Health Homes

Health Homes and Medical Homes

The terms medical home and health home may sound similar, but represent different approaches to care coordination across health care.

A medical home (aka person-centered medical home or patient-centered medical home (PCMH)) is a care model that involves the coordinated care of individual's overall health care needs (and where individuals are active in their care).

A health home (aka Medicaid health home) — as defined in Section 2703 of the Affordable Care Act — offers coordinated care to individuals with multiple chronic health conditions, including mental health and substance use disorders. The health home is a team-based clinical approach that includes the consumer, his or her providers, and family members, when appropriate. The health home builds linkages to community supports and resources as well as enhances coordination and integration of primary and behavioral health care to better meet the needs of people with multiple chronic illnesses.

Care management is central to the recent shift away from focus on episodic acute care to focus on health management of defined populations, especially those living with chronic health conditions. This shift in focus results from lessons learned from primary and behavioral health care integration efforts, as health homes recognize the importance of caring for the whole person. Such a shift would necessitate **integrating primary and behavioral healthcare** and, as seen in the **IMPACT model**, explicitly building care manager/behavioral health consultant and consulting psychiatrist functions into the medical home model.

The chart below can be a quick reference to the key differences between health homes and medical homes.

	Medicaid Health Home	Patient-Centered Medical Home

Target Population	Individuals with chronic conditions	All populations across the lifespan
Typical Providers	May include primary care practices, community mental health organizations, addiction treatment providers, federally qualified health centers, and other safety-net providers	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 Care is Organized	Team-based, whole-person orientation with explicit focus on integration of behavioral health and primary care	Team-based, whole person orientation achieved through coordinated care
Provider Requirements	State Medicaid determined	State Medicaid and NCQA determined
Payment	Usually PMPM for six required services with more intensive care coordination and patient activation	Payment is in line with added value; usually small PMPM

Resources from CIHS

Advancing Behavioral Health Integration within NCQA Recognized Patient-Centered Medical Homes reviews the National Committee for Quality Assurance's (NCQA) patient-centered medical home (PCMH) standards and how they relate to the integration of behavioral health into primary care. HRSA-supported safety-net providers who have integrated behavioral health services can use this resource as a guide when preparing to apply to be recognized as a PCMH with NCQA.

Population Management in Community Health Center-Based Health Homes explains the principles and steps integrated care providers can take to implement population health management.

Behavioral Health Homes for People with Mental Health & Substance Use Conditions: The Core Clinical Features helps prepare behavioral health provider organizations to become health homes by outlining the essential clinical features. In addition, the paper introduces several real-world examples of how behavioral health provider organizations are successfully implementing the clinical features of a health homes around the country.

Financing and Policy Considerations for Medicaid Health Homes for Individuals with Behavioral Health Conditions: A Discussion of Selected States' Approaches reviews the policy considerations and options for states and providers to establish reimbursement methodologies and payment rates for health homes.

One Stop Shopping: What does the Health Home Model mean for Behavioral Health? Check out our **special edition of eSolutions** to learn more about Article 2703 and how it will affect your state.

Want a general overview of health homes? Our **fact sheet** provides an introduction to the Medicaid health home.

Other Resources

Substance Use Disorders and the Person-Centered Healthcare Home, developed by the National Council for Behavioral Health explores the integration of SU treatment with healthcare services and what a PCMH looks like for people living with chronic substance use conditions.

Designing Medicaid Health Homes for Individuals with Opioid Dependency: Considerations for States
A new brief, developed by CHCS for the Centers of Medicare & Medicaid Services' **Health Home Information Resource Center**, highlights key features of approved health home models from Maryland, Rhode Island and Vermont that are tailored to individuals with opioid dependency.

The Patient-Centered Primary Care Collaborative (PCPCC) **Primary Care Innovations and PCMH Map** is a unique tool that demonstrates the widespread uptake of medical home initiatives across the country.

To support ongoing assessment of the effectiveness of the Health Home model, the Centers for Medicare & Medicaid Services (CMS) has established a recommended Core Set of health care quality measures that it intends to promulgate in the rulemaking process.The **Technical Specifications and Resource Manual** presents the technical specifications for each measure in the Health Home Core Set. Each specification includes a description of the measure, information about the eligible population, key definitions, and other relevant measure information.

The Patient-Centered Medical Home's Impact on Cost & Quality: An Annual Update of the Evidence
This report by the Patient-Centered Primary Care Collaborative with support from the Milbank Memorial Fund highlights recently published outcomes of patient-centered medical home (PCMH) initiatives from across the United States. The expanding body of research provided in the report suggests that when fully transformed primary care practices have embraced the PCMH model of care, a number of consistent, positive outcomes can be found.

The Centers for Medicare and Medicaid Services and states are partnering to transform health care systems by creating and testing new models of care delivery and payment. **The State Innovation Models: Early Experiences and Challenges of an Initiative to Advance Broad Health System Reform** shares interviews with officials from states

participating in the State Innovation Models (SIM) Initiative which reveals that the readiness of providers and payers to adopt innovations varies, requiring different starting points, goals, and strategies.

Integrated Delivery Systems Toolkit

The National Academy for State Health Policy (NASHP), with the support of the Kaiser Permanente Community Benefit, is working with states that are well positioned to begin integrating delivery systems and pursuing payment reforms.They are capturing ideas and expertise from states to help equip others with the knowledge and tools they'll need to start advancing integration and payment reform as well. This **online "toolkit"** for state policy makers is part of that work: it holds short, relevant documents that the project team has curated in the course of its work or identified from other public sources.

Health Home Information Resource Center on Medicaid.gov

The **Health Home Information Resource Center** on Medicaid.gov offers a variety of technical assistance services for states as well as a resource library of continuously updated materials. States may use the resource center to request one-on-one technical assistance, access peer-learning opportunities, and find resources to guide their health home design and implementation. States can request health home technical assistance by completing the request form available at **Medicaid.gov** and sending it to **healthhomes@cms.hhs.gov**.

The National Academy for State Health Policy's (NASHP) Medical Home Map tracks state efforts to advance medical homes for Medicaid and CHIP participants. In addition to analysis of medical home programs in each state, map users can now explore state medical home activity across five key domains: payments to medical homes, multi-payer initiatives, ACA Section 2703 health homes, medical home qualification standards, and shared practice supports.

The **Medicare-Medicaid Integration Study Hall Call Series** is a virtual learning opportunity for states preparing to implement either capitated or managed fee-for-service Medicare-Medicaid financial alignment models. Topics have included enrollment, program monitoring, member outreach, readiness reviews, and provider network development. Any state pursuing an integrated model for Medicare-Medicaid enrollees may participate.

The **Affordable Care Act authorized a health home provision** [Sec. 2703 & Sec. 19459 (e)] that enables states to build a person-centered care system to improve outcomes for beneficiaries and ensure better services and value for state Medicaid and other programs, including mental health and substance abuse agencies. **SAMHSA's webpage** houses a

host of information, including **state guidance** on ACA Sec. 2703 (the health home provision) for people with behavioral health disorders.

Compare and Contrast: Medicaid Health Homes and Patient Centered Medical Homes from the National Council for Behavioral Health provides a brief overview of the differences between Medicaid Health Homes and Patient Centered Medical Homes.

The Collaborative Care: An Evidence-Based Approach to Integrating Physical and Mental Health in Medical Health Homes webinar highlighted details of the Collaborative Care Model, describes the evidence documenting its effectiveness, and describes how it operates from the perspective of primary care providers, specialty mental health providers, and payers. It also provides a brief update on health home activities at the national level with a focus on efforts to integrate physical and behavioral health services.

AHRQ's Early Evidence on the Patient-Centered Medical Home, released in February 2012, looks at more than 480 practices, and provides a table summarizing findings on pages 9-10.

The National Council for Behavioral Health developed **Behavioral Health/Primary Care Integration and The Person-Centered Healthcare Home**, a report that assesses the need and importance of health homes, models, and policies that affect the implementation and sustainability of health homes. The **Care Models for Persons with Chronic Substance Use video** also discusses the National Council report.

NCQA's Patient-Centered Medical Home 2011 is an innovative program for improving primary care. In a set of standards that describe clear and specific criteria, the program gives practices information about organizing care around patients, working in teams, and coordinating and tracking care over time. The NCQA Patient-Centered Medical Home standards strengthen and add to the issues addressed by NCQA's original program.

The **Joint Principles of the Patient-Centered Medical Home** were developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association to describe the characteristics of the Patient-Centered Medical Home.

Federal and State Policy

The November 2012 issue of Health Affairs focuses on trends in Medicaid patient-centered medical home payment that can inform public and private payment strategies more broadly, NASHP Program Director Mary Takach wrote, **About Half Of The States Are**

Implementing Patient-Centered Medical Homes For Their Medicaid Populations. Both public and private payers are testing the patient-centered medical home model by shifting resources to enhance primary care as an important component of improving the quality and cost-effectiveness of the U.S. health care delivery system.

State Plan Amendments

As of July 2013, the Centers for Medicare and Medicaid Services has approved Medicaid health homes in twelve states. Access the **approved state plan amendments**.

Webinars

Seizing the Opportunity: Early Medicaid Health Home Lessons
Center for Health Care Strategies, Inc. (CHCS) webinar
Presented by Kathy Moses
April 24, 2014

- **Slides**
- **Recording**
- **Brief**

A (Health) Home Run: Operationalizing Behavioral Health Homes
January 18, 2013
Presented by Laurie Alexander, Benjamin Druss, and Joe Parks

- **Presentation**
- **Recording**
- **Transcript**

Integrated Care within the Patient Centered Medical Home: The Health Center Perspective
November 8, 2012
Presented by Ann Lewis, Judith Steinberg, and Marty Lynch

- **Presentation**
- **Recording**
- **Transcript**

Behavioral Health Homes: The Core Clinical Features
May 30, 2012
Presented by Laurie Alexander and Benjamin Druss

- **Presentation**
- **Recording**
- **Transcript**

Person-Centered Health Homes
May 16, 2011
Presented by Chuck Ingoglia and Larry Fricks

- **Presentation**
- **Transcript**

Recordings (synched audio and slides) remain in our archive for one year. For webinar recordings more than one year old, contact us at Integration@TheNationalCouncil.org.