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

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| **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 |
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| **Staffing** | May include primary care practices, community mental health centers, addiction treatment providers, federally qualified health centers, health home agencies, ACT teams, and other safety-net providers | Typically defined as physician-led primary care practices,  but also mid-level practitioners (such as nurse practitioners) |
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| **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. |
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| **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 |
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| **Payers** | Currently are a Medicaid-only construct | In existence for multiple payers: Medicaid,  commercial insurance, etc. |
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| **Provider Requirements** | State Medicaid plan determined with CMS approval | State Medicaid and NCQA determined |
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| **Payment** | Usually PMPM 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 added value; usually small PMPM |
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| **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 |
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| **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 |
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**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](http://www.thenationalcouncil.org/galleries/resources-services%20files/HMA%20June%202011%20Webinar.pdf)

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