

Three State Approaches to Patient-Centered Medical Homes:

Advancing Primary Care Innovation in Medicaid Managed Care

CHCS Center for
Health Care Strategies, Inc.

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Advancing Primary Care Innovation in Medicaid Managed Care: A State Toolkit

This module is part of ***Advancing Primary Care Innovation in Medicaid Managed Care: A State Toolkit***, which was created to help states leverage their managed care contracts and request for proposals to advance innovation in primary care.

The two-part toolkit outlines strategies to support states in: (1) defining primary care priorities and advancing core functions; and (2) achieving primary care innovation goals through managed care contractual levers.

To view the full toolkit, visit www.chcs.org/primary-care-innovation.

One common state strategy for expanding primary care practice capabilities is supporting Patient-Centered Medical Homes (PCMH) implementation. The medical home is a care delivery model aimed at providing patient-centered, accessible, coordinated, and comprehensive primary care with a commitment to quality improvement.¹ These foundational primary care elements can be opportune building blocks for states interested in incenting more advanced provider capabilities.

While many states have adopted PCMH models, the Center for Health Care Strategies (CHCS) collected information about three state PCMH programs that go beyond primary care basics and promote enhanced care delivery transformation. This PCMH analysis explores how **New York, Ohio, and Oregon's** PCMH requirements go beyond the NCQA's 2017 PCMH standards, one of the most widely adopted PCMH models, to address the following high-quality primary care attributes:²

1. Integration of primary health care with public health, social services, and behavioral health;^{3, 4, 5}
2. Proactive patient and family engagement to address physical, social, and cultural barriers to care;^{6, 7, 8}
3. Mobile or digital health;^{9, 10, 11, 12, 13, 14}
4. Active use of data to manage and improve patient care and system performance;^{15, 16, 17}
5. Geographic empanelment, including appropriate risk stratification and targeting;^{18, 19}
6. Multidisciplinary teams with community health workers;^{20, 21, 22} and
7. Medical home capabilities as a foundation.^{23, 24, 25}

The following analysis also describes how states leverage Medicaid managed care for implementation, as well as specific payment methods used to reimburse PCMHs.

Overall, CHCS found that all three state programs have standards that go beyond NCQA PCMH behavioral health (BH) core requirements. For example, these three state programs include additional BH screening requirements, coordination standards, and quality metrics. These programs also include a number of advanced patient engagement capabilities such as training staff on cultural competence, meeting patient language needs, and requiring care plan elements beyond baseline NCQA PCMH requirements. However, these programs have fewer advanced requirements related to mobile health, use of data, geographic empanelment, and multidisciplinary teams, suggesting areas for future development.

The table on the following pages is a CHCS analysis of how state PCMH requirements compare to NCQA PCMH 2017 requirements, not a comprehensive description of state PCMH programs.²⁶ State standards that are optional or similar to NCQA core requirements are not listed. The crosswalk does list standards that are required by state programs but optional ("elective") under NCQA PCMH 2017.



New York	Oregon	Ohio
Overview of approach		
<p>The New York State Department of Health, in collaboration with NCQA, developed the New York State Patient-Centered Medical Home (NYS PCMH), which builds off the NCQA PCMH model.</p> <ul style="list-style-type: none"> ■ In 2017, NYS transitioned its model of advanced primary care from Advanced Primary Care (APC) to NYS PCMH.²⁷ ■ NYS PCMH converts 12 ‘Elective’ NCQA criteria into ‘core’ (required) criteria, in the areas of behavioral health, care coordination, Health IT, and VBP. NCQA reviews practice documentation and determines recognition status.²⁸ ■ The NY PCMH program covers initial provider costs for recognition and provides technical assistance through a SIM award.²⁹ ■ Participating practices are eligible for enhanced reimbursement under the Medicaid PCMH Incentive Program.³⁰ This program was created through 2009 legislation and CMS approved a related state plan amendment (SPA) in 2010.^{31, 32} ■ Selected practices are also eligible for enhanced reimbursement (typically via PMPM payments or pay-for-performance [P4P] arrangements) from commercial health plans participating in Regional Oversight Management Committees (ROMC).³³ 	<p>Oregon Health Authority (OHA) administers the Patient-Centered Primary Care Home Program (PCPCH), which is integrated into its broader CCO program.</p> <ul style="list-style-type: none"> ■ The PCPCH program was created through 2009 legislation.³⁴ ■ PCPCH requirements have some alignment with the NCQA PCMH model — in some cases, recognized NCQA PCMH clinics in Oregon may submit an abbreviated PCPCH application.³⁵ ■ PCPCH clinics are recognized at five different tiers. All practices must meet the 11 must-pass standards and select optional standards. To be recognized at the highest tier (5-STAR), practices must also meet 11 out of 13 specified measures. OHA reviews practice applications and determines recognition status.³⁶ ■ CCOs must include PCPCHs in their networks and PCPCH enrollment is a CCO quality measure.^{37, 38} 	<p>The Governor’s Office of Health Transformation and the Ohio Department of Medicaid developed the Comprehensive Primary Care (Ohio CPC) program, which closely aligns with Medicare’s CPC+ program.³⁹</p> <ul style="list-style-type: none"> ■ Ohio CPC was developed through a SIM award and implemented under existing Medicaid authority. CMS approved a CPC SPA in 2018.^{40, 41, 42} ■ Ohio CPC practice requirements are similar to CPC+ requirements, though payment streams differ.⁴³ To enroll in the program, practices submit application to Ohio Medicaid. Ohio Medicaid works with a vendor to conduct program monitoring.^{44, 45} ■ Practices are compensated for PCMH activities and cost and quality performance.⁴⁶ ■ Previously, Ohio CPC eligibility criteria included national accreditation or CPC+ participation. OH removed these requirements in 2019.^{47, 48}

New York	Oregon	Ohio
Attribute 1: Integration of primary health care with public health, social services, and behavioral health		
<p>NYS PCMH requires that practices:</p> <ul style="list-style-type: none"> ■ Screen for alcohol use disorder and SUD. ■ Set expectations for information exchange for BH referrals.^{49, 50} 	<p>PCPCH requires that practices:</p> <ul style="list-style-type: none"> ■ Screen for BH conditions, including SUD. <p>PCPCH 5-STAR Criteria include:</p> <ul style="list-style-type: none"> ■ PCPCH has a cooperative referral process with specialty mental health, substance abuse, and developmental providers. ■ PCPCH provides integrated BH services, including population-based, same-day consultations by behavioral health providers. ■ PCPCH tracks referrals and cooperates with community service providers outside the PCPCH.^{51, 52, 53} 	<p>Ohio CPC requires that practices:</p> <ul style="list-style-type: none"> ■ Employ care management strategies and plans that support integration of BH.^{54, 55} <p>Additionally, the CPC quality and efficiency measure set includes:</p> <ul style="list-style-type: none"> ■ Antidepressant medication management; ■ Follow up after hospitalization for mental illness; ■ Tobacco screening and cessation intervention; ■ Initiation of alcohol and other drug dependence treatment; and ■ Behavioral health-related inpatient admits per 1,000.^{56, 57}
Attribute 2: Proactive patient and family engagement to address physical, social, and cultural barriers to care		
<p>NYS PCMH requires that practices:</p> <ul style="list-style-type: none"> ■ Address disparities in care. ■ Educate staff on health literacy or cultural competence.^{58, 59} 	<p>PCPCH requires that practices:</p> <ul style="list-style-type: none"> ■ Offer providers who speak a patient/family's language or telephonic trained interpreters.⁶⁰ <p>PCPCH 5-STAR Criteria include:</p> <ul style="list-style-type: none"> ■ PCPCH develops written care plan for patients with complex medical or social concerns. Plans should include at least self-management goals, goals of care, and action plan for exacerbations of chronic illness. ■ PCPCH translates written patient materials into all languages spoken by more than 30 households or 5% of the practice's patient population. ■ Assess patient experience through CAHPS survey and use data in quality improvement process.^{61, 62, 63} 	<p>Ohio CPC requires that practices:</p> <ul style="list-style-type: none"> ■ Create and provide care plans to high-risk patients that include patient preferences, functional/lifestyle goals, potential barriers to meeting goals, and self-management plans.^{64, 65}
Attribute 3: Mobile or digital health		
<p>NYS PCMH requires that practices have a system for two-way electronic communication between the practice and patients.^{66, 67}</p>	<p>No requirements.</p>	<p>No requirements.</p>

New York	Oregon	Ohio
Attribute 4: Active use of data to manage and improve patient care and system performance		
<p>NYS PCMH requires that practices:</p> <ul style="list-style-type: none"> ■ Exchange data with the State Health Information Network for New York (SHIN-NY) that supports management of complex patients.⁶⁸ NYS provides funding through SIM for participating practices to connect to the SHIN-NY.^{69,70} ■ Use a certified electronic health record system.⁷¹ 	No requirements.	No requirements. Participating practices receive attribution, performance, and referral reports. The referral report provides provider performance and patient activity information for select episodes of care. ⁷²
Attribute 5: Geographic empanelment, including appropriate risk stratification and targeting		
NYS PCMH requires that practices have a comprehensive risk stratification process. ^{73, 74}	No requirements.	<p>Ohio CPC requires that practices use risk stratification from payers and other available data to stratify patients and integrate risk status into health records and care plans.^{75, 76, 77}</p> <p>In cases where attribution cannot be determined based on patient choice or claims, geography may be a factor for determining attribution.⁷⁸</p>
Attribute 6: Multidisciplinary teams with community health workers		
No requirements beyond NCQA PCMH Recognition.	No requirements.	No requirements.
Attribute 7: Medical home capabilities as a foundation		
NYS PCMH builds off the NYS APC and the NCQA PCMH model. NYS PCMH converts 12 'elective' NCQA criteria into 'core' (required) criteria (as described in "Attribute 1-6" rows above, and "other required standards" row below). ⁷⁹	Oregon includes required and optional standards similar to NCQA PCMH standards. Oregon's PCPCH program organizes standards into the domains of access to care, accountability, comprehensive whole-person care, continuity, coordination and integration, and person and family centered care. ^{80, 81}	<p>Ohio CPC includes many requirements similar to NCQA PCMH and CPC+ standards. Ohio CPC organizes standards into the domains of access to care, risk stratification, population health management, team-based care, care management, follow up after hospital discharge, test and specialist referrals, and patient experience.^{82,83}</p> <p>Previously, participating practices were required to have either national accreditation or participate in CPC+. For 2019, OH has removed these requirements.^{84,85}</p>

New York	Oregon	Ohio
Other required standards beyond NCQA PCMH core criteria		
<p>NYS PCMH requires that practices:</p> <ul style="list-style-type: none"> ■ Provide continuity of medical record information when the office is closed; ■ Make care plans accessible across settings of care; ■ Obtain patient discharge summaries; ■ Set expectations for information exchange for specialist referrals; and ■ Engage in an up-side risk contract.^{86,87} 	<p>PCPCH requires practices to:</p> <ul style="list-style-type: none"> ■ Track at least one quality measure from the PCPCH quality measure set;⁸⁸ ■ Report they routinely offer comprehensive preventive and medical services; ■ Have a written agreement with hospital providers or provide routine hospital care;⁸⁹ and ■ Coordinate hospice and palliative care, and counseling. <p>PCPCH 5-STAR criteria require practices to:</p> <ul style="list-style-type: none"> ■ Develop a clinic-wide improvement strategy;⁹⁰ ■ Meet a benchmark for percent of patient visits with assigned clinician or team;⁹¹ ■ Define care coordination roles for care team members and tell patients/family the name of the team member responsible for their care coordination; and ■ Exchange information and coordinate care with specialized settings.^{92, 93, 94} 	<p>Ohio CPC requires that practices:</p> <ul style="list-style-type: none"> ■ Provide continuity of medical record information when office is closed;⁹⁵ ■ Coordinate with managed care plans for population health and care management; ■ Ask about self-referrals and request reports from clinicians; and ■ Obtain patient discharge summaries.^{96, 97, 98}
Payment method		
<p>Practices with NCQA PCMH 2014 Level 3 Recognition, NCQA PCMH 2017 Recognition, or NYS PCMH Recognition (NCQA 2017 + 12 addition 'Core' requirements) are eligible to receive incentive payments through the Medicaid PCMH Incentive Program, effective July 1, 2018:</p> <ul style="list-style-type: none"> ■ Medicaid Managed Care \$6 PMPM. ■ FFS incentive payment add-on amounts of \$29.00 and \$25.25 for professional and institutional claims respectively, available for qualified evaluation and management codes.⁹⁹ <p>Select practices that are recognized as NYS PCMH can receive enhanced reimbursement through commercial payers that participate in three ROMCs. While the payment arrangements vary from ROMC to ROMC, they typically include either a PMPM or P4P.¹⁰⁰</p>	<p>CCOs are required to implement value-based payments and prioritize implementing alternative payments and incentives for PCPCHs.¹⁰¹</p> <ul style="list-style-type: none"> ■ In 2016, all CCOs allocated at least 31% of primary care spending to non-claims-based payment, which include: payments to incent efficiency or quality, payments for patient-centered medical homes, or payments to improve provider capacity and infrastructure.¹⁰² ■ Starting in 2020, CCOs will be required to provide PMPM payments to PCPCH clinics, as a supplement to any other payments, in order to support development of infrastructure and operations for PCPCHs.¹⁰³ 	<p>CPC practices may be eligible for two payment streams in addition to existing payment arrangements:</p> <ul style="list-style-type: none"> ■ PMPM payment, to support CPC activity requirements. PMPM amounts are based on risk tiers (Tier 1-\$1.80, Tier 2- \$8.50, Tier 3- \$22).¹⁰⁴ ■ Shared savings payment, based on achieving total cost of care savings (available to practices or practice partnerships with at least 60,000 member months over the performance period).^{105, 106} ■ To be eligible for PMPM and shared savings payments, practices must pass 50% of applicable quality and efficiency metrics.¹⁰⁷

New York	Oregon	Ohio
Managed care implementation		
<ul style="list-style-type: none"> Enhanced PCMH payments are distributed to providers through Medicaid MCOs for managed care members.¹⁰⁸ 	<ul style="list-style-type: none"> CCOs are required to enroll a significant percentage of members in PCPCHs. CCOs are required to have a plan to increase the number of enrollees served by PCPCHs and assist providers in achieving higher PCPCH tiers.¹⁰⁹ State law requires CCOs to allocate at least 12% of health care expenditures to primary care by 2023.¹¹⁰ PCPCH enrollment is one of the 19 CCO quality measures used to determine reward payments out of 'quality pool' funds. The PCPCH enrollment measure is based on percentage of CCO membership enrolled in a PCPCH, with higher tier PCPCHs weighted more heavily.^{111, 112} 	<ul style="list-style-type: none"> CPC PMPM and shared savings payments are distributed to practices through Medicaid managed care plans (MCPs) for managed care members.¹¹³ MCPs are required to coordinate with and support CPC practices in implementing CPC activities. This includes activities such as member outreach and data sharing.¹¹⁴

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About this Resource

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About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and community-based organizations to develop innovative programs that better serve beneficiaries of publicly financed care, especially those with complex, high-cost needs. To learn more, visit www.chcs.org.

ENDNOTES

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- ⁵⁶ Ohio Department of Medicaid. "Quality Metrics." Comprehensive Primary Care Program. Available at: <https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/CPC/qualityMetricSpecs.pdf>
- ⁵⁷ Ohio Department of Medicaid. "Overview of CPC efficiency metrics." Available at: <https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/CPC/efficiencyMetricSpecs.pdf>
- ⁵⁸ These competencies are optional under NCQA PCMH.
- ⁵⁹ National Committee for Quality Assurance. "NYS PCMH Standards and Guidelines." Op. cit.
- ⁶⁰ NCQA PCMH only requires practices to assess language needs of their population.
- ⁶¹ NCQA PCMH has less advanced requirement related to meeting language needs. NCQA PCMH requires practices to assess language needs of their population and has an optional standard related to tailoring patient materials to communication needs.
- NCQA has similar, but less extensive, requirements related to care plan development, and collection of patient experience data. NCQA PCMH standards require that practice develop care plans, but inclusion of a self-management plan is optional. NCQA requires similar collections and use of patient experience data but use of a standardized survey tool is optional.
- ⁶² Oregon Health Authority. "2017 PCPCH Standards - NCQA PCMH 2017 Standards – Crosswalk." Op. cit.
- ⁶³ Oregon Health Authority. "Patient-Centered Primary Care Home Program 2017 Recognition Criteria Technical Specifications and Reporting Guide." Op. Cit.
- ⁶⁴ Ohio Department of Medicaid. "Ohio 2019 CPC Activity Requirements." Op. cit.
- ⁶⁵ Ohio Department of Medicaid. "Overview of CPC activity requirements". Op. cit.
- ⁶⁶ These competencies are optional under NCQA PCMH.
- ⁶⁷ National Committee for Quality Assurance. "NYS PCMH Standards and Guidelines." Op. cit.
- ⁶⁸ This competency is optional under NCQA PCMH.
- ⁶⁹ This competency is optional under NCQA PCMH.
- ⁷⁰ Email exchange with New York State Department of Health staff, May 9, 2019
- ⁷¹ National Committee for Quality Assurance. "NYS PCMH Standards and Guidelines." Op. cit.
- ⁷² Ohio Governor's Office of Health Transformation. "How to Read Your Ohio CPC Referral Reports." August 2017. Available at: <https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/CPC/How-to-Read-CPC-Referral-Reports.pdf?ver=2017-08-07-134242-633>
- ⁷³ This competency is optional under NCQA PCMH.
- ⁷⁴ National Committee for Quality Assurance. "NYS PCMH Standards and Guidelines." Op. cit.
- ⁷⁵ This requirement is similar to an optional NCQA PCMH criterion.
- ⁷⁶ Ohio Department of Medicaid. "Ohio 2019 CPC Activity Requirements." Op. cit.
- ⁷⁷ Ohio Department of Medicaid. "Overview of CPC activity requirements". Op. cit.
- ⁷⁸ Ohio Governor's Office of Health Transformation. "Ohio Comprehensive Primary Care (CPC) Practice Webinar #1: Attribution and Payment". February 6, 2018. <https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/CPC/PPW-AttPayment%20.pdf?ver=2018-02-06-143337-287>
- ⁷⁹ National Committee for Quality Assurance. "NYS PCMH Standards and Guidelines." Op. cit.
- ⁸⁰ Oregon Health Authority. "2017 PCPCH Standards - NCQA PCMH 2017 Standards – Crosswalk." Op. cit.
- ⁸¹ Oregon Health Authority. "Patient-Centered Primary Care Home Program 2017 Recognition Criteria Technical Specifications and Reporting Guide." Op. Cit.
- ⁸² Ohio Department of Medicaid. "Ohio 2019 CPC Activity Requirements." Op. cit.
- ⁸³ Ohio Department of Medicaid. "Overview of CPC activity requirements". Op. cit.
- ⁸⁴ Ohio Department of Medicaid. "2019 Ohio CPC Eligibility Requirements." Op. cit.

⁸⁵ Ohio Department of Medicaid. "Eligibility Requirements 2018." Op. cit.

⁸⁶ These competencies are optional under NCQA PCMH.

⁸⁷ National Committee for Quality Assurance. "NYS PCMH Standards and Guidelines." Op. cit.

⁸⁸ NCQA PCMH requires practices to track quality measures from certain categories, but does not require selection from a defined measure set.

⁸⁹ NCQA PCMH requires coordination but not a written agreements with hospitals.

⁹⁰ NCQA PCMH has quality improvement criteria but does not require a comprehensive strategy to guide multiple QI projects.

⁹¹ NCQA PCMH has a similar criteria but does not require practices to meet a benchmark.

⁹² This competency is optional under NCQA PCMH.

⁹³ Oregon Health Authority. "2017 PCPCH Standards - NCQA PCMH 2017 Standards – Crosswalk." Op. cit.

⁹⁴ Oregon Health Authority. "Patient-Centered Primary Care Home Program 2017 Recognition Criteria Technical Specifications and Reporting Guide." Op. Cit.

⁹⁵ This competency is optional under NCQA PCMH.

⁹⁶ This competency is optional under NCQA PCMH.

⁹⁷ Ohio Department of Medicaid. "Ohio 2019 CPC Activity Requirements." Op. cit.

⁹⁸ Ohio Department of Medicaid. "Overview of CPC activity requirements". Op. cit.

⁹⁹ New York State Department of Health. "2018-2019 Enacted Budget Initiative: Patient Centered Medical Home Statewide Incentive Payment Program: Revised Incentive Payments and Updated Billing Guidance." New York State Medicaid Update, April 2018, Volume 34, Number 4. Available at: https://www.health.ny.gov/health_care/medicaid/program/update/2018/2018-04.htm#pcmh

¹⁰⁰ Email exchange with New York State Department of Health staff, May 9, 2019

¹⁰¹ Health Plan Services Contract, Coordinated Care Organization Contract # 143115-10 with Health Share of Oregon, p.89. Oregon Health Authority, Effective January 1, 2018. Available at: <https://multco.us/file/69710/download>

¹⁰² Oregon Health Authority and Department of Consumer and Business Services. "Primary Care Spending in Oregon: A Report to the Oregon State Legislature." February 2018. Available at: <https://www.oregon.gov/oha/HPA/CSI-PCPCH/Documents/SB-231-Report-2018-FINAL.PDF>

¹⁰³ CCO 2.0 Request for Applications, RFA OHA-4690-19, Attachment 8 — Value-Based Payment Questionnaire. Oregon Health Authority, January 25, 2019. Available at: <https://www.oregon.gov/oha/OHPB/CCODocuments/07-CCO-RFA-4690-0-Attachment-8-VBP-Questionnaire-Final.pdf>

¹⁰⁴ Ohio Department of Medicaid. "Ohio Comprehensive Primary Care (CPC) Program Per-Member-Per-Month (PMPM) Payment Definition and Methodology." Available at: <https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/CPC/PMPM-definition.pdf>

¹⁰⁵ Ohio Department of Medicaid. "What is Ohio CPC?" Available at: <https://medicaid.ohio.gov/provider/PaymentInnovation/CPC#1657109-cpc-requirements>

¹⁰⁶ Ohio Department of Medicaid. "Total cost of care definition and methodology." Available at: <https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/CPC/SharedSavingsMethodology.pdf?ver=2017-12-12-101215-823>

¹⁰⁷ Governor's Office of Health Transformation. "Thresholds for CPC quality and efficiency metrics." Available at: <https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/CPC/Thresholds.pdf?ver=2016-12-21-132914-243>

¹⁰⁸ Medicaid Managed Care/Family Health Plus/HIV Special needs Plan/Health and Recovery Plan Model Contract. Division of Health Plan Contracting and Oversight, Office of Health Insurance Programs, New York State Department of Health, effective March 1, 2014, as amended October 1, 2015. Available at: https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf

¹⁰⁹ Health Plan Services Contract, Coordinated Care Organization Contract # 143115-10 with Health Share of Oregon, op. cit, p. 76.

¹¹⁰ J. Vandehey and S. Jarem. "The future of coordinated care in Oregon: Introductory Webinar". Op. cit.

¹¹¹ Oregon Health Authority. "2019 CCO Incentive Measure Set". July 2018. <https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2019-Incentive-Measures.pdf>

¹¹² Health Plan Services Contract, Coordinated Care Organization Contract # 143115-10 with Health Share of Oregon, op. cit, p. 126-129.

¹¹³ Ohio Department of Medicaid. "CPC Payments." Available at: <https://medicaid.ohio.gov/provider/PaymentInnovation/CPC#1657108-cpc-payments>.

¹¹⁴ Ohio Medical Assistance Provider Agreement for Managed Care Plan, pp.136-139. The Ohio Department of Medicaid, July 2018. Available at: <https://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/Provider%20Agreements/ManagedCare-PA-201807.pdf>