

## The Patient-Centered Medical Home Frequently Asked Questions (FAQ)

### 1. What is a “patient-centered medical home” (PCMH)?

The [patient-centered medical home or PCMH](#) (sometimes referred to as *medical home*, or *advanced primary care*) is an innovation in health care delivery designed to improve patient experience, improve population health, and reduce the cost of care. Although its origins date back to 1967 (in pediatrics), the medical home concept has grown over the past decade, with nearly 500 public and private sector PCMH initiatives [being tracked across the United States](#).

*The five core attributes of the PCMH as defined by the Agency for Healthcare Research and Quality are:*

- ***Patient-centered:** The PCMH supports patients in learning to manage and organize their own care based on their preferences, and ensures that patients, families, and caregivers are fully included in the development of their care plans. It also encourages them to participate in quality improvement, research, and health policy efforts.*
- ***Comprehensive:** The PCMH offers whole-person care from a team of providers that is accountable for the patient’s physical and behavioral/mental health needs, including prevention and wellness, acute care, and chronic care.*
- ***Coordinated:** The PCMH ensures that care is organized across all elements of the broader health care system, including specialty care, hospitals, home health care, community services, and long-term care supports.*
- ***Accessible:** The PCMH delivers accessible services with shorter waiting times, enhanced in-person hours, 24/7 electronic or telephone access, and alternative methods of communication through health information technology (HIT).*
- ***Committed to Quality and Safety:** The PCMH demonstrates commitment to quality improvement and the use of data and health information technology (HIT) and other tools to assist patients and families in making informed decisions about their health.*

While most PCMH primary care practices strive to incorporate all of the attributes, the medical home is not a “one size fits all” framework. Each practice implements the attributes based on its own unique characteristics, such as: the size of the practice; the location (i.e. urban versus rural setting); the composition (solo/small practice, mid-size primary care practice, large multi-specialty practice, academic-affiliated practice, etc.); the patient population it serves (health status, other social & economic characteristics); whether financial or performance incentives are provided, etc.

### 2. How does a practice become a PCMH?

As a practice implements the PCMH framework – sometimes referred to as quality improvement “practice transformation” – they begin incrementally. The PCPCC strongly recommends that practices begin their practice transformation efforts in partnership with patients and/or family caregivers from the practice. Patients and families can be powerful partners in helping guide practice improvement by prioritizing strategies that will have significant impact on helping their practice become more person/family-centered.

Although there is variation in approach, most experts suggest that practices start by self-assessing their assets and gaps. For example, practices that have already implemented an electronic health record system would be

better positioned for PCMH transformation. After conducting their self-assessment, practices should then adopt structural and organizational leadership changes (facility, personnel, technology, engage with patient and family advisors); next, they should adopt workflow/process modifications (team building, efficiency of operations, care coordination); and as a result, they can make and assess process and outcome improvements (quality, cost, patient experience and clinician experience). The process is lengthy (estimates between 18 months to 3 years, depending on myriad factors) and requires a focus on continuous improvement and learning.

Many PCMH practices – but certainly not all – choose to become “certified” or “recognized” by an outside entity (national accrediting body, health plan, state agency). PCMH recognition programs vary in the amount of required documentation, application costs and overall efforts. This can enhance the practice’s ability to obtain increased reimbursement, if there are payers in their marketplace that offer it.

Although there are differences in terms of how each practice implements and measures the PCMH attributes, most PCMHs incorporate a team-based care approach, with clinicians and staff working at the top of their skill set. They provide care coordination that helps patients – especially vulnerable ones – navigate the “medical neighborhood” (specialists, hospitals, home health, other health care ancillary services) and increasingly connects them to community resources that support their health and well-being. While providing this type of advanced primary care, the practice focuses on enhanced trusted relationships with patients, families, and caregivers by keeping them at the center of this model.

### **3. Why are PCMHs (advanced primary care) so important?**

Improving and investing in primary care has become a major health policy objective because the cost of care in the U.S. health system is unsustainable – and its value is too often suspect. Over the last 30 years, the U.S. health care system has grown increasingly more fragmented, inefficient, and expensive. Notably, and not coincidentally, most countries with more efficient and effective systems prioritize primary care through more aligned payment and workforce policies.

For most Americans, primary care serves as the entry point and touchstone of the health care system, delivering and coordinating care for patients and families, with an emphasis on promoting population health and managing chronic illness. As such, primary care is well positioned to help repair and optimize our broken care delivery system. With greater investment in and support for comprehensive patient-centered primary care through the PCMH, we can more systematically promote Triple Aim outcomes of better care, smarter spending, and healthier people. We can also make a positive impact on the Quadruple Aim, which includes improving the satisfaction and “joy of practice” for primary care teams.

### **4. What is the Centers for Medicare & Medicaid Services (CMS) doing to help PCMH practices?**

As part of the Affordable Care Act, the Centers for Medicare and Medicaid Innovation (CMMI) is spearheading one of the most aggressive efforts in recent history to address delivery system reform. Numerous alternative payment models (APMs) are poised to support PCMH implementation and sustainability. Significant experimentation and testing of alternative payment arrangements is well underway, ranging from accountable care, to episode-based payment initiatives, to up-front payments that support primary care practice transformation, to initiatives that focus on specific populations, such as Medicaid, CHIP, or individuals dually eligible for Medicaid and Medicare. Multi-payer initiatives like the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration, the Comprehensive Primary Care (CPC) Initiative, and Comprehensive Primary Care Plus (CPC+) are learning how to best align local, regional, and national payer and provider interests in order to scale and spread best practices and to optimize both delivery and payment reform. Given increasing provider “measurement fatigue,” alignment of both payment and performance measurement across public and private payers is key to garnering support from primary care practices transitioning to these value-based payment models.

## **5. What does MACRA do to/for PCMHs?**

A much-heralded legislative achievement, the [Medicare Access and CHIP Reauthorization Act](#) (MACRA) is widely known for repealing the annual payment cuts required by the Medicare sustainable growth rate formula and reauthorizing the Children’s Health Insurance Program (CHIP). However, MACRA also shifts clinician reimbursement away from fee-for-service to value-based payments over a fixed time period and aligns performance measures – both important for PCMH financial sustainability.

As MACRA is implemented over the next four years, primary care practices should consider the payment pathway that best meets their patients’ needs. MACRA creates two new innovative payment pathways for PCMH, both of which acknowledge advanced primary care as critical to advancing system-wide transformation. In the Merit-based Incentive Payment System (MIPS) pathway, practices can maximize the score for their clinical practice improvement activities by becoming a PCMH (one of a four-part composite quality score to determine any annual bonus or penalty payment, in addition to fee-for-service payment). Under the APM pathway, practices that are certified as advanced PCMHs can qualify as an APM without having to put themselves at risk of financial loss (referred to as “two-sided risk arrangements” – with risk of earning and losing payment incentives). As MACRA is implemented, CMS will define PCMH certification for the purpose of payment incentives, making it urgent and important to have a unified vision of the PCMH model.

## **6. How does the medical home relate to accountable care organizations (ACOs)?**

Accountable care organizations (ACOs) are broadly defined as: “a group of health care providers who accept shared accountability for the cost and quality of care delivered to a population of patients.” Because of primary care’s central role in care coordination and patient engagement, ACOs require a strong primary care strategy in order to sustain their goals for population health improvement and lower total cost of care. ACOs typically provide more primary care services (lower cost care) and less acute care services (higher cost care) in hospitals and other settings.

As payment for primary care practices is fundamentally restructured to support value-based care, advanced primary care and medical homes must be recognized as foundational to ACOs and other integrated delivery reforms. This means explicitly rewarding primary care clinicians and their teams for meeting performance targets within ACOs, and ensuring that incentives are shared directly with practices and providers — and not just limited to the organization or health system.

## **7. What are other barriers/challenges to PCMHs?**

Even with the flexibility and additional resources available through some alternative payment models, practices still face several potential challenges when assuming the financial risk and accountability of a PCMH. These challenges include:

- The need for adequate and predictable payment together with appropriate risk adjustment, especially when caring for high-cost, high-need patients;
- Interoperable electronic health records, which are integrated with the primary care workflow, population health management tools, and other technology (such as telehealth for many rural and underserved practices, or mobile applications to connect with patients);
- Timely access to real-time, integrated data at the point of care; and
- Alignment across multiple payers for standardized cost, quality, performance, and meaningful patient experience metrics.

As the PCMH model continues to gain traction in both public and private markets, standardization and alignment of performance measures is becoming increasingly important to providers. Under the current fractured payment system, primary care practices submit claims to many different health plans and payers, and they express growing concern about new and differing requirements across payers that create confusion, financial risk, and administrative burden on their care teams.

**8. What are the limitations of the current definition of PCMH?**

Because of the variability in PCMH definition and certification in the public and private sectors, existing PCMH measures should be aligned to enhance our ability to evaluate PCMHs and understand which components of the model are most impactful. As part of Medicare payment reform implementation, the Centers for Medicare and Medicaid Services (CMS) will define and reward “certified” PCMH practices. Ultimately, certified PCMH recognition should be a “good housekeeping seal of approval” demonstrating achievement of the PCMH attributes, ensuring consumer confidence in the practice and its clinicians, and recognized practices should be rewarded with increased payment or other incentives. In the immediate term, because “medical home” is not well understood by the public, CMS has an important opportunity to unify around a clear PCMH definition and recognition process that offers measurable value and impact to patients, providers, and payers, as well as to researchers evaluating the model.

**9. What is the [Patient-Centered Primary Care Collaborative \(PCPCC\)/Patient-Centered Primary Care Foundation \(PCPCF\)](#)?**

For nearly a decade, the Patient-Centered Primary Care Collaborative (PCPCC) – a not-for-profit membership organization – has advocated a vision of an effective and efficient U.S. health system built on a strong foundation of primary care and the PCMH. The PCPCC’s mission is to serve as the unifying voice of advanced primary care to improve delivery and payment systems. We do this by convening diverse stakeholders — including patients, providers, payers, and many other interested partners; communicating timely and accurate information to key influencers and the public; and advocating and educating about priority issues that show promise in improving health care delivery for all stakeholders. The PCPCC achieves its mission through the work of its [executive members](#), [Stakeholder Centers](#), experts, and thought leaders focused on key issues of delivery reform, payment reform, patient and family/caregiver engagement, and benefit redesign to drive health system transformation.