Patient Centered Medical Home (PCMH)

Patient Centered Medical Home SPECIFIC PROGRAM / ACTIVITY FACTS

Patient Centered Medical Home (PCMH), a medical home model of care, offers a way to improve health care by transforming how primary care is standardized and delivered. The medical home model of care is based on the following core principles:

- Comprehensive Health Care directed by the patient's personal provider;
- Team-based, ongoing patient-centered care;
- Care Coordination across the health system using information technology;
- Enhanced Access through expanded hours, new communication methods, or alternative visits; and
- Quality and Safety through evidence-based medicine, quality improvement, and performance measurement.

Providers: The program began in 2014 with 5 providers. Practices must maintain PCMH recognition by the National Committee for Quality Assurance (NCQA). As of November 2022, there are 25 practices enrolled in the program.

Reimbursement: Providers are reimbursed risk-stratified, per-member-per-month (PMPM) care management fees. Members are assigned a health risk score and assigned to one of three tiers based on their medical risk using diagnoses and claims history. The care management fee amount corresponds to the risk-tier level. The costs below are for SFY 2022.

- Tier per member per month rate:
  - Tier One: $3.33.
  - Tier Two: $9.33.
  - Tier Three: $15.33.

- PCMH providers report quality measures annually to the Department. Medicaid merges claims data with the providers' clinical data for each measure to determine performance rates for each measure. The quality measures include preventive services and utilization elements.

Complex Care Management Tier also known as Tier 4: PCMH providers have the option to participate in the Complex Care Management tier. Complex Care Management (CCM) is designed to partner with Patient Centered Medical Home (PCMH) providers to reduce costly services for Medicaid members with high utilization of emergency department and hospital visits that might be prevented by less costly primary care interventions. A CCM team works to improve the member's health by focusing on both medical and social factors impacting their health. Providers are reimbursed $470.10 per member per month for member's enrolled in the program.

A PCMH provider's CCM team must:

- Include a nurse and a Licensed Behavioral Health Professional or a paraprofessional with at least 40 hours of behavior health training;
- Meet face-to-face with the member in their home or other non-clinic location approved by the member to determine the member's health care needs;
- Meet with the member at least weekly for the first three months and biweekly for the remaining three months; and
- Provide services to no more than 30 members at one time.

Members must meet specific requirements to be enrolled in the program including being attributed to the provider's PCMH clinic, having two or more chronic medical conditions, have had two or more ER visits in the last 60 days or 2 or more inpatient stays for the same reason in the last 6 months. Members cannot be enrolled in the CCM program for more than 6 months without Department approval.

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