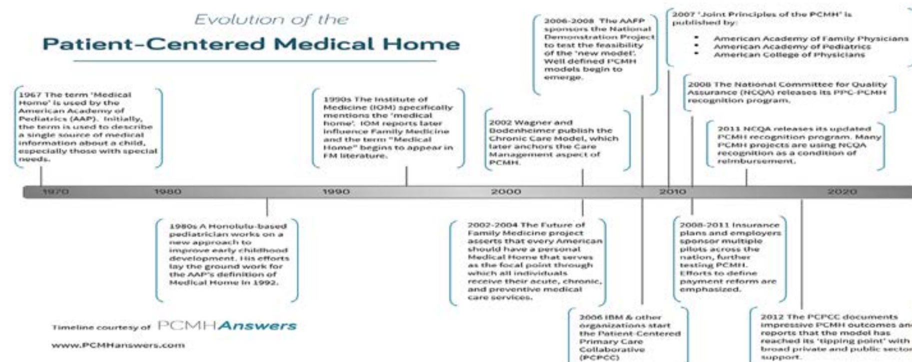
Quality Care and Patient-Centered Medical Home (PCMH)

History, Background, Timeline[1]

- The American Academy of Pediatrics introduced the term "medical home" in 1967 as a set of practices to improve care for children with chronic diseases.
- In 1996, the Institute of Medicine (IOM) published Primary Care: America's health in a New Era redefining primary care and placing emphasis on the importance of integrated, accessible health care services and patient-centeredness.
- Over the next ten years, numerous publication and reports were published on need for health systems reform, quality care and the importance of developing new reimbursement models to sustain family medicine and primary care. This includes the Chronic Care Model, developed by Dr. Ed Wagner, which was "born" in 2002, emphasizing the critical role of primary care to prevent, manage and treat chronic illness.
- In 2008, The National Committee for Quality Assurance (NCQA), URAC, Joint Commission, and the Accreditation Association for Ambulatory Health Care (AAAHC) launched medical home accreditation programs and the Commonwealth Fund launches the five-year Safety Net Medical Home Initiative designed to help 65 community health centers in five states transform into patient-centered medical homes.
- In 2010, the ACA signed into law included numerous provisions for enhancing primary care and medical homes, such as primary care payment increases through Medicare and Medicaid, expansion of insurance coverage, and significant investments in medical home pilots, workforce development and training, prevention and wellness, community health centers, and additional care delivery innovation.
- Definition: the Agency for Healthcare Research and Quality (AHRQ) defines a medical home "not simply as a place but as a model of the organization of primary care that delivers the core functions of primary health care. The medical home encompasses five functions and attributes: comprehensive care, patient-centered, coordinated care, accessible services, and quality and safety."[2]

Today, NCQA PCMH Recognition is the most widely adopted model for transforming primary care practices into medical homes. NCQA first developed the PCMH recognition program at the request of, and in collaboration with, four key medical professional societies – the American Academy of Pediatrics, the American College of Physicians, the American Osteopathic Association and the American Academy of Family Physicians. Since the initial program was released in 2008, it has gone through two substantial revisions, in 2011 and 2014, with upcoming revisions in 2017. Research confirms medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care.[3]



[1] PCPCC: https://www.pcpcc.org/content/history
[2] AHRQ: https://pcmh.ahrq.gov/page/defining-pcmh
[3] NCQA: https://pcmh.ahrq.gov/page/defining-pcmh

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Affordable Care ACT (HHS) and PCMH

The Affordable Care Act helped to prioritize quality and value-based care by encouraging the utilization of all types of primary care providers in innovative care models and increasing support for primary care.[4] It contains various provisions that support implementation of the medical home model including new payment policies and Medicaid demonstrations.[5]

As a result of the ACA[6]*:*

- Primary care providers receive a 10% Medicare bonus payment for primary care services.
- A new Medicaid state option is created to permit certain Medicaid enrollees to designate a provider as a health home, and states taking up the option receive 90% federal matching payments for two years for health home-related services.
- Small employers receive grants for up to five years to establish wellness programs.
- The Center for Medicare & Medicaid Innovation (CMMI) launches the Pioneer Accountable Care Organization (ACO) Model and Advance Payment ACO Model, which offers shared savings and other payment incentives for selected organizations that provide efficient, coordinated, patient-centered care.
- States begin planning for the establishment of American Health Benefit Exchanges and Small Business Health Options Program Exchanges, which facilitate the purchase of insurance by individuals and small employers.
- Teaching Health Centers are established to provide payments for primary care residency programs in community-based ambulatory patient care centers.
- States indicate to the Secretary of HHS whether they will operate a health insurance marketplace. (HHS) to test medical homes among other new care-delivery models to refocus the U.S. health care system on the benefits of primary care.
- Over $35 million was awarded to *147 HRSA funded health centers* in 44 states to support facility improvements and to deliver better coordinated care.
- Medicaid payments for primary care services increase to 100% of the Medicare payment rate through 2014.
- Providers receive a one percentage point increase in federal matching payments for preventive services.
- Essential Health Benefits in the health insurance marketplaces include prevention, wellness, and chronic disease management.
- In 2012, representing more than 1,000 members, the PCPCC publishes *Benefits of Implementing the Medical Home: Cost and Quality Results* providing cost, quality and outcomes data for more than 40 medical home initiatives throughout the U.S.

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[4] AAPA: https://www.aapa.org/threeColumnLanding.aspx?id=1705
[5] NCSL: http://www.ncsl.org/research/health/the-medical-home-model-of-care.aspx
[6] *ACA Title III, Subtitle A, Part III, Encouraging Development of New Patient Care Models (Sec. 3021 – CMMI established)*
ACA Title III, Subtitle F, Health Care Quality Improvements (Sec. 3502 – Community health teams to support PCMH)

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PCMH Recognition Programs

1. Accreditation Association for Ambulatory Health Care (AAAHC) Medical Home *(www.aaahc.org)*
2. National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home *(www.ncqa.org)*
3. The Joint Commission (TJC) Designation for Your Primary Care Home *(www.jointcommission.org)*
4. URAC Patient-Centered Medical Home Accreditation *(www.urac.org)*

Federal PCMH Incentive Programs

Comprehensive Primary Care (CPC) Initiative[7] – Centers for Medicare and Medicaid Innovation (CMMI)[8]

- Four-year, multi-payer initiative designed to test practice redesign models.
- The CPC Initiative operates in seven U.S. states and offers bonus payments to family physicians who improve care coordination for their patients. **(AR, OK, OR, CO, OH/KY, NJ, NY)**
- CMS pays selected primary care practices in seven geographic markets a care management fee (initially set at an average of $20 per beneficiary per month) to support enhanced, coordinated services for Medicare beneficiaries in addition to fee-for-service payments.
- In 2015, CMS decreases the care management fee to $15 per beneficiary per month with the opportunity for shared savings for practices that can demonstrate decreased cost and improved quality of care.

Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration[9]

- This demonstration project operates in many U.S. states and offers bonus payments to FQHCs to improve the quality and coordination of patient care. Participants in the project are required to achieve Level 3 PCMH recognition from the National Committee for Quality Assurance (NCQA).

Other Innovation Programs

State Innovation Model Grants (SIM)[10]

- The State Innovation Models (SIM) Initiative through Medicaid is providing financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries.
- **Round 1 Awards:** $300 million was awarded to 25 states to design or test innovative health care payment and service delivery models in the form of Model Design (16 states), Model Pre-Test (3 states), and Model Test awards (6 states: Oregon, Vermont, Massachusetts, Arkansas, Minnesota and Maine).
- **Round 2 Awards:** SIM initiative is providing over $660 million to 32 awardees. This includes both model design awardees (21 states who will design or further refine plans) and model test awardees (11 states that are ready to implement their State Health Care Initiative Plan).

[7] *CPCI: https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/Seven-Regions.html*
[8] *CMMI: https://innovation.cms.gov/*
[9] *FQHC Advanced PCP Demo: https://innovation.cms.gov/initiatives/fqhcs/*
[10] *SIM: https://innovation.cms.gov/initiatives/state-innovations/*

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Quality Data Sets – A Snapshot		
Agency/ Measure	**Description**	**Link**
AHRQ's National Quality Measures Clearinghouse	A public resource for summaries of evidence-based quality measures and measure sets. NQMC also hosts the HHS Measures Inventory.	https://www.qualitymeasures.ahrq.gov/
CMS Quality Measures	CMS implements quality initiatives to assure quality health care for Medicare Beneficiaries through accountability and public disclosure. CMS uses quality measures in its various quality initiatives that include quality improvement, pay for reporting, and public reporting.	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/index.html?redirect=/qualitymeasures/
HEDIS and NCQA Quality Measurement (HEDIS)	The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. HEDIS consists of 81 measures across 5 domains of care. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis.	http://www.ncqa.org/hedis-quality-measurement
HRSA's Uniform Data System Resources for Health Centers (UDS)	Each year, Health Center Program grantees and look-alikes report on their performance using the measures defined in the Uniform Data System (UDS). HRSA offers manuals, webinars, trainings online and at various state/regional/national meetings, and other technical assistance resources to assist health centers in collecting and submitting their data.	https://bphc.hrsa.gov/datareporting/reporting/index.html
Meaningful Use (MU)	Medicare and Medicaid have developed incentive programs to provide financial incentive to eligible professionals (EP), eligible hospitals (EH) and critical access hospitals (CAH) for use of an EHR (Electronic Health Record). The overall objective is improvement of patient care.	https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2016ProgramRequirements.html
National Quality Forum (NQF)	Improving healthcare data usability and transparency to better measure, report on, and take action to improve healthcare quality, used by CMS and others.	http://www.qualityforum.org/measures_reports_tools.aspx
Physician Quality Reporting System (PQRS)	The Physician Quality Reporting System (PQRS) is a quality reporting program that encourages individual eligible professionals (EPs) and group practices to report information on the quality of care to Medicare.	https://pqrs.cms.gov/#/home

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Integrated Care: Medicaid Health Homes Under the ACA

The Affordable Care Act Section 2703 gives states an opportunity to improve care coordination and care management for Medicaid beneficiaries with complex health care needs through health homes. Health homes integrate physical and behavioral health (mental health and substance use) and long-term services and supports for high-need, high-cost Medicaid populations. States were required to submit a Medicaid State Plan Amendment (SPA) to CMS to create a health home program. As of November 2016, 20 states and the District of Columbia have approved SPAs, with some states submitting multiple SPAs to target different populations or phase-in regional implementation (resulting in 28 unique models). More than one million Medicaid beneficiaries have been enrolled in health homes to date. Nearly a dozen other states are planning health home models.

- *Factsheet*
- *Map*
- *State by State breakdown*

Primary Care in Behavioral Health
SAMHSA awarded 100 community behavioral health organizations more than $26.2 million collectively in Primary and Behavioral Health Care Integration (PBHCI).[11]

Behavioral Health in Primary Care
Primary care settings have become a gateway for many individuals with behavioral health and primary care needs. To address these needs, many primary care providers are integrating behavioral health care services into their setting. Models have emerged that include the use of care managers, behavioral health consultants, behavioralists, or consultation models.[12]

Health Homes vs. PCMH		
Features	**Medicaid Health Home**	**PCMH**
Target Population	Individuals with chronic conditions	All populations across the lifespan
Typical Providers	May include primary care practices, community mental health organizations, addiction treatment providers, federally qualified health centers, and other safety-net providers	Typically defined as physician-led primary care practices, but may include some mid-level practitioners such as nurse practitioners
Payer(s)	Currently a Medicaid-only construct	Exist for multiple payers (e.g.. Medicaid, commercial insurance)
How Care is Organized	Team-based, whole-person orientation with explicit focus on integration of behavioral health and primary care	Team-based, whole person orientation achieved through coordinated care
Provider Requirements	State Medicaid determined	State Medicaid and NCQA determined
Payment	Usually PMPM for six required services with more intensive care coordination and patient activation	Payment is in line with added value; usually small PMPM

[11] http://www.integration.samhsa.gov/integrated-care-models/primary-care-in-behavioral-health
[12] http://www.integration.samhsa.gov/integrated-care-models/behavioral-health-in-primary-care

Quality Care and Patient-Centered Medical Home (PCMH)

Certified Community Behavioral Health Clinics (CCBHCs)

CCBHCs were created through Section 223 of the Protecting Access to Medicare Act (PAMA), which established a demonstration program based on the Excellence in Mental Health Act. The Excellence in Mental Health Act demonstration program—also known as the Excellence Act or the Section 223 demonstration program—is a two-year, 8-state initiative to expand Americans' access to mental health and addiction care in community-based settings.

The Excellence Act established a federal definition and criteria for Certified Community Behavioral Health Clinics (CCBHCs) and stipulated that CCBHCs may receive an enhanced Medicaid reimbursement rate based on their anticipated costs of care. CCBHCs are responsible for directly providing (or contracting with partner organizations to provide) nine required types of services, with an emphasis on the provision of 24-hour crisis care, utilization of evidence-based practices, care coordination, and integration with physical health care. Ultimately, the demonstration program is expected to infuse more than $1.1 billion into community-based services, making it the largest investment in mental health and addiction care in generations.

In December 2016 the Substance Abuse and Mental Health Services Administration announced the selection of the eight participating states:

- Minnesota
- Missouri
- New York
- New Jersey
- Nevada
- Oklahoma
- Oregon
- Pennsylvania[13]

Accountable Care Organizations and Community Health Centers

Accountable care strategies are spreading from Medicare and commercial insurance to Medicaid programs, thus extending the benefits of payment and delivery reform to the safety net. Medicaid Accountable Care Organizations (ACOs) are now emerging in **18 states** and a quarter of all ACOs nationally have contracts with Medicaid. The majority of the emerging Medicaid ACOs are led by hospitals and health plans, not community health centers.[14]

Community health centers are well-suited to pursue accountable care strategies and serve as the integrators of care on a community basis for a number of reasons:

- CHCs are key providers of primary care to large segments of the Medicaid and uninsured populations, and a strong primary care system is critical to improving health outcomes, reducing unnecessary hospitalizations and emergency department visits, and lowering costs.
- Unlike hospitals, health centers have a clear incentive to reduce inpatient use when medically appropriate.

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[13] https://www.thenationalcouncil.org/topics/certified-community-behavioral-health-clinics/

[14] http://healthaffairs.org/blog/2015/09/02/community-health-center-strategies-for-pursuing-accountable-care/
ACO Map/Project Scope by State

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- Health centers have a history of *addressing social determinants of health* and behavioral health concerns, and a strong mission of improving the population health of the communities they serve.

Size is the main challenge to community health centers' ability to participate in accountable care. Accountable care is characterized by providers accepting increased levels of financial risk in exchange for assuming responsibility for populations of patients and changing the delivery of care to improve cost and quality outcomes. Five strategies health centers are currently using to overcome the barriers associated with small size in order to bear increased risk and accountability are:

- Intrinsic Growth
  - Grow as rapidly as possible through revenue and patient population to facilitate the ability to assume risk (applicable to larger health centers)
- "Big in a Small Pond"
  - Become dominant provider in geographic service area (applicable to smaller health centers). Greater incentives to make community-level investments and helps retain patients over time
- Affiliation with Other Health Centers
  - An affiliated group of health centers can negotiate risk-based contracts on behalf of its members. These coalitions can accept financial risk for health outcomes and negotiate contracts with select payers
- Affiliation with a Hospital Partner
  - Community health centers can affiliate with a compatible hospital partner that would play the dominant role in leading accountable care efforts. This approach allows health centers to benefit from the hospital's size and clout in contract negotiations.
- Community Coalition
  - Some communities are taking a more comprehensive approach by forming community-based coalitions to lead accountable care efforts. While still an emerging concept, these coalitions provide community health centers with the opportunity to participate in accountable care while furthering their mission of prevention and population-based health approaches in the broader community. This structure allows health centers to participate in accountable care without being dominated by either a hospital or a health plan.

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State	HRSA Funded CHC PCMH	CPCi	FQHC APCPD	SIM	CMS SPA (HH)	PBHCI	MACO	CCBHC
AL	☒	☐	☒	☐	☒	☐	☒	☐
AK	☒	☐	☒	☐	☐	☒	☐	☐
AZ	☒	☐	☐	☒	☐	☒	☐	☐
AR	☒	☒	☒	☒	☐	☐	☒	☐
CA	☒	☐	☒	☒	☐	☒	☒	☐
CO	☒	☒	☒	☒	☐	☒	☒	☐
CT	☒	☐	☒	☒	☐	☒	☐	☐
DE	☒	☐	☐	☒	☐	☐	☐	☐
FL	☒	☐	☒	☐	☐	☒	☐	☐
GA	☒	☐	☒	☐	☐	☒	☐	☐
HI	☐	☐	☒	☐	☐	☒	☐	☐
ID	☐	☐	☒	☒	☒	☐	☐	☐
IL	☒	☐	☒	☒	☐	☐	☒	☐
IN	☒	☐	☒	☐	☐	☒	☐	☐
IA	☒	☐	☒	☒	☒	☒	☒	☐
KS	☒	☐	☒	☐	☐	☐	☐	☐
KY	☒	☒	☒	☒	☐	☒	☐	☐
LA	☒	☐	☒	☐	☐	☒	☒	☐
ME	☒	☐	☒	☒	☒	☒	☒	☐
MD	☐	☐	☒	☒	☒	☒	☐	☐
MA	☒	☐	☒	☒	☐	☒	☒	☐
MI	☒	☐	☒	☒	☐	☒	☐	☐
MN	☒	☐	☒	☒	☐	☒	☒	☒
MS	☒	☐	☒	☐	☐	☐	☐	☐
MO	☒	☐	☒	☐	☒	☒	☐	☒
MT	☐	☐	☒	☒	☐	☐	☐	☐
NE	☒	☐	☒	☐	☐	☒	☐	☐
NV	☒	☐	☐	☒	☐	☐	☐	☒
NH	☒	☐	☒	☒	☐	☒	☐	☒
NJ	☒	☒	☒	☐	☐	☒	☒	☐
NM	☒	☐	☒	☒	☐	☒	☐	☒
NY	☒	☒	☒	☒	☒	☒	☒	☐
NC	☒	☐	☒	☐	☒	☒	☒	☐
ND	☐	☐	☒	☐	☐	☐	☐	☐
OH	☒	☒	☒	☒	☒	☒	☐	☐
OK	☒	☒	☒	☒	☐	☒	☐	☒
OR	☒	☒	☒	☒	☒	☒	☒	☒
PA	☒	☐	☒	☒	☐	☒	☐	☒
RI	☒	☐	☒	☒	☒	☒	☐	☐
SC	☒	☐	☒	☐	☐	☒	☐	☐
SD	☒	☐	☒	☐	☒	☐	☐	☐
TN	☒	☐	☒	☒	☐	☒	☐	☐
TX	☒	☐	☒	☐	☐	☒	☒	☐
UT	☐	☐	☐	☒	☐	☒	☒	☐
VT	☒	☐	☐	☒	☐	☐	☒	☐
VA	☒	☐	☒	☒	☐	☒	☐	☐
WA	☒	☐	☒	☒	☒	☒	☒	☐
WV	☒	☐	☒	☒	☐	☒	☐	☐
WI	☒	☐	☒	☒	☒	☒	☐	☐
WY	☐	☐	☒	☐	☐	☐	☐	☐
DC	☒	☐	☒	☒	☐	☒	☐	☐
PR	☐	☐	☐	☐	☐	☐	☐	☐

Quality Care and Patient-Centered Medical Home (PCMH)

Total	44	8	46	33	14	38	18	8

Quality Care and Patient-Centered Medical Home (PCMH)

Resources

- **NACHC Patient Centered Medical Home Institute** – Exists as organizational infrastructure support to strengthen state based infrastructure and partnerships that deliver on the Triple Aim of improved population health, patient and community engagement, and value.
  http://nachc.org/clinical-matters/clinical-quality/patient-centered-medical-home/

- **Institute for Healthcare Improvement** –Innovator, convener, partner, and driver of results in health and health care improvement worldwide. They partner with leaders and practitioners to improve health of individuals and populations through improvement capability, person and family centered care, patient safety, quality, cost and value, and triple aim for populations.
  http://www.ihi.org/about/Pages/default.aspx

- **Patient-Centered Primary Care Collaborative** – An advocacy organization that serves as a “driver of change,” educating and advocating for ideas, concepts, policies, and programs that advance the goals of high-performing primary care as the foundation of our health care system. Goal is to unify and engage diverse stakeholders in promoting policies and sharing best practices that support growth of high-performing primary care and the patient-centered medical home.
  https://www.pcpcc.org/about

- **MacColl Center for Health Care Innovation** – A research organization located within The Group Health Research Institute that shares its commitment to publicly available practical research. Works with health systems and funding agencies to develop new models of care, lead research on complex system change, and provide training, facilitation and technical assistance in model application and care improvement.
  http://maccollcenter.org/about-us

- **National Academy for State Health Policy –** NASHP is an independent academy of state health policymakers. It provides a forum for constructive work across branches and agencies of state government on critical health issues by: convening state leaders to solve problems and share solutions; conducting policy analyses and research; disseminating information on state policies and programs; and providing technical assistance to states.
  http://www.nashp.org/about-nashp/

- **Safety Net Medical Home Initiative –** Initiated in 2008, the Safety Net Medical Home Initiative was a five-year Patient-Centered Medical Home (PCMH) demonstration to help 65 primary care safety net sites in five states become high-performing medical homes and improve quality, efficiency and patient experience. Supported by The Commonwealth Fund, Qualis Health and the MacColl Center for Health Care Innovation at the Group Health Research Institute.
  http://www.safetynetmedicalhome.org/sites/default/files/Recap-1013.pdf