

Health Policy Issue Brief

Patient Centered Medical Home (PCMH)



Background

Over the past few decades, extraordinary improvements in health care have been made with numerous technological breakthroughs that save lives and improve quality of life. At the same time, the process whereby individuals receive their healthcare has become fragmented as patients often see numerous providers in the course of their care, utilize emergency departments for services, or are subject to numerous and/or unnecessary tests and interventions.

The Patient Centered Medical Home (PCMH) is a philosophy of care that aims to reduce fragmentation in the delivery of patient care. The PCMH seeks to coordinate all of the necessary health care services for a patient.

Policy makers are increasingly interested in the use of PCMHs to improve access, care management and patient outcomes. However, the challenge with PCMHs is determining how to align incentives between payers and primary care providers and encourage providers to allocate the resources necessary to implement procedures that achieve the goals of PCMH.

Aside from a small number of instances, the PCMH model does not often lead to near-term healthcare savings. As such, particularly during these times of economic hardship, states must recognize this challenge when implementing such models of care and therefore, implement practical payment arrangements. One such arrangement is the capitated payment model in which a state provides a specific amount of funding to an entity to manage all costs of comprehensive care. Such a payment system may lead to better coordination of care resulting in better outcomes and lower costs.

Interaction with Medicaid Health Plans

Across the nation, approximately 47% of Medicaid beneficiaries are enrolled in a Medicaid health plan, with other beneficiaries receiving fee-for-service (FFS) or primary care case management (PCCM) services. Medicaid health plans have a long track record of providing quality care to beneficiaries and being accountable for access, cost and quality. Such programs seek to improve access to coordinated health care services including preventive care and to control health care costs. The health plan monitors quality of care and implements preventive programs, thereby striving to improve access to care while more effectively controlling costs.

Recently-passed health-reform legislation included funding incentives for states to promote medical homes for the chronically ill in Medicaid. Effective implementation of the PCMH for Medicaid beneficiaries requires the expertise and support of Medicaid health plans. In fact, Molina Healthcare currently has a financial incentive program in place to help solo and small practice providers become National Committee for Quality Assurance (NCQA) certified PCMHs.

Provider organizations alone do not have data and operational management systems to evaluate total cost, fully manage financial risk or assess quality across the continuum of services. Partnerships between health plans, physicians, and other providers such as nurses, advance practice nurses, and care coordinators are essential to effective transformation of the health care system.

States should promote collaborations with Medicaid health plans and providers to develop and maximize the effectiveness of PCMH models, and should explicitly include Medicaid health plans in state strategies to implement PCMHs. It is also essential for states to establish performance and evaluation metrics to assess effectiveness of the PCMH in improving health outcomes of Medicaid beneficiaries.