Questions about national vs. Connecticut-specific standards for patient-centered medical homes

Below are some things we've heard about the decision whether to keep using national standards to certify PCMHs or develop a Connecticut-specific certification standard, and some information related to those statements.

1. **"Connecticut's SIM plan is to make standards higher than NCQA[i] and other national standards"**
    a. Minutes of early SIM[ii] meetings tell a different story -- that the purpose was to allow for a less rigorous standard (see minutes of June 24, and July 8, 2013 SIM Care Management Committee meetings).
    b. But if this is really the goal, Connecticut could easily make additional parts of NCQA's program "must pass" or add state-specific standards on top of NCQA' ("NCQA plus"). Many states make these changes and NCQA staff are happy to help with that.
    c. In fact, NCQA is working with New York to create a new school-based health center PCMH certification.

2. **"The expense of getting certified isn't worth it for practices"**
    a. It costs $2,280 for a Connecticut practice of five for NCQA PCMH certification that lasts three years.
    b. In 2012, the average Connecticut Medicaid PCMH averaged $150,000 in higher reimbursements, far more than the NCQA cost.
    c. The number of Connecticut providers applying for NCQA PCMH certification is up substantially this year over last.
    d. The state could reimburse practices directly for recognition expenses. The Health Services and Resources Administration (HRSA) does this for Federally-Qualified Health Centers. This cost – along with the cost to procure support for practices to transform, which is critical – could be easily built into the SIM budget.
    e. DSS and CHN have had great success in getting primary care providers to sign up as PCMHs for Connecticut Medicaid under the NCQA standards. As of May 8th there were 1,193 individual providers with NCQA certification in Connecticut's Medicaid program.
    f. No providers have objected to the NCQA standards as a reason not to join the Connecticut Medicaid PCMH program.

3. **"It takes a lot of administrative time and can be disruptive to transform into a PCMH"**
    a. Right, that's the point- to "transform" practices.
    b. PCMH practices have to be open beyond usual business hours, have to track referrals, arrange appointments and transportation, among other PCMH functions.
    c. SIM can provide assistance to practices to help them transform to a PCMH, as Connecticut's Medicaid program does through the glide path.
    d. CHN[iii] reports that virtually no Connecticut Medicaid practices which begin the PCMH certification process through the glide path fail to follow through to full certification.

4. **"Some doctors report that nothing changed when their practice transformed; other doctors report that some PCMH practices aren't doing anything differently – they filed the paperwork but nothing changed"**
    a. Hard to reconcile with #3 above, but . . .
    b. We've heard from many doctors who've transformed into a PCMH and report substantial, very valuable changes – it was challenging, but worth it.
    c. Depending on how a practice operates, some doctors may not directly experience the changes of becoming a PCMH. Other members of the team are making the reminder calls, arranging transportation, and getting lab results. Doctors may not see any of this, but practice managers and other members of the team will see the difference, and it matters to **patients.**
    d. We may not be sure what is in the "secret sauce" of PCMH transformation, but the difference is seen in the better health outcomes inside PCMHs vs. non-PCMH practices, as in Connecticut's own recent experience in the Medicaid program. And that's all that matters.

5. **"Lots of practices provide PCMH functions but just don't have the certification"**
    a. That's great, but if they want the extra financial rewards, they have to prove their value with certification. The whole point of SIM and payment reform is to be sure that we are "paying for value."
    b. Many practices start the process of transformation with a gap analysis and find they have more room to improve than they imagined.

6. **"PCMHs are only certified every three years. They are slacking off the important PCMH functions in the interim when no one is checking."**
    a. Care delivered in PCMHs is better than in non-PCMH practices. The evidence supports that the current schedule of re-certification is working.
    b. The point assumes that providers are not interested in improving care for patients. Primary care providers didn't get in the business to deliver bad care and run on the proverbial 'hamster wheel.' Studies have shown physician satisfaction is better in PCMH practices.

c. Connecticut's Medicaid program conducts annual reviews of PCMHs to ensure they are maintaining the core elements of the model between NCQA applications, as well as integrating care with each patient's oral and behavioral health providers. Other payers and/or the state could adopt this simple innovation to ensure compliance with PCMH standards and NCQA is itself considering such an innovation,
d. The new 2014 NCQA standards require practices to designate an individual(s) who are responsible for sustaining the changes within the practice.

7. **"PCMH status just identifies practices that were already providing better quality care."**
    a. Good – that means PCMH status recognition and the payments that follow are supporting better quality care, which is the point of value-based purchasing.
    b. Most practices that have earned PMCH certification describe it as a demanding but valuable transformation in the way they provide care. We have spoken to many providers who were initially skeptical that transformation would make a meaningful difference in their practice, but, after earning certification, they were convinced.

8. **"NCQA and other national PCMH standards don't include my only priority (i.e. oral health, cultural and linguistic access standards)"**
    a. All health care issues need a strong foundation of comprehensive, coordinated care to be effective. Great oral health or other services provided in a setting with weak PCMH quality standards does not support overall health, and individual services won't be well coordinated if health care in general is not.
    b. Many states work with national PCMH accrediting bodies to add state-specific standards, e.g. "NCQA Plus." Options include making otherwise optional parts of NCQA's program mandatory or adding state-specific requirements on top. This could include a requirement that providers coordinate with dental providers.

9. **"Small practices have trouble meeting national PCMH standards"**
    a. In fact 89% of NCQA recognized PCMHs have fewer than ten clinicians.
    b. Over 2,500 practices with one or two clinicians have earned recognition – the vast majority at Level 3 (the highest level).

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[i] NCQA certifies 80% of PCMHs nationally

[ii] Connecticut's State Innovation Model plan, developed by the administration in response to a federal grant opportunity, to radically reform health care for all Connecticut residents

[iii] Community Health Network, Medicaid administrator for the state