# Magnolia Health PCMH
# Patient Centered Medical Home

8/11/2025

# 2024 HRSA Overview of the State

Mississippi is still ranked last among all states for overall health system according to the Commonwealth Fund.

- Mississippi ranks 49th for access and affordability
- 48th for prevention and treatment
- 43rd for avoidable hospital use and costs
- 30th for income disparity
- 50th for healthy lives

# What is a Patient Centered Medical Home?


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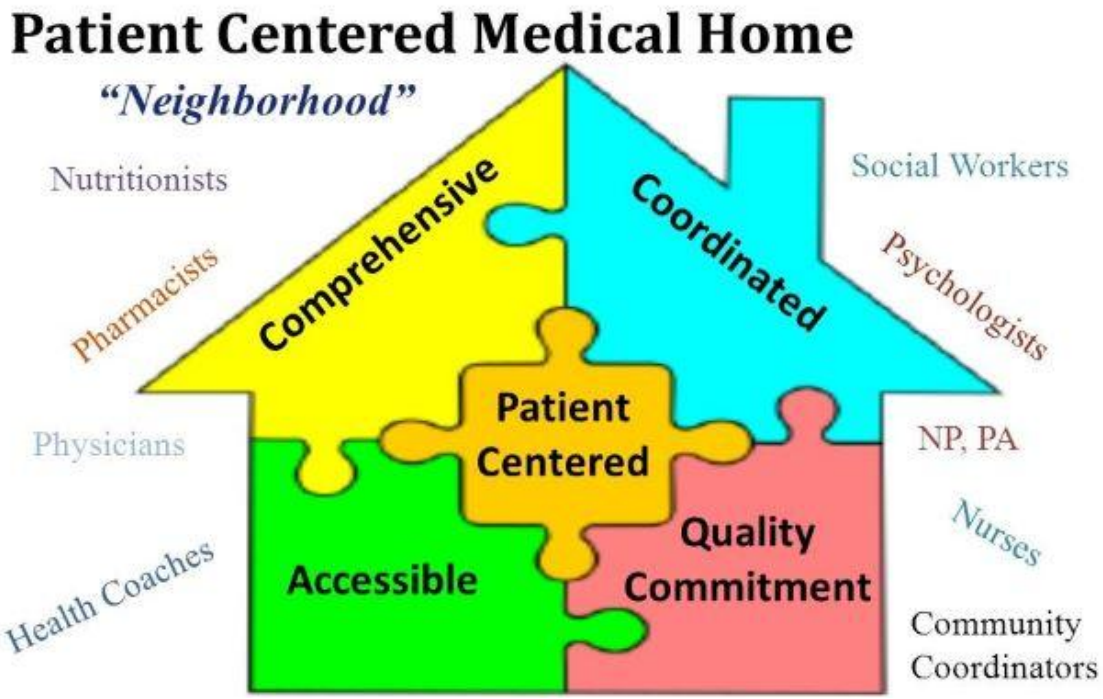
# The PCMH Transforms Primary Care

- Coordinating care across all community and medical services
- Improving the patient experience
- Establishing relationships with patients' and families
- Providing comprehensive care through a coordinated team
- Focusing on patients' mental and physical health



# What are the benefits of PCMH recognition?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# Magnolia Health Partner In Quality Incentives

## FINANCIAL INCENTIVES

- First year financial incentive based on PCMH transformation
- Each year after, incentives are tied to the provider's Medicaid quality scores

Paid in alignment with the fiscal calendar year

## NCQA PARTNER IN QUALITY INCENTIVES

- 20% discount on NCQA PCMH application for Magnolia Health Partner in Quality providers
- There is no NCQA cost for HRSA funded providers.
- Special designation in the Magnolia Health Provider Directory

## REPORTING

- Quarterly practice specific reports
- Assistance with data interpretation
- PCMH consultant services at no cost to the provider

## MEMBER ASSIGNMENT

- Preferential assignment in the auto assignment process, if desired

# Other Benefits of PCMH Recognition

- Improved relationships between patients and their clinical care teams
- Improved quality outcomes
- Improved the patient experience
- Increased staff satisfaction
- Reduced health care costs
- Potential increased revenue and success in value-based care models

# Magnolia Health Dedicated PCMH Support

Designated CCE provides consultation throughout the entire transformation process

- Assists with NCQA PCMH application and set up for QPASS
- Schedules regular Health Plan provider meetings to review and collect all documented concepts and required information
- Reviews documentation prior to submitting to NCQA through QPASS
- Coordinates 3 check ins with NCQA over the 12-month transformation  period
- Manages annual PCMH provider reporting
- Manages reporting provider demographic changes


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# PCMH Readiness


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# Practice Eligibility Requirements

- Outpatient Primary Care Practices
- Solo or Group Practice, including nurse-led practices
- 75% of patients come for primary care
- All eligible clinicians should apply together
- Recognition is received at the geographic site level

# Clinician Eligibility Requirements

- Current, unrestricted license as a DO, MD, APRN or PA
- Clinicians who are eligible to be selected by a patient as a PCP
- Internal Medicine, Family Medicine, Pediatrics

***Nonprimary care specialty clinicians who do not have a panel of patients are not included.***

# Practice Readiness

- Electronic Health Record for all patient documentation
- Staff is skilled to use a computer system
- Clinicians in a practice must practice the same procedures and protocols
- Clinicians and staff, as appropriate, have access and share electronic medical records for all patients treated at the site.

*Magnolia's Certified Content expert will meet with provider to determine readiness.*

# PCMH Transformation Process


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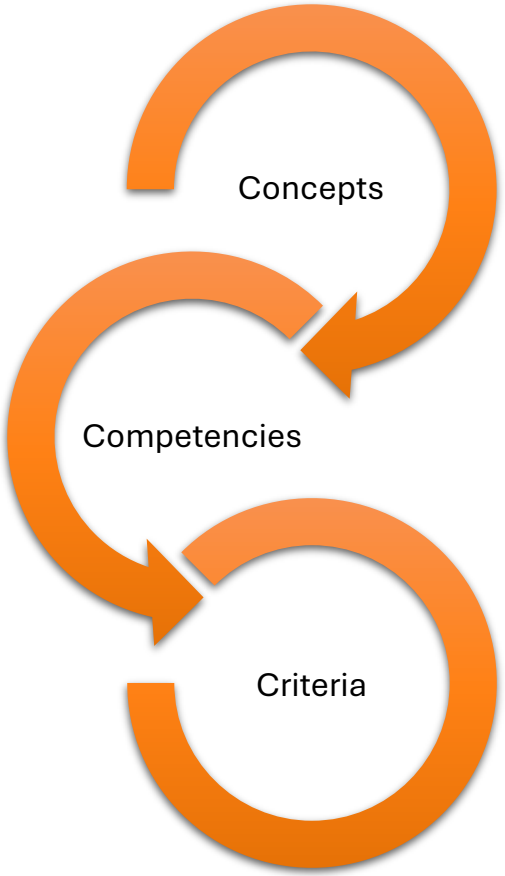
# PCMH Enrollment

- CCE assists practice in enrolling in Q-PASS
- Agreements and payment are submitted through Q-PASS with CCE assistance
- NCQA assigns an NCQA Representative (liaison) for that practice
- Magnolia's CCE schedules an introductory call with the provider
- CCE and provider create a transformation plan, review the process, navigate resources
- CCE coordinates schedules for 3 NCQA check ins and regular Health Plan meetings

# PCMH Recognition: 4 Step Process

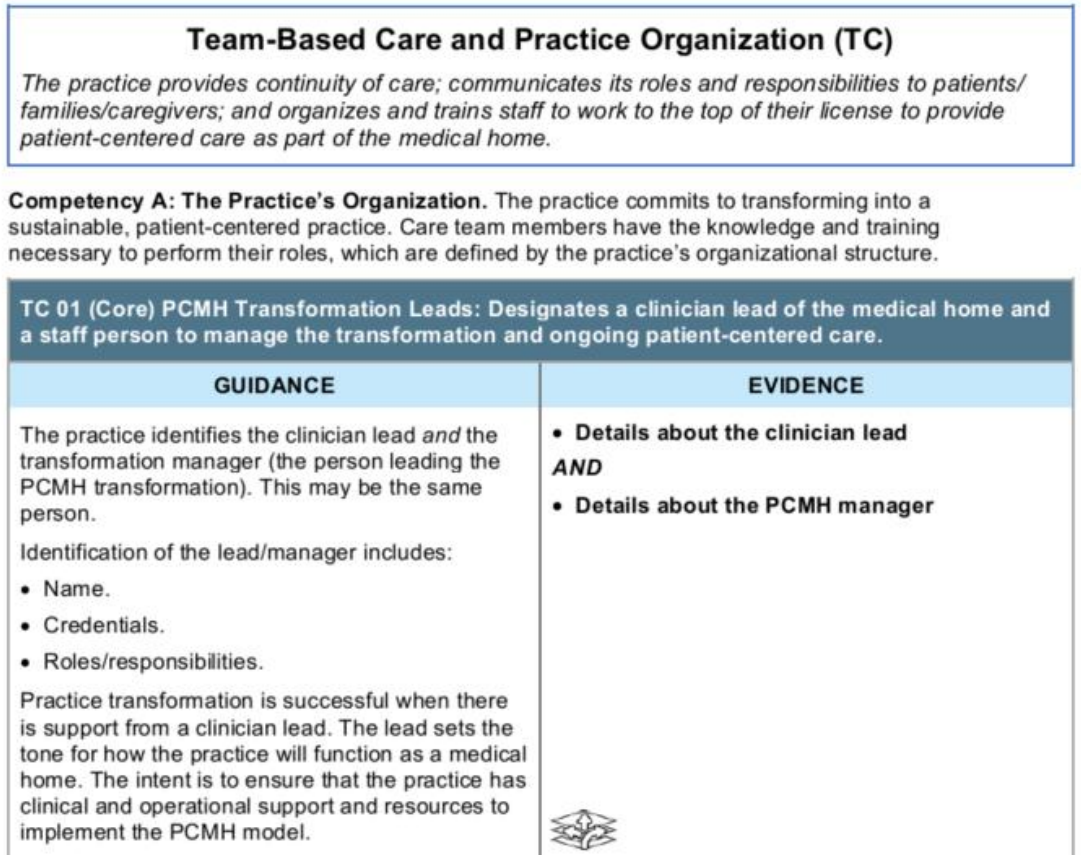
| | |
|---|---|
| 1. Learning and understanding | Learn the PCMH concepts and required criteria |
| 2. Practice Transformation | Demonstrate evidence |
| 3. Evaluation and Recognition | Through NCQA online check ins and virtual access |
| 4. Ongoing maintenance and improvement | Annual reporting to maintain PCMH recognition status |

# The PCMH Transformation Format




- Concepts are the foundation
- Competencies organize the criteria in each concept
- Criteria are the activities within each competency

# PCMH Standards and Guidelines



**Team-Based Care and Practice Organization (TC)**

*The practice provides continuity of care; communicates its roles and responsibilities to patients/families/caregivers; and organizes and trains staff to work to the top of their license to provide patient-centered care as part of the medical home.*

**Competency A: The Practice's Organization.** The practice commits to transforming into a sustainable, patient-centered practice. Care team members have the knowledge and training necessary to perform their roles, which are defined by the practice's organizational structure.

**TC 01 (Core) PCMH Transformation Leads: Designates a clinician lead of the medical home and a staff person to manage the transformation and ongoing patient-centered care.**

| GUIDANCE | EVIDENCE |
|---|---|
| The practice identifies the clinician lead *and* the transformation manager (the person leading the PCMH transformation). This may be the same person.<br>Identification of the lead/manager includes:<br>• Name.<br>• Credentials.<br>• Roles/responsibilities.<br>Practice transformation is successful when there is support from a clinician lead. The lead sets the tone for how the practice will function as a medical home. The intent is to ensure that the practice has clinical and operational support and resources to implement the PCMH model. | • **Details about the clinician lead**<br>***AND***<br>• **Details about the PCMH manager** |

Team-Based Care and Practice Organization (TC)

- **Concept**: Criteria description using a two-letter abbreviation (TC)
- **Competency:** Description of criteria subgroup
- **Criteria:** Brief statement highlighting PCMH requirements
- **Guidance:** Information about the expectation of each criterion
- **Evidence:** Describes the evidence that must be submitted

# 6 Concepts of PCMH Care

1. Team Based Care and Practice Organization (TC)
2. Knowing and Managing Your Patients (KM)
3. Patient Centered Access and Continuity (AC)
4. Care Management and Support (CM)
5. Coordination and Care Transitions (CC)
6. Performance Measurement and Quality Improvement (QM)

# Evidence Reporting / Check Ins

Gather, prepare and load evidence  into Q-PASS

Screen sharing technology allows for virtual evidence

3 NCQA check ins scheduled over a12-month period

# Review Oversight Committee (ROC)

- The ROC Reviews findings and makes final decisions

| | |
|---|---|
| Core Criteria | Practices must meet all **39** core criteria |
| Elective Criteria | Practices must Earn **25** credits in elective criteria across 5 of 6 concepts |
| Transfer Credits | Practices can earn automatic transfer credit for some PCMH NCQA criteria. |

# CONGRATULATIONS ON PCMH RECOGNITION!

Practices will receive an email from NCQA with results within 30 days

Practices will receive an NCQA Certificate of Recognition

Practices will receive special PCMH designation in the provider directory

Remember, the annual reporting date is 1 month prior to the anniversary date

# QUESTIONS?

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