Medical Home Concept Versus Medicaid Health Home

White paper

Kansas Healthcare Collaborative

Medical Home Concept

Medical Home is a model for primary care delivery in which a primary care provider works with a care team to coordinate all aspects of patient care. The term has been in use for decades to conceptualize a set of management principles, technical capabilities, knowledge, skills and ethos that constitute high value primary care.[1] The medical home model has been adapted and implemented in a variety of ways by various professional organizations, government agencies and programs, quality improvement partnerships, and other efforts.

Patient Centered Medical Home (PCMH)

The PCMH is a formulation of the Medical Home concept that emerged in 2007 when the four major professional organizations for primary care physicians issued the Joint Principles of the Patient Centered Medical Home.[2] It has emerged as a leading model for primary care delivery transformation to achieve the twin goals of improving care quality and reducing cost. PCMH is the foundation for numerous programs and partnerships including TransforMED, the Patient Centered Primary Care Collaborative, the Utilization Review Accreditation Commission's PCMH accreditation program, the Joint Commission's PCMH certification program, the National Committee for Quality Assurance's PCMH recognition program and others.[3]

Medicaid Health Home

The Health Home is a new provision in Medicaid authorized through the Affordable Care Act. The Health Home is a service delivery model meant to expand on the medical home concept by emphasizing linkages to community and social-supports, and enhanced coordination between medical and behavioral health care.[4] Medicaid beneficiaries with two or more chronic conditions, one chronic condition and at risk for another, or who have a serious mental illness are assigned by one of the Medicaid Managed Care Organizations (MCOs) to a Health Home Partner (HHP) who provides one or more of the Health Home Services: comprehensive care management, care coordination, health promotion, comprehensive transitional care from inpatient to other settings, individual and family support and referral to community and social support services. HHPs may be physician-based clinics, hospitals, home health agencies, centers for independent living, public health agencies, FQHCs, Safety Net Clinics or other community-based providers.

	Medicaid Health Home[5]	PCMH
Patient Population	Eligible beneficiaries with specified conditions are identified through Medicaid claims and assigned to providers.	Includes all patients in the practice across the lifespan. Identifying and managing patient populations is a PCMH function.
Provider	Core services may be provided by Health Home Partners (HHPs), designated MCOs, or contracted through third parties.	All aspects of care are coordinated by a physician-led care team.
Payment Structure	Each MCO receives a per-member per-month payment from Medicaid. MCOs contract with HHPs to provide Health Home Services.	Payers may recognize the added value of PCMH-recognized practices through a variety of reimbursement mechanisms. Not limited to one insurance provider.
Role of Health Information Technology (HIT)	MCOs and HHPs are required to implement an EHR, use one of the two Kansas health information exchanges, use member web portals and secure messaging for care coordination, health promotion, transition planning, support services and referral to community and social support services.	Many standards are related to use of HIT, and are generally aligned with meaningful use and other federal program requirements. Specific HIT capabilities are not necessarily essential for recognition as a PCMH.

References and Resources

1. For a summary from the perspective of pediatrics, see:
   Sia, C., Tonniges, T.F., Osterhus, E. and Taba, S. (2004). History of the Medical Home Concept. *Pediatrics*. 113(5): 1473-1478.
   The Patient-Centered Primary Care Collaborative (PCPCC) has published a timeline of key developments in the medical home concept:
   http://www.pcpcc.org/content/history-0; Accessed 4/7/2014.

2. American Academy of Family Physicians, the American College of Physicians, American Academy of Pediatrics and the American Osteopathic Association. (2007). "Joint Principles of the Patient-Centered Medical Home".
   http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf; Accessed 4/7/2014
   Guidelines for Patient-Centered Medical Home (PCMH) Recognition and Accreditation Programs:
   http://www.medicalhomeinfo.org/downloads/pdfs/Guidelines-PCMHRecogAccredPrograms.pdf; Accessed 4/8/2014.

3. Websites for PCMH programs and partnerships:
   - TransforMED: http:www.transormed.com; Accessed 4/8/2014.
   - Patient-Centered Primary Care Collaborative (PCPCC): http://www.pcpcc.org; Accessed 4/8/2014.
   - URAC: https://www.urac.org/accreditation-and-measurement/accreditation-programs/all-programs/patient-centered-medical-home/; Accessed 4/8/2014.
   - The Joint Commission: http://www.jointcommission.org/topics/default.aspx?k=695; Accessed 4/8/2014.
   - National Committee for Quality Assurance:
     http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx; Accessed 4/8/2014.

4. Letter to State Medicaid Directors providing guidance on the Health Home Provision:
   http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf; Accessed 4/8/2014.

5. Draft Program Manual for the Serious Mental Illness State Plan Amendment:
   http://www.kancare.ks.gov/health_home/download/KanCare_Health_Homes_Program_Manual_SMI.pdfAccessed 5/19/2014
   Draft Program Manual for the Chronic Conditions State Plan Amendment:
   http://www.kancare.ks.gov/health_home/download/KanCare_Health_Homes_Program_Manual_CC.pdf; Accessed 5/19/2014.