How Are Health Homes Different From Patient Centered-Medical Homes?

Category	Health Home	Patient- Centered Medical Home
Populations served	Individuals with Medicaid with approved chronic conditions which vary state to state. Also includes children.	All populations served
Staffing	May include primary care practices, community mental health centers, addiction treatment providers, federally qualified health centers, health home agencies, Assertive Community Treatment teams, and other safety-net providers	Typically defined as physician-led primary care practices, but also mid-level practitioners (such as nurse practitioners)
Care Focus	Strong focus on care coordination between physical health and behavioral health as well as other community systems. Special focus on population of people with behavioral health challenges (including substance abuse treatment). In addition to care coordination, core services include health promotion, individual and family support and community connections.	Focused on the delivery of traditional medical care: referral and lab tracking, guideline adherence, electronic prescribing, provider-patient communication, etc.
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

Category	Health Home	Patient- Centered Medical Home
Payers	Currently are a Medicaid-only construct	In existence for multiple payers: Medicaid, commercial insurance, etc.
Provider Requirements	State Medicaid plan determined with CMS (Center for Medicare and Medicaid) approval	State Medicaid and NCQA (National Committee for Quality Assurance)determined
Payment	Usually PMPM (per member per month) for six required services with more intensive care coordination and patient activation. The enhanced federal match is in effect for 8 quarters	Payment is in line with the added value of the coordinated services ; usually small PMPM
Technology	Use of IT for coordination across continuum of care, including in-home solutions such as remote monitoring in patient homes	Use of IT for traditional care delivery
Location of service	Community based care with focus on meeting the person in their natural environment. Some services may be provided in a central location but focus is on the community	Facility based service

Sources: This document combines content from the two sources below with additional content from the National Council consulting team.

Smith, Alicia. (2011, June 7). Overview of the Medicaid health home care coordination benefit.
National Council webinar

Resource Center for Integrated Health Solutions site: http://www.integration.samhsa.gov/integrated-care-models/health-homes