

Supporting the Patient Centered Medical Home in Medicaid and SCHIP: Savings and Reimbursement

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A significant number of people in the United States do not have access to high quality, point-of-entry primary care.¹ For those with access to primary care, the health care system does not encourage primary care providers to develop relationships with them, and, when appropriate, their families, to better address the complete array of their health issues.

Availability of primary care is particularly limited for low-income individuals and members of racial and ethnic minorities – people who are disproportionately likely to be in poor health and least likely to have a dependable source of health care.² Substantial evidence indicates that access to a medical home – defined as timely, well-organized care with enhanced access to providers – can reduce or eliminate racial and ethnic disparities in health outcomes.³

At the same time, there is a growing reluctance on the part of medical school graduates and interns to enter the field of primary care. In fact, from 1997 to 2005, the number of medical school graduates who chose to become primary care physicians decreased by 50 percent.⁴

Increasingly, private and public payers are interested in developing models that better support the provision of effective, patient-centered primary care, including the Patient Centered Medical Home (PCMH) model. In the PCMH model, care teams attend to the multi-faceted needs of patients, and provide whole person, patient centered care. The four major primary care physician groups – American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, American Osteopathic Association – as well as national employers, health plans, and others agree that the PCMH model is a way to address the diminishing role primary care plays in our health system.

This *State Health Policy Briefing* explains the PCMH model and explores reimbursement strategies states are using to help medical practices become medical homes. It is the first in a series of four briefs that will explore different categories of policies that states can use to support improved delivery of primary care.

Defining the Patient Centered Medical Home

First advanced by the American Academy of Pediatrics (AAP) in the 1960s, the concept of the medical home is one that evolved as a site where children with special health care needs (CSHCN) could receive a unique brand of continuous and comprehensive care. The idea was conceived in response to the notion that “care for CSHCN is often provided

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