Advanced Primary Care (APC) — 2027 APC Program

Public Comment Questionnaire — Split by Subheading

The template below lists each public comment question included in the Advanced Primary Care Accreditation (New Program) and reflects the corresponding responses submitted through National Committee for Quality Assurance's (NCQA's) web-based public comment form.

Background Questions

Background Questions

#	Topic / Element	Question / Prompt	Response
1	Background Questions	Which of the following best describes your organization? Physician-owned medical group Hospital or health system-affiliated medical group Accountable care organization Health plan Vendor Employer or purchaser Patient advocacy or community organization State or federal agency Other (fill in the blank)	Other: State purchasers (Covered California, the California Department of Health Care Services (DHCS), and the California Public Employees' Retirement System (CalPERS))
2	Background Questions	Is your organization currently Patient-Centered Medical Home (PCMH) Recognized?	No.
3	Background Questions	Approximately how many patients, members or individuals does your organization serve each year?	Covered California – 1.7 million DHCS – 15 million CalPERS – 1.5 million

Global Questions

Global Questions

#	Topic / Element	Question / Prompt	Response
4	Global Questions	How valuable would Advanced Primary Care Accreditation be to your organization? Please explain the factors that contribute to your scoring. Very valuable Valuable Neither valuable or not valuable Not valuable Very not valuable	Valuable - We see substantial value in establishing a clearer national framework for high-performing primary care, particularly as value-based payment continues to expand. The score is not "Very Valuable" because some elements may still create implementation burden, challenges with peer comparison, and challenges with technical interoperability readiness.
5	Global Questions	Do you support the order and organization of the program's standards? Support Support with Modifications Do Not Support	Support. The overall structure follows a more intuitive progression from oversight and population identification through care delivery, patient experience, behavioral health, quality, and data exchange.
6	Global Questions	Does the program include activities that don't add value or are out of scope for primary care organizations?	Yes, though a few areas may still be burdensome or insufficiently calibrated to current operational realities, peer-comparison expectations, and some technical interoperability requirements.
7	Global Questions	How should Artificial Intelligence (AI) be reflected, if at all, in program standards, given where primary care organizations are today? Yes No	AI should be reflected pragmatically and cautiously. The updated standards appropriately recognize AI as one possible modality for interactive communication, but we would not recommend AI-specific requirements beyond clear expectations for human oversight, appropriateness, and accountability.
8	Global Questions	What AI activities should standards address?	Appropriate areas include ambient documentation/scribing, patient communication support, workflow triage, population health analytics/business intelligence, and Fast Healthcare Interoperability Resources (FHIR) mapping/readiness. Standards should focus on transparency, validation, human oversight, and fit-for-purpose use rather than mandating AI adoption.

#	Topic / Element	Question / Prompt	Response
9	Global Questions	What observable value does AI deliver in primary care?	The most observable near-term value is reduced documentation burden, operational efficiency, and improved ability to translate data into actionable workflows. Potential value also includes faster data mapping and stronger dashboarding/business intelligence, but the standards should not overstate current maturity in the field. Future iterative updates to the APC standards might address AI in narrower ways once there is more maturity and broad acceptance for specific AI use cases relevant to APC standards.
10	Global Questions	Does your organization leverage AI for Fast FHIR® mapping/readiness? Yes No	Not applicable. Our organizations are closely tracking emerging uses of AI for interoperability and mapping, but we would caution NCQA against assuming widespread current adoption across primary care organizations.
11	Global Questions	Based on your organization's experience, what other problems could a quality measurement program for advanced primary care organizations help address?	A strong quality measurement program for advanced primary care could help address fragmented expectations across payers/programs, weak alignment between payment and delivery expectations, measure proliferation and measure fatigue, and insufficient focus on outcomes-oriented primary care performance.
12	Global Questions	Are there specific areas of the standards where submitting the required data sources may be challenging? Yes No	Yes. The most challenging areas are external exchange data, behavioral health information-sharing, attribution-dependent quality reporting, and FHIR-based quality reporting where practices depend on external data feeds, vendor capabilities, and plan alignment.
13	Global Questions	Will the proposed standards help your organization meet objectives? If so, how? If not, why not? Yes No	Yes, if implemented pragmatically. The standards can help define the operational capabilities expected of advanced primary care organizations across planning, coordination, access, behavioral health, quality, and data exchange.
14	Global Questions	Are key expectations not addressed in the proposed requirements?	Potential areas for further refinement include clearer flexibility around readmissions data sources, caution with peer comparison, and continued attention to implementation burden for advanced interoperability requirements.

Scoring

Scoring

#	Topic / Element	Question / Prompt	Response
15	Scoring	Do you support the scoring structure of each element (Met, Partially Met, Not Met)? Support Support with Modifications Do Not Support	Support.
16	Scoring	Do you support tiered Accreditation statuses? Support Support with Modifications Do Not Support	Support. Tiered accreditation statuses can be useful if they reflect meaningful differences in demonstrated capability rather than documentation volume alone. Tiered statuses also create incentives and pressure for practices to improve over time.
17	Scoring	Do you have concerns about scoring of specific standards or elements? Yes No	Yes. The main scoring concerns are less about the Met / Partially Met / Not Met structure itself and more about feasibility and comparability for a few elements, especially peer benchmarking and advanced technical requirements.
18	Scoring	Would you like to leave feedback on this topic for NCQA's consideration?	Overall, we support the direction of the program and appreciate the effort to define advanced primary care in operational terms. We encourage continued emphasis on feasibility, parsimony, and alignment with real-world implementation conditions.

Standards

PHM 1: PHM Program Oversight — Element A: PHM Governance Structure

#	Topic / Element	Question / Prompt	Response
19	Element A: PHM Governance Structure	Does this element apply to care delivery organizations? Yes No	Yes, some form of governance or oversight is appropriate. However, successful primary care transformation for value-based payment (VBP) requires organization governance that extends beyond Population Health Management (PHM) program oversight. Framing governance narrowly around PHM risks producing compliance-oriented documentation that does not reflect the breadth of strategic leadership necessary for advanced primary care organizations to succeed under VBP. NCQA may want to consider framing this as a "Value Strategy," not "PHM Program Oversight." This broader strategy could incorporate things like a value statement (a value-centered mission), value goals and strategies (which likely would be tied to specific items in the APC standards), business strategy and use cases (how does the practice plan to sustain this work?), and other similar items. We also encourage NCQA to explicitly allow small and independent practices to satisfy governance expectations by integrating PHM oversight within existing quality improvement or strategic planning structures, rather than requiring a standalone PHM committee.

PHM 1: PHM Program Oversight — Element B: Annual PHM Plan

#	Topic / Element	Question / Prompt	Response
20	Element B: Annual PHM Plan	Do you support inclusion of this element? Support Support with Modifications Do Not Support	Support with Modifications. We support the concept but recommend reframing it as a broader "Value Strategy" that may be embedded within a larger strategic planning process for the practice. Our experience is that many practices do not engage in any strategic planning of any kind. Additionally, we advise that the length of the annual plan should be changed to 2-3 years (regardless of whether it is reframed as a "Value Strategy"). All work related to value and PHM has a very

#	Topic / Element	Question / Prompt	Response
			long-time horizon and long arc. Changes often take years to implement and move the needle. Nonetheless, there should be goals that are tied to specific years within the 2-to-3-year period; that approach would allow the practice to evaluate if they are making iterative improvements each year toward their broader multi-year goals.
21	Element B: Annual PHM Plan	Does your organization currently have and maintain a population health management plan or strategy? Yes No	N/A.

PHM 1: PHM Program Oversight — Element C: Communication About PHM Programs

#	Topic / Element	Question / Prompt	Response
22	Element C: Communication About PHM Programs	Do you support inclusion of this element? Support Support with Modifications Do Not Support	Support with Modifications. Meaningful communication about PHM programs is foundational to patient engagement and program effectiveness. We encourage NCQA to ensure that Factor 2 sets a sufficiently high bar for meaningful, individualized communication, rather than allowing routine one-way notice or passive website availability to satisfy the requirement. Communications should be tailored, accessible, and available in languages and formats that reflect the diversity of the practice's patient population.

PHM 1: PHM Program Oversight — Element D: Annual PHM Evaluation

#	Topic / Element	Question / Prompt	Response
23	Element D: Annual PHM Evaluation	Do you support inclusion of this element? Support Support with Modifications Do Not Support	Support. We support the full evaluation cycle, including outreach and participation reporting and PHM committee review. We recommend that NCQA reinforce in scoring guidance that evaluation must drive action and improvement, not documentation alone. If NCQA moves to the annual plan in Element B becoming multi-year, this evaluation could still be annual and look at specific goals tied to each year.

#	Topic / Element	Question / Prompt	Response
24	Element D: Annual PHM Evaluation	Is this element feasible for care delivery organizations? Yes No	Generally, yes, with flexibility. We recommend NCQA allow organizations to integrate PHM governance and planning with existing quality or strategic planning processes rather than requiring duplicative structures, provide practical examples for small practices, and consider phased expectations for less-resourced organizations.

PHM 2: Population Identification — Element A: Population Assessment

#	Topic / Element	Question / Prompt	Response
25	Element A: Population Assessment	Do you support factors listed? Support Support with Modifications Do Not Support	Support with Modifications. We support the annual needs assessment requirement and its expectation that organizations assess clinical, behavioral, social, cultural, and linguistic needs using available data. We recommend NCQA consider explicitly referencing older adults, patients with disabilities, and prospectively attributed patients not yet seen in examples. We also encourage clearer guidance on adequate documentation when data availability is limited, use of plan-provided or external data, and Social Determinants of Health collection that remains compliant with state and federal privacy requirements.

PHM 2: Population Identification — Element B: Targeting, Segmentation and Bias Evaluation

#	Topic / Element	Question / Prompt	Response
26	Element B: Targeting, Segmentation and Bias Evaluation	Do you support inclusion of this element? Support Support with Modifications Do Not Support	Support. We support all three factors, and particularly support Factor 3, which requires organizations to review whether their segmentation approach is appropriately matching patients to intended interventions, an important accountability mechanism that helps ensure population health resources reach the patients who most benefit. We recommend NCQA reinforce that stratification relying exclusively on utilization or cost data does not satisfy the element's intent, as this is a critical guardrail against perpetuating health inequities. Additionally, we recommend adding mention of “assigned but not seen” as a potential criterion for consideration by practices.

#	Topic / Element	Question / Prompt	Response
27	Element B: Targeting, Segmentation and Bias Evaluation	Is this element feasible for your organization? Yes No	Yes. As public purchasers, our perspective on feasibility centers on whether these standards can be meaningfully implemented across the networks serving our enrollees. Feasibility will vary by practice size and data infrastructure, and meaningful population needs assessments cannot be conducted without access to claims, lab, and pharmacy data that is typically held by health information exchanges (HIEs), health plans, and state agencies. NCQA should reinforce that health plans and purchasers have an essential enabling role in making PHM 2 feasible, and that data sharing with contracted primary care practices is a shared system responsibility.

PHM 3: Complex Care Management — Element A: Access to Care Management

#	Topic / Element	Question / Prompt	Response
28	Element A: Access to Care Management	Is this element feasible for care delivery organizations? Yes No	Generally, yes. The three referral pathways outlined in this element (medical management program, discharge planner, and clinician) represent clinically meaningful and operationally feasible access points across the networks serving our enrollees. We recommend NCQA clarify that practices are expected to demonstrate both clinical and socioeconomic referral pathways, as connecting patients to community resources and social supports is essential to whole-person care management and cannot be separated from clinical referral functions. We also noticed that “patient or caregiver referral” was dropped from prior versions of the standards. We believe this type of referral does have value, and we are unclear why this was dropped.
29	Element A: Access to Care Management	How does your organization define “care management”? What activities are included?	Care management should include risk identification, comprehensive assessment, care planning, medication reconciliation, transitions of care and referral coordination, barrier assessment, follow-up, and connection to community resources. The exact model may vary by organization, but the purpose is to help patients with complex needs access and coordinate appropriate services.

#	Topic / Element	Question / Prompt	Response
30	Element A: Access to Care Management	Is care management a responsibility of primary care? Why or why not? Yes No	Yes, in part, and shared. Primary care has a central role in care coordination, whole-person assessment, proactive outreach, and facilitating connections to specialty, behavioral health, and community services for attributed patients. However, hospitals, health plans, and community organizations share this responsibility, particularly for highly complex patients. NCQA should clearly reflect the cross-sector nature of care management accountability and avoid implying that primary care alone is responsible for outcomes dependent on health plan data, specialist responsiveness, or community resource availability. Additionally, patients sometimes end up with multiple care managers across different systems. These care managers often perform duplicative assessments and services; the standards should specifically include how to minimize duplication.

PHM 3: Complex Care Management — Element B: Care Management Process

#	Topic / Element	Question / Prompt	Response
31	Element B: Care Management Process	Is this element feasible for care delivery organizations? Yes No	Yes. The four-factor structure appropriately focuses on the core, high-value functions of care management and is well-suited to the range of primary care organizations expected to implement this element. We recommend NCQA ensure the explanations for each factor are specific enough to guide consistent implementation and confirm whether this element may be fully delegated to an external care management vendor, which is an important clarification for practices that contract those services. At the same time, we appreciate that this Element is much simpler than earlier draft versions; the simplification will ensure this Element is more feasible and less overwhelming to practices.
32	Element B: Care Management Process	If applicable, what does your organization's care management process include? Does the process align with the factors in this element?	N/A.

PHM 4: Self-Management Tools — Element A: Topics of Tools

#	Topic / Element	Question / Prompt	Response
33	Element A: Topics of Tools	Do you support inclusion of this element? Support Support with Modifications Do Not Support	Support. Evidence-based self-management tools are an appropriate component of advanced primary care. We recommend NCQA expand optional topic examples to include substance use and clarify that print-based tools, health coaching, and in-person methods fully satisfy the requirement for populations with limited digital access. Tools should reflect the cultural and linguistic diversity of the practice population.

CTC 1: Team-Based Care Strategy — Element A: CTC Strategy

#	Topic / Element	Question / Prompt	Response
34	Element A: CTC Strategy	Does this element add value to the program? Why or why not? Yes No	Yes. Team-based care strategy is core to advanced primary care. We recommend NCQA consider alignment with existing requirements in other programs and accreditations to reduce duplication and documentation burden.

CTC 2: Care Coordination — Element A: Referral Management

#	Topic / Element	Question / Prompt	Response
35	Element A: Referral Management	Are the referral expectations in this element feasible for primary care organizations? Why or why not? Yes No	Yes, but practices may need flexibility in how they operationalize referral closure. We recommend NCQA include alternative support for clinical decision-making such as asynchronous e-consults where accessible and clinically appropriate given its robust evidence base in multiple peer reviewed studies.

CTC 2: Care Coordination — Element B: Transitions of Care

#	Topic / Element	Question / Prompt	Response
36	Element B: Transitions of Care	Do you support inclusion of this element? Support Support with Modifications	Support with Modifications. Care transitions are an important part of accountable primary care and should remain in the program. We recommend NCQA designate Factor 1 (identifies discharged

#	Topic / Element	Question / Prompt	Response
		Do Not Support	patients) as a required factor in scoring because without a systematic process for identifying who has been discharged, Factors 2 and 3 cannot be reliably executed. Additionally, Factor 1 would benefit from highlighting best practices for identifying patients (Admission, Discharge, and Transfer (ADT) notifications feeds or an equivalent electronic health record (EHR) function [Care Everywhere] that actively notifies the practice of admissions, discharges, and transfers).

CTC 2: Care Coordination — Element C: Reporting on Readmissions

#	Topic / Element	Question / Prompt	Response
37	Element C: Reporting on Readmissions	Do you support inclusion of this element? Support Support with Modifications Do Not Support	Support. We strongly recommend retaining the readmissions-related element, with the understanding that the data necessary to calculate these rates may not be readily available to practices without external sources. NCQA should specify how practices are expected to collect discharge and readmission data. Without clear guidance on acceptable data sources (e.g., ADT feeds, Care Everywhere, health plan-reported data), practices risk undercounting readmission rates by relying on ad hoc discharge identification rather than a systematic approach. We recommend NCQA explicitly address acceptable data collection methods either within this element or in a dedicated data section. Additionally, we recommend NCQA allow alternative calculation methodologies beyond the two prescribed formulas, such as the Agency for Healthcare Research and Quality (AHRQ) Re-Engineered Discharge (RED) Toolkit 30-day risk-standardized readmission rate (RSRR) methodology or Managed Care Organization (MCO)-produced actuarial readmission rates. Lastly, we recommend NCQA define both "attribution" and "high-risk" as used in Factor 2 and endorse only a defined set of acceptable attribution models and discharge workflows. Attribution models vary widely across systems (from Primary Care Practitioner (PCP) assignment to retrospective utilization-based attribution as used in many Medicare models), and without a clear definition,

#	Topic / Element	Question / Prompt	Response
			practices will apply inconsistent approaches. Similarly, "high-risk" should be explicitly defined.
38	Element C: Reporting on Readmissions	What readmission type (all-cause, potentially preventable, clinically related, other) may be feasible for primary care organizations? All-Cause Potentially Preventable Condition/Procedure-Specific or Clinically Related Other	The all-cause approach is the most feasible for primary care as it avoids the burden of reviewing each readmission individually to determine whether it was preventable. The more fundamental issue is data access. If this element is retained, we recommend NCQA recognize ADT notifications, health plan discharge reports, and HIE-sourced data as acceptable evidence and clarify that independent calculation is not required.

CTC 3: Staff Culture and Experience — Element A: Assessment of Staff Experience

#	Topic / Element	Question / Prompt	Response
39	Element A: Assessment of Staff Experience	How does your organization assess staff experience?	N/A.
40	Element A: Assessment of Staff Experience	Do you support the proposed factors to assess staff experience? Support Support with Modifications Do Not Support	Support.

CTC 3: Staff Culture and Experience — Element B: Care Team Burnout Monitoring and Mitigation

#	Topic / Element	Question / Prompt	Response
41	Element B: Care Team Burnout Monitoring and Mitigation	Do you support inclusion of this element? Support Support with Modifications Do Not Support	Support with Modifications. Burnout affects care quality and workforce sustainability, and mitigation belongs in an advanced primary care framework. We recommend NCQA strengthen Factor 2 by requiring that evaluation results include at least a preliminary identification of potential interventions. While Factor 3 addresses specific resources, the evaluation itself should begin to surface actionable direction rather than simply reporting findings. We also recommend NCQA consider adding ambient scribing to the list of Factor 3 examples, as it is an emerging tool with reasonable

			potential to reduce documentation burden and support clinician well-being.
42	Element B: Care Team Burnout Monitoring and Mitigation	How does your organization currently assess staff burnout?	While not a direct equivalent, Covered California and CalPERS administer employee engagement surveys, within which certain questions correlate strongly with burnout risk.

CTC 4: Alternative Payment Arrangements — Element A: Alternative Payment Arrangement Participation

#	Topic / Element	Question / Prompt	Response
43	Element A: Alternative Payment Arrangement Participation	Do you support inclusion of this element? Support Support with Modifications Do Not Support	Support with Modifications. Generally, yes but we recommend several clarifications. We recommend NCQA reframe the Pay-for-Performance (P4P) example to reflect the payer-to-organization relationship. The Alternative Payment Model (APM) is between the insurer and the organization, not between the organization and its individual clinicians. Secondly, we recommend NCQA consider breaking the current 2-factor structure into 3 factors (P4P, upside, and upside/downside), as these represent meaningfully different levels of financial risk and should not be grouped together. Lastly, we recommend NCQA reference the Health Care Payment Learning & Action Network (HCP-LAN) Framework and the Milbank/California Department of Health Care Access and Information (HCAI) Expanded Non-Claims Payment Framework as the classification standard and specify which contract types qualify for each factor to ensure consistent application across organizations.

CTC 4: Alternative Payment Arrangements — Element B: Risk Absorption Capacity

#	Topic / Element	Question / Prompt	Response
44	Element B: Risk Absorption Capacity	Do you support inclusion of this element? Support Support with Modifications Do Not Support	Support. This element appropriately focuses on whether organizations have clear ownership and processes for managing APM financial performance. We recommend NCQA clarify what constitutes sufficient evidence for each factor, particularly for smaller organizations that may not have formal committee structures or dedicated analytics infrastructure.

#	Topic / Element	Question / Prompt	Response
45	Element B: Risk Absorption Capacity	Does this element add value to the program? Why or why not? Yes No	Yes. Establishing clear ownership and accountability for APM financial performance is a meaningful addition to the program. This element signals that APC is not only about clinical quality but also about organizational readiness to manage financial risk responsibly.
46	Element B: Risk Absorption Capacity	Is this element feasible? Yes No	Yes, partially. Feasibility varies significantly by organization size and maturity. Larger organizations with dedicated finance or analytics functions will find this element manageable, while smaller practices may struggle to demonstrate the governance infrastructure required. We recommend NCQA clarify the minimum evidence threshold and confirm that existing governance materials are sufficient, without requiring purpose-built documentation or formal committee structures that may not exist in smaller primary care settings. Additionally, many practices address these factors via larger organizations they are part of (Independent Practice Associations (IPAs), Clinically Integrated Networks (CINs), or both), and specific reference to these larger organizations should be added to make clear when and how IPAs and CINs may fill some of these roles (rather than just the practice itself).

CTC 4: Alternative Payment Arrangements — Element C: Primary Care Reinvestment for Risk-Critical Capabilities

#	Topic / Element	Question / Prompt	Response
47	Element C: Primary Care Reinvestment for Risk-Critical Capabilities	Do you support inclusion of this element? Support Support with Modifications Do Not Support	Support. Reinvestment in primary care capabilities is important. We recommend NCQA provide a standardized reporting template and methodology guidance to reduce variation in how organizations calculate and document reinvestment.
48	Element C: Primary Care Reinvestment for Risk-Critical Capabilities	Does the value-based terminology in this element resonate? Yes No	No. The terminology around "VBP revenue attributable to primary care" and "risk-critical capabilities" requires clearer definition. We recommend NCQA align its taxonomy with the HCP-LAN Framework and the Milbank/HCAI Expanded Non-Claims Payment Framework to ensure consistent application across organizations. Providing more clarity on "VBP revenue attributable to primary care" is essential because without it, there is a risk that only revenue narrowly tied to traditional primary care services will be attributed to primary care. For example, an organization (if at risk in

#	Topic / Element	Question / Prompt	Response
			VBP for much more than primary care) might only attribute P4P payments on traditional quality measures in primary care (cancer screening, chronic disease management, etc.) but leave out attribution for broader VBP measures of success that are partially driven by primary care (reductions in total costs of care, readmissions, length of stay, etc.). While the context of the APC standards would imply that organizations should *not* narrowly interpret attribution to primary care, without more definition, there is a high risk this will occur. While NCQA may not want to narrowly define attribution to primary care, more guiding principles are recommended. Under VBP, as savings and payments are accrued, reinvestment in primary care is essential.
49	Element C: Primary Care Reinvestment for Risk-Critical Capabilities	Would this element be valuable to your organization? Why or why not? Yes No	Yes, if simplified and standardized. Reinvestment reporting creates meaningful accountability for how VBP dollars are deployed. It could help reinforce investment in primary care infrastructure and capabilities that support value-based care.
50	Element C: Primary Care Reinvestment for Risk-Critical Capabilities	Is this element feasible? Yes No	Yes. We recommend NCQA reduce ambiguity, align to common contract structures, and provide clear guidance on what counts toward each category. We also recommend NCQA reference the HCP-LAN Framework and the Milbank/HCAI Expanded Non-Claims Payment Framework as the classification standard and specify which contract types qualify for each factor to ensure consistent application across organizations.

PSE 1: Access to Services — Element A: Access to Care Team

#	Topic / Element	Question / Prompt	Response
51	Element A: Access to Care Team	Should NCQA require use of an Electronic Medical Record (EMR) with two-way communication for 24/7 access (rather than phone-only access)? Yes No	Yes. The standards appropriately expect a secure interactive electronic system that allows two-way communication, while also allowing multiple communication channels and alternative care delivery options beyond phone-only access.
52	Element A: Access to Care Team	Do you support inclusion of this element? Support	Support.

#	Topic / Element	Question / Prompt	Response
		Support with Modifications Do Not Support	

PSE 1: Access to Services — Element B: Enhanced Communication Opportunities

#	Topic / Element	Question / Prompt	Response
53	Element B: Enhanced Communication Opportunities	Are the requirements in this element considered “enhanced”? Yes No	Yes. The standards define enhanced communication as digital appointment scheduling, automated reminders, virtual check-in, and virtual clinical assessments or consultations.

PSE 1: Access to Services — Element C: Demonstrating Appointment Availability

#	Topic / Element	Question / Prompt	Response
54	Element C: Demonstrating Appointment Availability	Do you support evaluating appointment turnaround time? Support Support with Modifications Do Not Support	Support.
55	Element C: Demonstrating Appointment Availability	Should NCQA use other metrics to assess appointment availability? Yes No	No. The standards’ current set of access metrics is reasonable because it covers routine and urgent visits for new and established patients plus transitional care management or post-discharge visits. NCQA could consider future stratification by high-need populations, but the current framework is usable as written.

PSE 2: Medication Management — Element A: Medication Reconciliation

#	Topic / Element	Question / Prompt	Response
56	Element A: Medication Reconciliation	Do you support inclusion of this element? Support Support with Modifications Do Not Support	Support.

#	Topic / Element	Question / Prompt	Response

PSE 2: Medication Management — Element B: Medication Response and Adherence

#	Topic / Element	Question / Prompt	Response
57	Element B: Medication Response and Adherence	Are reports a feasible data source for this element? Yes No	Yes, generally. The standards identify documented process as the data source and specify prescription claims or pharmacy records from sources such as Surescripts, HIEs, insurers, and Pharmacy Benefit Managers (PBMs), which is a reasonable approach.
58	Element B: Medication Response and Adherence	Do you support inclusion of this element? Support Support with Modifications Do Not Support	Support.

PSE 2: Medication Management — Element C: Prescribing Patterns

#	Topic / Element	Question / Prompt	Response
59	Element C: Prescribing Patterns	What should NCQA assess with regard to prescribing patterns or medication tracking?	NCQA should assess prescribing patterns in a way that supports safe, evidence-based prescribing and action based on identified trends. The standards appropriately focus on monitoring all prescribed medications, evaluating provider patterns, and acting on the results.

PSE 3: Patient-Centered Experience — Element A: Assessment of Patient Experience

#	Topic / Element	Question / Prompt	Response
60	Element A: Assessment of Patient Experience	Do you support the list of domain areas as factors, or should NCQA require a specific patient experience tool/survey? Support Support with Modifications Do Not Support	Support. We support use of domain areas rather than a single mandated survey tool. The standards specify core patient experience domains and allow either validated tools or other qualitative methods, provided the feedback is representative of the patient population. Additionally, for survey methodology, we recommend setting some minimum threshold for number of surveys to ensure the sample is of a reasonable size; this could

#	Topic / Element	Question / Prompt	Response
			either be a percentage of active patients (e.g., 5%) or a minimum numerical threshold (like 100 per year, though we recognize this is more complex given the different sizes of practices).
61	Element A: Assessment of Patient Experience	How does your organization currently evaluate patient experience?	CalPERS conducts an annual Health Plan Member Survey of its Commercial and Medicare members and is derived from evidence-based tools such as the Consumer Assessment of Healthcare Providers and Systems surveys. CalPERS also conducts a supplemental survey each year that focuses on a particular area of interest such as high-needs members' experience of care coordination and care management.

PSE 3: Patient-Centered Experience — Element B: Demonstrating Improvement on Patient Experience

#	Topic / Element	Question / Prompt	Response
62	Element B: Demonstrating Improvement on Patient Experience	Do you support inclusion of this element? Support Support with Modifications Do Not Support	Support. NCQA should also consider encouraging patient participation in governance or improvement planning related to the feedback.

BH 1: Access and Integration — Element A: Demonstrating Access to Behavioral Health Services

#	Topic / Element	Question / Prompt	Response
63	Element A: Demonstrating Access to Behavioral Health Services	Do you support inclusion of this element? Support Support with Modifications Do Not Support	Support. The scope of Behavioral Health (BH) services needs to be clearly explained to members. In 2024, about 62 million United States adults (23%) had a mental health issue (Substance Abuse and Mental Health Services Administration (SAMSHA)) and more than 1 in 5 adults experience a mental health issue in any given year (National Alliance on Mental Illness (NAMI)). There are geographic barriers, workforce issues, stigma, and cost issues that prevent access to BH and Substance Use Disorder (SUD) services, that disproportionately affect minorities, people with low socioeconomic status (SES), and rural communities.
64	Element A: Demonstrating Access	Do you believe this element adds value to the program?	Yes. It helps anchor whole-person care and acknowledges the central role of BH in primary care transformation.

#	Topic / Element	Question / Prompt	Response
	to Behavioral Health Services	Yes No	
65	Element A: Demonstrating Access to Behavioral Health Services	What is the minimum behavioral health access needed for an advanced primary care organization?	At a minimum, advanced primary care should be able to identify common BH needs, conduct screening, provide brief interventions and follow-up for mild to moderate conditions within scope, prescribe when appropriate, and maintain reliable referral pathways for needs requiring specialty care. There should be a means of monitoring the referral pathway to ensure a follow-up.

BH 1: Access and Integration — Element B: Behavioral Health Referrals

#	Topic / Element	Question / Prompt	Response
66	Element B: Behavioral Health Referrals	What data sources are feasible and appropriate for this element? Report Materials Documented Process Other	Report; Documented Process; Other. EHRs, referral logs, workflow.

BH 1: Access and Integration — Element C: Integrated Services

#	Topic / Element	Question / Prompt	Response
67	Element C: Integrated Services	What does behavioral health integration look like for your organization?	Covered California, CalPERS, and DHCS all prioritize the integration of BH with primary care in our contracts with our health plans. Integrated BH should include a description of the integration but allow for flexibility because “one size does not fit all.” When BH is a part of primary care, it “normalizes” the conversation and reduces stigma and the barriers to care.
68	Element C: Integrated Services	Do you support this element’s factors? Yes No	Yes. Staffing, integrated care plans and communication are necessary elements of BH integration.

#	Topic / Element	Question / Prompt	Response
69	Element C: Integrated Services	Should NCQA reference a specific model of behavioral health integration for the program? Yes No	No, as long as there is a clearly defined approach to integration by the provider. Covered California has included health plan contract provisions related to behavioral health integration since 2019, but those provisions have not resulted in meaningful alignment in integrated behavioral health models or a meaningful increase in the number of members receiving integrated behavioral health care. Plans interpret integration differently and implement across a wide continuum, from integrated delivery systems to use of co-location or the full Continuity of Care Model. The California Quality Collaborative (CQC) Behavioral Health Integration (BHI) Initiative in California found no statewide consensus on the definition of BHI, or a specific model. Based on these experiences, we recommend a focus on the goals of integration: care, workflow and shared data while maintaining flexibility in how the integration is operationalized.

BH 2: Behavioral Health Screenings — Element A: Routine Behavioral Health Screenings

#	Topic / Element	Question / Prompt	Response
70	Element A: Routine Behavioral Health Screenings	Should anxiety screening remain a required factor? Yes No	Yes, as it identifies treatable mental health conditions early and is historically recommended by the U.S. Preventive Services Task Force (USPSTF). Also helps normalize mental health services and connect people to care sooner.
71	Element A: Routine Behavioral Health Screenings	Do you support screening for suicide risk/ideation? Support Support with Modifications Do Not Support	Support. We support systematic screening for suicide risk and ideation, best implemented as a triggered response to a positive depression screen or other clinical indication rather than as a universal upfront screen. While the USPSTF has issued a statement (insufficient evidence) for routine suicide risk screening in primary care, we believe this evidence gap should not preclude plan-level action and encourages issuers to implement systematic approaches to identifying members at risk.
72	Element A: Routine Behavioral Health Screenings	Do you support combining depression and suicide screening factors? Support Support with Modifications Do Not Support	Do not support combining the screenings. In support of the APC's sequenced approach, we recommend suicide risk screening triggered by a positive depression screen or other clinical indication, not as a universal upfront screen. NCQA should ensure standard language clearly signals this triggered expectation to avoid misinterpretation.

#	Topic / Element	Question / Prompt	Response
73	Element A: Routine Behavioral Health Screenings	Should NCQA include a cadence for routine screenings (e.g., at least annually)? Yes No	No. In the absence of evidence for established cadence, a pragmatic approach might include screening adults who have not been screened previously and using clinical judgment while considering risk factors, comorbid conditions, and life events to determine if additional screening of patients at increased risk is warranted. Depression and Suicide Risk Screening: Evidence report https://jamanetwork.com/journals/jama/fullarticle/2806145.

BH 2: Behavioral Health Screenings — Element B: Clinically Indicated Screenings

#	Topic / Element	Question / Prompt	Response
74	Element B: Clinically Indicated Screenings	Do you support the listed screenings? If not, are other screenings more appropriate for primary care? Support Support with Modifications Do Not Support	Yes, support listed screenings.
75	Element B: Clinically Indicated Screenings	How feasible is post-traumatic stress disorder (PTSD) screening in the primary care setting?	Agree that PTSD screening is feasible, as it is a brief screening tool, however as it does not appear in the USPSTF's A or B recommendation for routine screening for adults, support is limited to clinically indicated populations at this time.

BH 3: Evidence-Based Care — Element A: Providing Brief Interventions

#	Topic / Element	Question / Prompt	Response
76	Element A: Providing Brief Interventions	Do you agree with the proposed factors? If not, why not? Yes No	Yes. Pharmacological intervention should explicitly include Medication-Assisted Treatment (MAT) for opioid and alcohol use disorder, and harm reduction tools (naloxone, fentanyl test strips) should be recognized as appropriate brief interventions.

BH 3: Evidence-Based Care — Element B: Monitoring Patients Over Time

#	Topic / Element	Question / Prompt	Response
77	Element B: Monitoring Patients Over Time	Is this element feasible for your organization type? Yes No	Yes. The feasibility varies based on staffing, workflows, tool availability, EHR functionality, and burden associated with longitudinal score tracking across multiple conditions. Though aspirational and perhaps not within scope of the APC standards, it would be ideal to track treatment response not just at an individual level, but also at a population level. For example, practices could work on evaluating “Depression Remission or Response for Adolescents and Adults (DRR–E)”, noting this measure is designed for health plan-level measurement. Individual-level tracking may miss opportunities to evaluate whether a practice’s BH interventions have an impact or fail to produce meaningful outcomes. However, we recognize that our feedback under Clinical Quality (CQ) 1 Element A states to move to a parsimonious list and adding additional measures like Depression Remission or Response (DRR-E) conflicts with that other feedback.
78	Element B: Monitoring Patients Over Time	Do you believe the requirements fall within the scope of primary care? Yes No	Yes. Screening, symptom tracking using standardized tools, brief intervention, care coordination, and warm referral/handoff are within scope for mild to moderate conditions. Clear escalation and referral triggers are essential to ensure monitoring does not substitute for timely specialty referral when conditions exceed primary care scope.

CQ 1: Quality Performance Measurement — Element A: Clinical Measurement Reporting

#	Topic / Element	Question / Prompt	Response
79	Element A: Clinical Measurement Reporting	Do you support the use of the following quality measures to assess clinical performance? If not, please describe recommended changes and your rationale (feasibility for reporting in primary care, relevance to clinical practice). Support Support with Modifications Do Not Support	Do Not Support. We recommend NCQA consider a more disciplined and parsimonious approach to measurement – prioritizing a smaller, durable set of outcomes-oriented measures already in wide use across programs, rather than a process-heavy reporting framework. The goal should be a deliberate shift away from process measures toward outcomes measures that reflect the true impact of advanced primary care. We also recommend NCQA include Continuity of Care (CoC) and other validated measures that directly reflect primary

#	Topic / Element	Question / Prompt	Response
			care capabilities, as these are better aligned with the goals of the APC program. Additionally, we strongly recommend NCQA require an assigned population approach (e.g., Healthcare Effectiveness Data and Information Set (HEDIS)-like attribution) rather than a clinic-seen-only specification and provide guidance on reconciling attributed and non-attributed populations (e.g., straight Medicare where there is no PCP assignment). We also strongly recommend NCQA reconsider the Attention-Deficit/Hyperactivity Disorder (ADHD) follow-up measure as the sole pediatric engagement measure; pediatric engagement measures (e.g., Weight Assessment and Counseling (WCC), W30, or similar) or vaccine measures represent larger populations and greater clinical impact.
80	Element A: Clinical Measurement Reporting	Given the existence of a separate behavioral health standard, do the measures in Clinical Quality sufficiently capture behavioral health performance in primary care? Are there key gaps? Should any behavioral health measures be added or removed? Yes No	No, partially. The inclusion of a depression screening measure in CQ 1 alongside a dedicated BH standard risks duplicative reporting. We recommend NCQA ensure the measure set remains parsimonious and that organizations are not required to report the same underlying data across multiple standards.

CQ 1: Quality Performance Measurement — Element B: Demonstrating Clinical Measurement Performance—50th Percentile

#	Topic / Element	Question / Prompt	Response
81	Element B: Demonstrating Clinical Measurement Performance—50th Percentile	When demonstrating clinical measurement performance relative to the national distribution (e.g., 50th percentile), would it be helpful to benchmark network/ACO performance against CMS MIPS benchmark decile distributions for comparable measures (by the same collection type, where available)?	Yes. Potentially, but with important caveats around equity and comparability. We caution that applying different benchmarks across different populations is not an equity-centered approach. We recommend NCQA allow gap closure or other improvement-based pathways as alternatives to account for real variability across primary care settings.

#	Topic / Element	Question / Prompt	Response
		Yes No	
82	Element B: Demonstrating Clinical Measurement Performance—50th Percentile	If not, do you recommend an alternative benchmarking approach?	If benchmarking is used, NCQA should ensure like-to-like comparison, clear peer definitions, and recognition of organizations serving distinct populations. In some cases, gap closure or improvement over time may be more meaningful than a simple cross-sectional peer threshold.
83	Element B: Demonstrating Clinical Measurement Performance—50th Percentile	Do you support requiring a specific number of measures to meet this benchmark? Yes No	No. We caution against requiring a high number of measures at benchmark. We recommend NCQA apply benchmark thresholds in a way that preserves measure parsimony and does not incentivize unnecessary measure expansion. Additionally, requiring a specific number of measures meet a benchmark may prevent some practices with a focus on particularly high-risk populations (e.g., people experiencing homelessness, older adults with complex health issues) from participating in APC; as noted before, a gap closure or improvement approach would help ensure those types of practices might participate in APC.

CQ 1: Quality Performance Measurement — Element C: Demonstrating Clinical Measurement Performance—80th Percentile

#	Topic / Element	Question / Prompt	Response
84	Element C: Demonstrating Clinical Measurement Performance—80th Percentile	When demonstrating clinical measurement performance relative to the national distribution (e.g., 80th percentile), would it be helpful to benchmark network/ACO performance against CMS MIPS benchmark decile distributions for comparable measures (by the same collection type, where available)? Support Support with Modifications Do Not Support	Support with Modifications. Similar concern as Question 81. High percentile benchmarks may be difficult to interpret fairly unless peer groups and attribution approaches are well defined.
85	Element C: Demonstrating Clinical	If not, do you recommend an alternative benchmarking approach?	Same as Question 82. If benchmarking is used, NCQA should ensure like-to-like comparison, clear peer definitions, and

#	Topic / Element	Question / Prompt	Response
	Measurement Performance—80th Percentile		recognition of organizations serving distinct populations. In some cases, gap closure or improvement over time may be more meaningful than a simple cross-sectional peer threshold.
86	Element C: Demonstrating Clinical Measurement Performance—80th Percentile	Do you support requiring a specific number of measures to meet this benchmark?	No. Same as Question 83. We caution against requiring a high number of measures at benchmark. We recommend NCQA apply benchmark thresholds in a way that preserves measure parsimony and does not incentivize unnecessary measure expansion.

CQ 1: Quality Performance Measurement — Element D: Improving Disparity Gaps

#	Topic / Element	Question / Prompt	Response
87	Element D: Improving Disparity Gaps	Do you support inclusion of this element? Support Support with Modifications Do Not Support	Support. Addressing disparity gaps is important and well aligned with the goals of advanced primary care.
88	Element D: Improving Disparity Gaps	Do you agree with the listed factors? If not, why not? Yes No	Generally, yes. The factors are directionally aligned with meaningful disparity work. We recommend NCQA ensure data requirements are feasible and that this element drives actionable improvement rather than documentation compliance alone.
89	Element D: Improving Disparity Gaps	Does the explanation for this element resonate? Yes No	Generally, yes. We recommend NCQA ensure it is grounded in usable data, clear subpopulation definitions, and practical action pathways that practices can realistically implement, and that the Factor 2 language aligns with the Explanation language.

DME 1: Data Integration and Exchange — Element A: Core Data Integration

#	Topic / Element	Question / Prompt	Response
90	Element A: Core Data Integration	Do you support this element's data integration sources? Support Support with Modifications Do Not Support	Support with Modifications. Proposed sources align with what Covered California and CalPERS require of contracted health plans, including claims and encounter data, medical and behavioral health claims, pharmacy data, care management data, and enrollment/eligibility information. We recommend clearer operational

#	Topic / Element	Question / Prompt	Response
			definitions distinguishing meaningful integration from passive data receipt.
91	Element A: Core Data Integration	What sources does your organization currently integrate?	California public purchasers require contracted health plans to integrate claims and encounter data, medical and behavioral health claims, pharmacy claims (excluding cost), care management data, and enrollment/eligibility information. Contractors must also execute the Data Sharing Agreement (DSA) under California's Data Exchange Framework (DxF) and participate in at least one designated Qualified Health Information Organization (QHIO). Hospital ADT event notification integration is also a tracked contract requirement. Depth of integration into quality and population health workflows varies across issuers — an area where NCQA's standards could add meaningful reinforcement at the primary care practice level.
92	Element A: Core Data Integration	Does the explanation for this element resonate? Yes No	Yes, partially. The intent resonates, but more operational specificity would make the standard more actionable — particularly around what counts as meaningful integration versus passive data receipt.

DME 1: Data Integration and Exchange — Element B: Advanced Data Integration

#	Topic / Element	Question / Prompt	Response
93	Element B: Advanced Data Integration	Do you support this element's data integration sources? Support Support with Modifications Do Not Support	Support with Modifications. We support the direction, and the inclusion of HIEs as a distinct advanced source is particularly relevant in the California context, where the state has invested significantly in a designated QHIO infrastructure. NCQA should more clearly distinguish between foundational and advanced capabilities to avoid overlap and ensure that each tier creates a genuinely differentiated expectation.
94	Element B: Advanced Data Integration	What sources does your organization currently integrate?	The California public purchasers have each embedded DxF-aligned exchange expectations in their contracts: DHCS requires DxF Policies and Procedures compliance, DxF-standard data sharing, and hospital/Skilled Nursing Facility ADT mandates; CalPERS requires California Health and Safety Code 130290 compliance and network provider DxF readiness; Covered California requires DSA

#	Topic / Element	Question / Prompt	Response
			execution, QHIO participation, standardized PCP data sharing, and active hospital ADT monitoring. Across all three, California's designated QHIOs represent real-world examples of the HIE factor NCQA proposes. Whether health plans meaningfully integrate these sources into population health workflows, rather than fulfilling a participation threshold, remains a shared purchaser focus and an area where NCQA's standards could add meaningful reinforcement.
95	Element B: Advanced Data Integration	Does the explanation for this element resonate? Yes No	Yes, partially. As noted above, stronger operational specificity would improve usability. For California purchasers, alignment with the state's DxF framework and QHIO infrastructure is an important reference point that NCQA may wish to acknowledge as a model for state-level advanced data integration expectations. California's Expedited Partner Therapy (EPT) guidance may also be a useful reference in this context.

DME 1: Data Integration and Exchange — Element C: Bidirectional External Exchange of Information

#	Topic / Element	Question / Prompt	Response
96	Element C: Bidirectional External Exchange of Information	Do you support inclusion of this element? Support Support with Modifications Do Not Support	Support with Modifications. Bidirectional exchange is an appropriate aspiration for advanced primary care. Covered California would emphasize that Factor 3 — clinical data exchange with payers — be designated a required Factor to achieve Met, as health plan-to-practice data sharing is foundational to the other factors and directly supported by existing purchaser contract obligations. Standards should acknowledge current barriers while clearly signaling the direction of travel.
97	Element C: Bidirectional External Exchange of Information	Which external data sources/types (claims, eligibility/rosters, HIE feeds, external labs, imaging, pharmacy/PBM, IIS, registries) are the most challenging to obtain and integrate into your systems, data tools/platforms for quality reporting/gap closure, attribution workflows, etc.? Please explain.	The most challenging sources are typically payer claims/eligibility/roster data, HIE feeds where coverage is incomplete, behavioral health data due to privacy (especially SUD data protected by 42 Code of Federal Regulations Part 2) and workflow constraints, pharmacy/PBM data, and external labs/imaging where interoperability is inconsistent. Challenges include vendor fees, separate feeds, siloed systems, and lack of standardization.

#	Topic / Element	Question / Prompt	Response
98	Element C: Bidirectional External Exchange of Information	What limitations, constraints or costs affect your ability to access or receive FHIR data, or to transform data into FHIR?	Major barriers include vendor readiness, external data access, mapping burden, validation burden, separate data feeds, and the cost of transforming fragmented data into usable FHIR outputs. Final requirements should account for these constraints and avoid assuming FHIR transformation can occur independently of broader plan-practice data sharing infrastructure.

DME 2: Use of Fast Healthcare Interoperability Resources — Element A: FHIR Data Integration Capability

#	Topic / Element	Question / Prompt	Response
99	Element A: FHIR Data Integration Capability	Which dQM inputs require external data sharing (claims, eligibility/rosters, HIE feeds, external labs, imaging, pharmacy/PBM, IIS, registries), and which are the most difficult to obtain and integrate reliably?	N/A.
100	Element A: FHIR Data Integration Capability	Are the evidence requirements (e.g., screenshots, sample outputs) clear and feasible?	N/A.
101	Element A: FHIR Data Integration Capability	Does this element appropriately account for variation in vendor capabilities and system configurations?	N/A.

DME 2: Use of Fast Healthcare Interoperability Resources — Element B: FHIR Data Production and Validation

#	Topic / Element	Question / Prompt	Response
102	Element B: FHIR Data Production and Validation	Are the required FHIR bundle components appropriate?	N/A.
103	Element B: FHIR Data Production and Validation	Is the requirement for validation against implementation guides clear?	N/A.
104	Element B: FHIR Data Production and Validation	Is the level of effort required to generate and validate FHIR datasets reasonable?	N/A.

#	Topic / Element	Question / Prompt	Response
105	Element B: FHIR Data Production and Validation	Are evidence and submission requirements (e.g., JSON file, validation outputs) clear and feasible?	N/A.
106	Element B: FHIR Data Production and Validation	Does this element appropriately reflect progression from Element A?	N/A.

DME 2: Use of Fast Healthcare Interoperability Resources — Element C: FHIR Digital Quality Measure Reporting

#	Topic / Element	Question / Prompt	Response
107	Element C: FHIR Digital Quality Measure Reporting	In the provided materials, three measure specifications—COL CD, URI CD, BPC CD—assess an organization's technical capability to submit data using FHIR. After reviewing the measure specifications, do you have questions or comments about their readability, clarity or interpretability (e.g., structure, terminology, logic, implementation guidance)?	N/A.
108	Element C: FHIR Digital Quality Measure Reporting	Which of the following best reflects how your organization defines patient attribution? All patients within a specific payer All patients covered under a particular contract Patients segmented by clinical or diagnostic risk Patients segmented by socio-economic risk Patients segmented by disease or disorder Patients segmented by level of engagement (e.g., patients with an Annual Wellness Visit vs. those who are not engaged)	N/A.
109	Element C: FHIR Digital Quality Measure Reporting	How challenging would it be for your organization to report the three measures using one attribution (network/ACO) approach, while continuing to report similar measures to health plans using a different, plan-defined attribution?	N/A.

#	Topic / Element	Question / Prompt	Response
110	Element C: FHIR Digital Quality Measure Reporting	What limitations, constraints or costs are there for accessing/reporting required data elements (vendor fees, separate data feeds, siloed systems)? Which are specific to FHIR dQMs vs. eCQMs, and what mitigations should NCQA consider?	N/A.
111	Element C: FHIR Digital Quality Measure Reporting	Beyond addressing barriers, what enablers would most help your organization successfully report FHIR-based quality measures? Please share additional feedback about becoming FHIR-ready.	N/A.
112	Element C: FHIR Digital Quality Measure Reporting	Does your organization have a roadmap or implementation plan for incorporating FHIR-based digital dQMs into your systems? Yes No	No. Covered California does not have a FHIR-specific roadmap at this time, as FHIR is not currently a component of our Qualified Health Plan contract requirements. California's DxF and QHIO infrastructure represent a foundational layer upon which FHIR-based exchange could logically build. We encourage NCQA to design its FHIR roadmap to complement — rather than duplicate or conflict with — existing state-level interoperability investments, and to ensure phased expectations account for significant variation in technical maturity across primary care organizations.

Additional Measures

Additional Measures

#	Topic / Element	Question / Prompt	Response
113	Additional Measures	How relevant, feasible and valuable are continuity of care measures such as the American Board of Family Medicine Continuity Measure?	Continuity of Care measures are highly relevant and more valuable than many condition-specific process measures because they capture a core function of primary care itself. A strong continuity measure is associated in the literature with lower mortality, lower total cost of care, fewer hospitalizations and emergency visits, and better patient experience. For that reason, NCQA should strongly consider Continuity of Care as a priority measure in the program. In policy-terms, a well-specified continuity measure may be more meaningful than many condition-specific measures combined. This is because it reflects whether primary care is functioning as primary care, rather than only whether isolated process steps were completed.
114	Additional Measures	How relevant, feasible and valuable are primary care experience and delivery measures such as the Primary Care Practice Centered Measure?	Primary care experience and delivery measures may be valuable if they remain focused, relevant, and not duplicative of existing standards.
115	Additional Measures	How relevant, feasible and valuable are patient-reported outcome measures such as self-reported overall health status, pain interference or pain intensity measures like the PROMIS® Pain Interference or the PEG scale?	Patient-reported outcome measures are valuable, but feasibility, workflow integration, and reporting burden should be considered carefully before broad inclusion.
116	Additional Measures	What considerations or challenges should NCQA consider in implementing program measures, particularly with respect to data collection, reporting burden, workflow integration, equity and digital readiness?	NCQA should pay close attention to data collection burden, workflow integration, attribution alignment, equity implications, digital readiness, vendor variation, and overall measure proliferation. The program is a chance to correct course toward a more parsimonious, operational, and durable framework rather than adding complexity.