Connecticut Health Policy Project

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FAQs about patient-centered medical homes in CT

As part of discussions about national health reform in Connecticut and SustiNet, questions have been raised about Patient-Centered Medical Homes.

What is a Patient-Centered Medical Home?

Currently, health care for each patient is delivered by a variety of providers in a variety of settings paid separately for each service they deliver. There is no incentive to share information, reduce duplications, or coordinate care. This lack of coordination is inefficient, one of the main drivers of skyrocketing health care costs, and compromises patient safety.

Patient Centered Medical Homes (PCMHs) are not buildings or hospitals, but a different way of delivering care. PCMHs offer coordinated, comprehensive primary health care that is accessible, continuous, compassionate and culturally appropriate. Care is delivered and coordinated by a team of professionals, all working at the top of their license and training, using the best technology tools to save time, money and keep patients well. Care is coordinated with specialists, hospitals, labs and pharmacies, avoiding duplicate care and preventing errors. PCMHs offer extended hours keeping patients with routine problems out of crowded and expensive emergency rooms. PCMHs give patients the information and support they need to manage their own care and stay healthy. PCMHs support primary care providers with resources and funding, making practice more attractive and easing our impending primary care shortage.

Do Patient-Centered Medical Homes save money?

There is growing evidence that PCMHs save money, while improving the quality of care – an irresistable opportunity for states. A recent comparison of seven large, mature PMCH programs across the US found annual savings between $71 and $503/patient. Extrapolated to all the state's coverage groups, potential savings could reach $300 million/year or more. The study also found that emergency room visits were reduced by as much as 20% and hospitalizations by 5 to 40%.[i]

Does Connecticut have any Patient-Centered Medical Homes?

Yes, we currently have 82 PCMHs that have completed an exhaustive certification process by the National Committee for Quality Assurance (NCQA, www.ncqa.org), the leading national standard-setting authority in the nation. Six months ago, Connecticut had no recognized PCMHs and many more practices are in the process of applying for recognition. NCQA recognition involves exhaustive documentation that each practice meets 149 standards including access and continuity of care, ability to track and coordinate care, patient self-care and community support, population health management, and performance measurement and improvement.

Connecticut's state employee plan has embarked on a PCMH pilot with ProHealth, a large primary care practice, to bring coordinated care to thousands of members. The program will expand to new practices soon and eventually reach all 200,000 plan members. Connecticut's Medicaid program has had a PCMH-related option for two years, Primary Care Case Management, which has struggled to meet enrollment expectations due to inadequate support from DSS. The new administration has announced plans to expand this program to all 600,000 Medicaid recipients in our state as soon as possible.

Despite the momentum, Connecticut lags far behind neighboring states in the number of PCMHs available to residents. However other states' success makes it clear that Connecticut can greatly expand the number of recognized PCMHs; we can learn from other states' experiences.

NCQA recognized patient-centered medical homes (as of 3/9/11)	
Connecticut	82
New York	3,069
Rhode Island	324
Massachusetts	211
Vermont	130
New Hampshire	252
New Jersey	244
Maine	359
Pennsylvania	1,001
US total	11,191

Is there funding for Patient-Centered Medical Homes in federal health reform?

Yes, the Affordable Care Act (ACA) includes several funding opportunities for states to support PCMHs. The current administration has signaled their intention to apply for the health home Medicaid option that provides 90% federal matching funds to states for two years for care coordination services for people with chronic conditions. This funding is mandatory in the federal law and unlikely to be subject to ACA defunding efforts.

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[i] D. Fields et. al., Driving Quality Gains and Cost Savings through Adoption of Medical Homes, Health Affairs 29:819-826, 2010.