NYC REACH

Regional Electronic Adoption Center for Health

New York State Patient-Centered Medical Home

The Patient-Centered Medical Home (PCMH) model helps primary care practices to provide patient-centered care, improve quality outcomes, and prepare for value-based payment arrangements. New York State has partnered with the National Committee on Quality Assurance (NCQA) to create NYS PCMH, a PCMH program designed specifically for NYS primary care practices. NYS PCMH is based on NCQA PCMH 2017 standards.

JOIN TODAY!

NYC REACH provides free technical assistance with participation. Spots are limited; enrollment ends November 30, 2019. To get started, e-mail Matt Gannon at: mgannon@health.nyc.gov

PROGRAM BENEFITS

Eligibility for Enhanced Payments

Practices that achieve NYS PCMH recognition receive a per-member per-month (PMPM) care management payment for all services provided to Medicaid patients. Practices that are PCMH 2014-recognized can advance to NYS PCMH at any time.

Alignment with Other Incentive Programs

Practices will integrate performance goals for other programs such as HRSA UDS reporting, Meaningful Use (MU), DSRIP, ACO, RHIO/QE implementation and incentive programs, and more.

Free Technical Assistance

NYC REACH offers **free** remote and on-site support to practices that participate in NYS PCMH. Support includes educational materials, trainings, webinars, and learning collaboratives, as well as assistance with MU, QPP/MIPS, and QE incentive programs.

PROGRAM GOALS

- Promote evidence-based guidelines and use of Health Information Technology
- Address gaps in behavioral health treatment
- Improve care coordination and communication
- Increase participation in value-based payment arrangements