Compare and Contrast:
Medicaid Health Homes and Patient Centered Medical Homes

Patient-Centered Medical Homes

The term medical home has been used for decades. It grew out of the pediatric field, where it described a model for addressing the complex health needs of children with multiple medical conditions. With its adoption by the larger healthcare field, it has come to signify a care model in which the patient has a designated primary care provider who operates as part of a care team with responsibility for coordinating the patient's overall healthcare needs.

More recently, the term patient-centered medical home (PCMH) surfaced, with the intent of underlining key elements that make a medical home model responsive to an individual's needs and activate patients to participate in their care. The model has been the basis for numerous efforts, including TransforMED and the Patient-Centered Primary Care Collaborative.[1,2] In 2007, the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association issued a joint statement on the PCMH's core principles.[3] It is also the term – and model – that the National Committee for Quality Assurance (NCQA) used in developing its medical home standards.[4]

States, Medicare and other payers are investing in Patient Centered Medical Homes as a way to transform primary care delivery for the entire population in this country.

Medicaid Health Homes

The Affordable Care Act (ACA) introduced a new Medicaid optional service and term in its description of a "Health Home." The act makes clear that the term was selected to convey that the comprehensive coordinated care model necessary to ensure quality and efficiency builds on the concept of medical homes, but must be explicit about the critical role of mental health, substance use, and community supports.[5,6]

Health Homes, as established in section 2703 of the Affordable Care Act, were developed to provide dedicated attention to people with or two or more chronic health conditions, or with one chronic condition and at risk for another, or who have serious mental illness, and, as a result of their condition, require care coordination above and beyond conventional medical home practice.

	Health Home [7]	Patient-Centered Medical Home [8]
Target Population	Enhanced Medicaid reimbursement for services to individuals with approved chronic conditions [9]	Serves all populations across the lifespan
Typical Providers	May include primary care practices, community mental health organizations, addiction treatment providers, Federally Quality Health Centers, health home agencies, etc.	Typically defined as physician-led primary care practices, but may include some mid-level practitioners such as Nurse Practitioners
Payer(s)	Currently a Medicaid-only construct	Exist for multiple payers (e.g., Medicaid, commercial insurance)
How is Care Organized	Team-based, whole-person orientation with *explicit* focus on the integration of behavioral healthcare and primary care; includes individual and family support services.	Team-based, whole person orientation achieved through care coordination
Provider Requirements	State Medicaid determined	State Medicaid and NCQA determined
Payment	Usually PMPM for 6 required services with more intensive care coordination and patient activation	Payment is in line with added value; usually small PMPM

[1] TransforMED, www.transformed.com/index.cfm.

[2] Patient-Centered Primary Care Collaborative, www.pcpcc.net/

[3] American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, & American Osteopathic Association (February, 2007). Joint Principles of the Patient Centered Medical Home. Retrieved from: www.pcpcc.net/content/joint-principles-patient-centered-medical-home.

[4] National Committee on Quality Assurance (2008). Standards and Guidelines for Physician Practice Connections®—Patient-Centered Medical Home (PPC-PCMH™) www.ncqa.org/Portals/0/Programs/Recognition/PCMH_Overview_Apr01.pdf.

[5] Office of the Legislative Counsel. (May, 2010). Legal Compilation of Patient Protection and Affordable Care Act (as amended through May 1, 2010). Retrieved from: http://docs.house.gov/energycommerce/ppacacon.pdf.

[6] Centers for Medicare & Medicare Services. (November 16, 2010). Letter to state Medicaid directors and state health officials. Retrieved from: www.cms.gov/smdl/downloads/SMD10024.pdf.

[7] As defined in Section 2703 of the Affordable Care Act, P.L. 111-148.

[8] As defined by the National Committee on Quality Assurance, www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx.

[9] "Chronic conditions" includes, but is not limited to, (1) mental health condition, (2) substance use disorder, (3) asthma, (4) diabetes, (5) heart disease, or (6) being overweight, as evidenced by having a body mass index (BMI) over 25. (Section 2703 of the Affordable Care Act, P.L. 111-148).