources and the process to identify and refer patients to community resources.
c. Appropriate staff are trained on a full range of comprehensive preventive services, including evidence-based care guidelines. Staff receive updated training when guidelines change.
d. Appropriate staff are trained on the test tracking process.
e. Appropriate staff are trained on the specialist referral process.
f. All trainings are completed at time of hire and annually thereafter.
g. Practice keeps staff records or logs of all training completion dates.

PCMH-103

Practice unit and/or PO maintains written policy and/or procedure documents for all standardized processes included in the Patient-Centered Medical Home program.

Guidelines:

a. Procedure documents must be in writing and identify all steps in the standard operating process, including timeframes as applicable.
b. Procedure documents include the purpose of the procedure and description of staff roles and responsibilities.
c. Written policy documents are required for test tracking and specialist referrals.
d. Written process/procedure documents are required for the following:
    i. Patient-provider partnership agreement (PCMH-101)
    ii. PCMH training (PCMH-102)
    iii. Planned care visits (PCMH-104)
    iv. Conducting outreach to patients for gaps in care (PHM-111)
    v. Medication reconciliation (PHM-112)
    vi. Providing comprehensive preventive care (PHM-114)
    vii. Community resources (PHM-115)
    viii. Monitoring utilization data (AC-122)
    ix. Scheduling for same-day appointments (AC-125)
    x. Transitions of care (CC-134)
e. All policy/process/procedure documents must be reviewed, revised, or updated at least annually.

PCMH-104

A standardized process is in place to deliver planned care visits to patients for preventive care and all chronic conditions relevant to practice's patient population.

Guidelines:

a. Appointment tracking and generation of reminders is in place for all patients.
b. Preparation is completed in advance of the visit to ensure practice has necessary information about patient's health, test results, care gaps, specialist consultation notes, and any other information needed.
c. Evidence-based care guidelines for preventive and condition-specific care are in use by all team members (e.g., gaps in care outreach, point of care alerts, appointment type and length, screening frequency, etc.).
d. Practice staff ensures follow-up is completed for all patients who have cancelled or missed their appointments, and those who need additional services.
e. Written documentation outlines the roles and responsibilities of all team members for planned visits.

Population Health Management (PHM)

PHM-111

A population health management tool is being used proactively and at point of care.

Guidelines:

a. A population health management tool is a database that enables population-level management, which allows providers to view patterns of care and gaps in care across their patient population.
b. Data must be in the form of fields that are accessible for tabulation and population management.
c. Tool incorporates relevant clinical information and utilizes evidence-based care guidelines to flag gaps in care for all chronic conditions relevant to the patient population and a range of preventive services.
d. Tool incorporates patient clinical information from practice's medical records, as well as health care services received at other sites that are necessary to manage the population.
e. Information is available and in use by the practice unit team at the point of care.
f. Tool is used to identify patients in need of services, and practice staff conducts regular outreach to proactively manage the patient population for both chronic conditions and a range of preventive services.

PHM-112

A standard process is in place for clinical staff to complete a full review of patient medication lists during every appointment, updating the patient record as indicated.

Guidelines:

a. During every patient encounter, a list of all medications currently taken by the patient is reviewed and updated, and any concerns regarding medication interactions or side effects are addressed. Adjustments are made during every encounter to ensure the list is current and matches current clinical needs, and any medication discrepancies or contraindications are resolved by a clinician.
b. Medication reconciliation may be done by prescribing practitioner, clinical pharmacist, advanced practice provider, or registered nurse. It may also be performed by other medical professionals (e.g., MA, LPN) if signed off by an acceptable practitioner identified above.

PHM-113

Practice unit has access to interpreter(s) in the languages commonly spoken by their patient population.

Guidelines:

a. Practice unit has access to interpreter(s) for all languages common to practice's established patients.
   i. Language services may consist of third-party interpretation services or multilingual clinical staff.
   ii. BCBSM does not provide specific guidance on which interpreter service to use. We encourage you to work with your organization's internal compliance and legal departments to determine the appropriate interpreter service to use in your practices.
   iii. Asking a friend or family member to interpret does not meet the intent.

PHM-114

Practice has a standard process to provide comprehensive preventive care for all patients.

Guidelines:

a. Practice utilizes evidence-based care guidelines from the United States Preventive Services Task Force (USPSTF) or other accredited organization to provide comprehensive preventive care to all patients.
   i. Clinical staff identifies and educates patients about personal health behaviors to reduce their risk of disease and injury.
   ii. Guideline-based screenings are conducted at appropriate intervals for early detection of diseases that lead to interventions for asymptomatic persons with risk factors.
   iii. Preventive assessments must include additional guideline-based screenings for tobacco use, depression, and lung cancer.
b. Practice unit or PO has a standardized process to modify existing point of care alerts based on identified risk (e.g., accelerated colonoscopy schedule for patients with polyps or family history).
c. A standardized process is in place for following up on any positive assessment results.
d. Practice unit or PO generates guideline-based reminders for appropriate risk assessment and screening tests.

PHM-115

Practice has a standard process to educate patients on the availability of community resources and to provide referrals for patients who indicate a need.

Guidelines:

a. Practice unit or PO utilizes a community resource repository, which includes a comprehensive list of geographically relevant community resources. The list is reviewed regularly and updated as needed.
b. Practice has a standard process to educate patients on community resource availability and assess community resource needs during new patient visits and annually for all patients. All practice staff are empowered to alert appropriate practice unit staff to possible psychosocial and other needs.
c. A standard referral process is in place for patients who indicate a need and are interested in receiving a community resource referral.
d. Community resource assessment and referral must be documented in the medical record.

Access to Care (AC)

AC-121

Patients have 24-hour access to a clinical decision-maker by phone, and the clinical decision-maker follows up in a timely manner and accesses and updates the patient's medical record with the instructions to the patient.

Guidelines:

a. Patients have 24-hour access to a clinical decision-maker by phone, and clinical decision-maker has a feedback loop within 24 hours or next business day to the patient's PCP.
    i. Clinical decision-makers communicate all clinically relevant information to patient’s PCP via phone conversation, email, automated notification in an EHR system, or by faxing regarding the interaction within 24 hours (or next business day) of the interaction.
b. For after-hour calls, clinical decision-makers direct the patient to an appropriate level of care in a timely manner.
c. The clinical decision-maker may not always need to access the patient's medical records during the call. Patient’s medical record is updated within 24 hours or by the next business day.

AC-122

Practice has a standardized process to monitor urgent care and emergency department utilization, in an effort to reduce inappropriate utilization.

Guidelines:

a. Practice unit and/or PO has a standard process to monitor urgent care and emergency department utilization.
b. Practice unit and/or PO conducts regular follow-up for primary care sensitive services received outside of the practice unit.

AC-123

Patients are educated on how to contact the practice/PCP to direct after-hours care to the appropriate level of service, in an effort to reduce inappropriate utilization of emergency department and urgent care.

Guidelines:

a. After-hours are defined as outside of regular practice business hours.
b. Patients are educated on how to contact the practice/PCP to receive directions on appropriate care for after-hours conditions.
c. “Call us first” campaigns, patient education materials on conditions appropriate for urgent care, emergency department care, or primary care may support the intent of the capability.
d. Patients who routinely have primary care sensitive encounters in the emergency department or urgent care setting are provided additional education.

AC-124

PO and/or practice has arranged for patients to have access to a non-ED after-hours provider for urgent care needs in the practice or at another location.

Guidelines:

a. After-hours are defined as outside of regular practice business hours.
    i. Services provided by the after-hours provider must be billable as an office visit or urgent care visit, not as an ER visit.
b. Patients are educated on how to contact the practice/PCP after hours and should be made aware of the location of urgent care centers, when applicable.
c. When notified of a non-ED after-hour encounter, practice has a standardized process to obtain clinically relevant information required to follow up with the patient.
d. In unusual, extenuating circumstances (such as a single provider practice in a rural or urban underserved area), practice units may meet the requirements by having a routine, standard procedure that practice unit clinicians remain after hours as necessary to see the majority of patients requesting routine or acute care.

AC-125

Same-day appointments are available to patients for acute and/or routine care.

Guidelines:

a. Same-day appointments are available throughout the business day, and patients are accommodated as appropriate.
b. Patients are seen on a timely basis in an effort not to extend wait times.
c. Patients are educated on the same day availability.
d. Same day availability may be used for patients being discharged from a facility who need a follow-up appointment.

Coordination of Care (CC)

CC-131

A standardized tracking process is in place to ensure that needed tests are completed; results are received, and patients are notified of results in a timely manner.

Guidelines:

a. Practice has a standardized approach with identified timeframes for ensuring patients receive needed tests and practice obtains results.
b. Timeframes are identified for patient notification of normal, abnormal, and critical results.
c. Patients are informed about how to access test results (e.g., phone, mail, email, portal).
    i. "No news is good news" does not meet the intent of the capability.
d. Patients requiring follow-up are flagged, and follow-up timeframes are specified.
e. Cancellation and no-show follow-up are tracked and assessed for continued necessity of test.
f. Results and follow-up action are documented in the patient's medical record.

CC-132

Process is in place for referrals to specialists for clinical evaluation deemed necessary by the PCP. PCP reviews consult test results and consultation notes when provided by the specialist. Patients are notified if follow up is required by the PCP.

Guidelines:

a. Practice identifies timeframes for suggested referral as routine or urgent.
b. Practice provides patients with information about the referral (specialist name, reason for referral, routine or urgent, if the patient is required to make the appointment).
c. Process is in place to assess if urgent referrals are completed.
d. PCP reviews consult notes and test results for PCP required follow up.
e. PCP follow up action(s) are documented in the patient's medical record.

CC-133

A process is in place to identify patients who are in crisis and refer them to appropriate resources. Practice ensures follow-up occurs on a timely basis.

Guidelines:

a. Practice has a process to identify resource needs for patients who are at high risk of decompensation for whom a referral to a resource is critical to successfully engage with the established plan of care.
b. Process includes mechanism to track patients who decline care and obtain information about reasons why assistance was not sought.
c. Timeframes are specified for patients requiring follow-up.
d. The purpose of tracking the referrals is to ensure patients receive the care they need and practice staff support the process.

CC-134

Patient transitions are well-managed, and patient care is coordinated across health care settings, through a process of active communication and collaboration among providers, patients, and caregivers.

Guidelines:

a. Standardized process is in place for notification of Admit, Discharge and Transfer (ADT) encounters for the practice patient population.
b. Following hospital discharge, a tracking process is in place to follow up with patients appropriate for a transition of care phone call or face to face visit within 24-48 hours. Practice defines which patients are appropriate for follow-up.
c. Documentation in patient medical record of post discharge follow up includes date of discharge, date of notification of discharge and date of post discharge patient contact.
d. Practice units are responsible for ensuring other providers have relevant medical information in a timely manner necessary to make care decisions.
e. Process is in place to coordinate care with payer case managers for patients with complex/catastrophic conditions.

Process Improvement (PI)

PI-141

Performance reports are generated, enabling POs and providers to monitor their population level performance over time, close gaps in care, and improve patient outcomes for chronic conditions and preventive services.

Guidelines:

a. Performance reports are standardized, routine, aggregate-level reports that provide current, clinically meaningful health care information on the active population of patients; this includes patients of all ages and patients with preventive only measures.
b. Performance reports are produced and distributed by the PO or practice unit. Reports are systematically reviewed and validated to ensure accuracy of data and for identification of opportunities for improvement or education. Practice maintains a repository of performance reports.
c. Performance reports include measures that adhere to generally accepted guidelines and contain relevant clinical information for both chronic conditions and a range of preventive services.

PI-142

Practice monitors patient experience data and identifies opportunities for improvement related to office efficiency and quality of care.

Guidelines:

a. Patient satisfaction and office efficiency measures are monitored on an ongoing basis.
b. Patient experience data may be obtained from surveys managed by the practice or the PO.
c. Patient experience data should include measures that evaluate practitioner support for patients in achieving health management goals as well as office efficiency measures.
    i. Reference information at Agency for Healthcare Research and Quality about CAHPS: http://www.ahrq.gov/cahps/index.html.
d. If the practice identifies areas of opportunity for improvement, follow-up occurs (e.g., process improvements are implemented; efficiencies are improved; practice culture is addressed).

Patient Centered Care (PCC)

PCC-151

Practice has a process to identify patients who would benefit from ongoing support based on clinical conditions, non-medical drivers of health or patient readiness to improve health outcomes.

Guidelines:

a. Practice has a process to identify patients who are candidates for additional ongoing support, enabling them to adhere to the plan of care.
b. Common identifiers may be:
    i. New chronic condition diagnosis requiring lifestyle changes or new medications
    ii. Patients with non-medical drivers of health needs (e.g., financial difficulties, lack of social support, housing, food insecurity, etc.)
    iii. Patients expressing readiness for behavior modification or lifestyle changes (e.g., weight loss, smoking cessation, dietary changes, etc.)
    iv. High ED or urgent care utilization for PCS issues
c. Practice has a process to provide this additional support for identified patients.

PCC-152

For patients who need additional support, written action or treatment plans are developed and incorporated into the medical record with patient specific goals.

Guidelines:

a. Physicians and other clinical team members are actively using goal setting techniques to develop patient action plans or treatment plans for patients who need additional support.
    i. Goal setting should focus on patient specific changes in behavior or concrete tangible results.
b. Patient action plan or treatment plan must be documented in the patient's medical record, enabling providers to monitor follow-up with patients during subsequent visits.
c. Self-Management support is provided to assist patients in implementing their action plan through mutually agreed upon communication method (e.g., face to face, portal, virtual or phone). Support can be provided as part of established visits or as a separate follow-up.
d. The patient is provided with a document that includes the agreed upon goals in language that is clear and easy for the patient to understand.