



AAFP

State Qualification /Certification Standards for the Patient-Centered Medical Home

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The [National Committee for Quality](#) (NCQA) promotes standards that are aligned with [the seven joint principles of the patient-centered medical home](#) (PCMH).

1. **Personal physician** – each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
2. **Physician directed medical practice** – personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
3. **Whole person orientation** – personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals for all stages of life.
4. **Care is coordinated and/or integrated** across all elements of the complex health care system.
5. **Quality and safety are hallmarks of the PCMH.** This includes practices going through a voluntary recognition process; ongoing education; use of evidence-based medicine and clinical decision-support tools to guide decision making; as well as other necessary elements to improve quality and safety.
6. **Enhanced access to care** is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
7. **Payment appropriately recognizes the added value** provided to patients who have a patient-centered medical home.

California

Welfare and Institutions Code, Section 15904. [CA S 1039 of 2007]

- (a) The State Department of Health Care Services shall issue a request for applications for funding the Health Care Coverage Initiative.
- (b) The department shall allocate federal funds available to be claimed under the Health Care Coverage programs.
- (c) The department shall select the Health Care Coverage programs that best meet the requirements and desired outcomes set forth in this part.
- (d) The following elements shall be used in evaluating the proposals to make selections and to determine the allocation of the available funds:
 - (1) Enrollment processes, with an identification system to demonstrate enrollment of the uninsured into the program.
 - (2) Use of a medical record system, which may include electronic medical records.
 - (3) Designation of a medical home and assignment of eligible individuals to a primary care provider. For purposes of this paragraph, "medical home means a single provider or facility that maintains all of an individual's medical information. The primary care provider shall be a provider from which the enrollee can access primary and preventive care.
 - (4) Provision of a benefit package of services, including preventive and primary care services, and care management services designed to treat individuals with chronic health care conditions, mental illness, or who have high costs associated with their medical conditions, to improve their health and decrease future costs. Benefits may include case management services.
 - (5) Quality monitoring processes to assess the health care outcomes of individuals enrolled in the Health Care Coverage program.
 - (6) Promotion of the use of preventive services and early intervention.
 - (7) The provision of care to Medi-Cal beneficiaries by the applicant and the degree to which the applicant coordinates its care with services provided to Medi-Cal beneficiaries.
 - (8) Screening and enrollment processes for individuals who may qualify for enrollment into Medi-Cal, the Healthy Families Program, and the Access for Infants and Mothers Program prior to enrollment into the Health Care Coverage program.
 - (9) The ability to demonstrate how the Health Care Coverage program will promote the viability of the existing safety net health care system.

California's definition of "medical home" provides emphasis on primary care and whole person care that is consistent with the NCQA definition. Although not specifically provided in the definition, the statute within which the definition is provided lists other components of a PCMH. For instance, use of electronic medical records and quality monitoring processes to assess health care outcomes promote both quality and safety. Provision (d) (4) promotes coordinated care incorporating preventative care, chronic care management, and case management services but does not require a personal physician to direct these medical services. Although California has not fully adopted the NCQA definition of PCMH, several components are included in the state's statutes.

According to a [September 2009 report](#), the [California Department of Health Care Services](#) (DHCS) seeks to improve the quality and efficiency of care provided to approximately 360,000 fee-for-service Medi-Cal beneficiaries with disabilities and chronic illnesses by creating a new statewide infrastructure of Enhanced Medical Homes (EMH). In this context, the EMH model is a system of care that provides access to a primary care provider, as well as targeted care management support for beneficiaries at high risk of using acute medical services. The state is working to renew an existing federal 1115 waiver that will expire in 2010.

Colorado

25.5-1-103. Definitions. [CO S 130 of 2007]

(5.5) "Medical Home" means an appropriately qualified medical specialty, developmental, therapeutic, or mental health care practice that verifiably ensures continuous, accessible, and comprehensive access to and coordination of community-based medical care, mental health care, oral health care, and related services for a child. A medical home may also be referred to as a health care home. A medical home shall offer family-centered, compassionate, culturally effective care and sensitive, respectful communication to a child and his or her family. If a child's medical home is not a primary medical care provider, the child must have a primary medical care provider to ensure that a child's primary medical care needs are appropriately addressed. All medical homes shall ensure, at a minimum, the following:

- (a) Health maintenance and preventative care;
- (b) Anticipatory guidance and health education;
- (c) Acute and chronic illness care;
- (d) Coordination of medications, specialists, and therapies;
- (e) Provider participation in hospital care; and
- (f) Twenty-four-hour telephone care.

25.5-1-123. Medical homes for children - legislative declaration - duties of the department - reporting requirements.

- (1) The General Assembly hereby finds and declares that:
 - (a) The best medical care for infants, children and adolescents is provided through a medical home as defined in section 25.5-1-103, and that is consistent with the joint principles of a patient-centered medical home. Those principles shall include a whole person orientation, care that is coordinated and integrated across all elements of the complex health care system and the patient's community, and care that provides for quality and safety of the patient where qualified health care practitioners provide primary care and help manage and facilitate all aspects of medical care;
 - (b) Infants, children, and adolescents and their families work best with a health care practitioner who knows the family and who develops a partnership of mutual responsibility and trust.
 - (c) Medical care provided through emergency departments, walk-in clinics, and other urgent-care facilities is often more costly and less effective than care given by a physician with prior knowledge of the child and his or her family; and
 - (d) The state department should strive to find a medical home for each child receiving services through the state medical assistance program, articles 4, 5, and 6 of this title, or the children's basic health plan, article 8 of this title.
- (2) On or before July 1, 2008, the state department, in conjunction with the Colorado medical home initiative in the department of public health and environment, shall develop systems and standards to maximize the number of children enrolled in the state medical assistance program or the children's basic health plan who have a medical home. The systems and standards developed shall include, but need not be limited to, ways to ensure that a medical home shall offer family-centered, compassionate, culturally effective care and sensitive, respectful communication to a child and his or her family.

(3) On or before January 30, 2008, and every January 30 thereafter, the state department shall report to the health and human services committees of the house of representatives and the senate, or any successor committees, on progress made toward maximizing the number of children with a medical home who are enrolled in the state medical assistance program or the children's basic health plan.

Colorado law specifically states that the definition of “medical home” used is consistent with the joint principles of a PCMH. However, these statutes are only relevant for children.

The [Colorado Multi-Stakeholder Patient Centered Medical Home Pilot](#) for adults is also based upon the PCMH joint principles.

DC

[DC B 2 of 2006](#)

Title V. Human Support Service. Subtitle A. Medical Homes Grant-Making. Sec. 5002. Grant-making authority.

(2) From operating funds available to the Department of Health not including funding for any contract authorized by the Act, an amount not to exceed \$1.9 million during fiscal year 2007 to support and stimulate the Medical Homes DC's public purpose of health improvement by ensuring that all residents of the District of Columbia, especially low-income residents and indigent residents, have a medical home where a primary care provider knows each patient's health history, where each patient can be seen regardless of ability to pay, and where each patient can routinely seek non-emergency medical care in the community where the patient resides.

The District of Columbia includes the personal primary care provider, whole person orientation, and enhanced access to care aspects of the joint principles. Physician directed care, coordinated / integrated care, quality/safety, and appropriate payment are not explicitly mentioned in this legislation.

Florida

[Title XXX Social Welfare, Chapter 409 Social and Economic Assistance. 409.91207 Medical home pilot project.](#) [FL SB 1986 of 2009]

(1) The agency shall develop a plan to implement a medical home pilot project that utilizes primary care case management enhanced by medical home networks to provide coordinated and cost-effective care that is reimbursed on a fee-for-service basis and to compare the performance of the medical home networks with other existing Medicaid managed care models. The agency is authorized to seek a federal Medicaid waiver or an amendment to any existing Medicaid waiver, except for the current 1115 Medicaid waiver authorized in s. [409.91211](#), as needed, to develop the pilot project created in this section but must obtain approval of the Legislature prior to implementing the pilot project.

(2) Each medical home network shall:

(a) Provide Medicaid recipients primary care, coordinated services to control chronic illness, pharmacy services, specialty physician services, and hospital outpatient and inpatient services.

(b) Coordinate with other health care providers, as necessary, to ensure that Medicaid recipients receive efficient and effective access to other needed medical services, consistent with the scope of services provided to MediPass recipients.

(c) Consist of primary care physicians, federally qualified health centers, clinics affiliated with Florida medical schools or teaching hospitals, programs serving children with special health care needs, medical school faculty, statutory teaching hospitals, and other hospitals that agree to participate in the network. A managed care organization is eligible to be designated as a medical home network if it documents policies and procedures consistent with subsection (3).

(3) The medical home pilot project developed by the agency must be designed to modify the processes and patterns of health care service delivery in the Medicaid program by requiring a medical home network to:

(a) Assign a personal medical provider to lead an interdisciplinary team of professionals who share the responsibility for ongoing care to a specific panel of patients.

(b) Require the personal medical provider to identify the patient's health care needs and respond to those needs either directly or through arrangements with other qualified providers.

(c) Coordinate or integrate care across all parts of the health care delivery system.

(d) Integrate information technology into the health care delivery system to enhance clinical performance and monitor patient outcomes.

(4) The agency shall have the following duties and responsibilities with respect to the development of the medical home pilot project:

(a) To develop and recommend a medical home pilot project in at least two geographic regions in the state that will facilitate access to specialty services in the state's medical schools and teaching hospitals.

(b) To develop and recommend funding strategies that maximize available state and federal funds, including:

1. Enhanced primary care case management fees to participating federally qualified health centers and primary care clinics owned or operated by a medical school or teaching hospital.
2. Enhanced payments to participating medical schools through the supplemental physician payment program using certified funds.
3. Reimbursement for facility costs, in addition to medical services, for participating outpatient primary or specialty clinics.
4. Supplemental Medicaid payments through the low-income pool and exempt fee-for-service rates for participating hospitals.
5. Enhanced capitation rates for managed care organizations designated as medical home networks to reflect enhanced fee-for-service payments to medical home network providers.

(c) To develop and recommend criteria to designate medical home networks as eligible to participate in the pilot program and recommend incentives for medical home networks to participate in the medical home pilot project, including bonus payments and shared saving arrangements.

(d) To develop a comprehensive fiscal estimate of the medical home pilot project that includes, but is not limited to, anticipated savings to the Medicaid program and any anticipated administrative costs.

(e) To develop and recommend which medical services the medical home network would be responsible for providing to enrolled Medicaid recipients.

(f) To develop and recommend methodologies to measure the performance of the medical home pilot project including patient outcomes, cost-effectiveness, provider participation, recipient satisfaction, and accountability to ensure the quality of the medical care provided to Medicaid recipients enrolled in the pilot.

(g) To recommend policies and procedures for the medical home pilot project administration including, but not limited to, an implementation timeline, the Medicaid recipient enrollment process, recruitment and enrollment of Medicaid providers, and the reimbursement methodologies for participating Medicaid providers.

(h) To determine and recommend methods to evaluate the medical home pilot project, including but not limited to, the comparison of the Medicaid fee-for-service system, MediPass system, and other Medicaid managed care programs.

(i) To develop and recommend standards and designation requirements for a medical home network that include, but are not limited to, medical care provided by the network, referral arrangements, medical record requirements, health information technology standards, followup care processes, and data collection requirements.

Provision (2) emphasizes coordinating services of care—including services concerning chronic disease management, prescriptions drugs, and hospital inpatient and outpatient care. Section (3) focuses on personal physicians, physician directed medical practices, and whole person orientations. Also included is the integration of health information technology, which can enhance quality and safety, as well as increases access to care through additional communication methods. The final section, (4), establishes various changes to payment options, which is another key element of the PCMH joint principles.

Georgia

[SR 664](#) of 2009 acknowledges the importance of a comprehensive approach to providing patient centered care.

Medical homes provide: (1) patient centered care that is accessible, continuous, and coordinated with a focus on maintaining a healthy lifestyle for patients with preventive and ongoing health services; and (2) primary care that is respectful of, and responsive to, individual patient preferences, needs, and values.

Physicians practicing in medical homes would: (1) target eligible individuals for program participation and be responsible for providing safe and secure technology to promote patient access to personal health information, developing a health assessment tool for the targeted individuals, and providing training for personnel involved in the coordination of care; (2) may be specialists or subspecialists for patients requiring ongoing care for specific conditions, multiple chronic conditions, or for those with a prolonged illness; (3) be required to use evidence based medicine and clinical decision support tools to guide their decision making to patient-specific symptoms; (4) be required to use health information technology and to encourage patients to engage in management of their own health through education and support systems

Personal physicians in medical homes would: (1) be eligible for case management fees and incentive payments for providing "medical home" services; (2) provide first contact and continuous care for their patients, shall be board certified and must have a staff and the resources to manage the comprehensive and coordinated care of each of their patients; (3) be responsible for providing ongoing support, oversight, and guidance to implement an integrated, coherent, cross-discipline plan of care developed in partnership with patients and any of their other medical providers.

The evaluation of the patient centered medical home would be: (1) based on patient satisfaction, provider satisfaction, clinical process and outcome measures, program costs and savings, and economic impact on health care providers; and (2) on the extent to which the medical home coordinated health care services, provided safe and high-quality care, encouraged long-term patient and provider relationships, engaged and educated consumers, and encouraged innovation in payment methodologies.

This Senate Resolution acknowledges each of the seven joint principles but does not specify how the PCMH can be used to enhance access to care. Only stating that medical homes provide patient-centered care that is accessible and that patients should have access to HIT, nothing on expanded hours or specific communication options is mentioned.

The Resolution also creates the Senate Study Committee on the Patient Centered Medical Home to be composed of seven members to be appointed by the President of the Senate. The legislation charges the committee with undertaking a study of the conditions, needs, issues, and problems mentioned above or related thereto and the availability and affordability of orally administered and intravenously and injected medications used to treat cancer and recommend any action or legislation which the committee deems necessary or appropriate. Any findings and recommendations, with suggestions for proposed legislation, were due to the General Assembly by December 31, 2009, when the committee was abolished. No further legislation

was introduced during the 2010 legislative session and no committee recommendations were published on the legislature's website.

The state Department of Community Health [Adolescent Health and Youth Development Outreach Program](#) works to improve health of adolescents by assisting them with enrolling in health care coverage and linking them to a medical home.

In Georgia, [Wellstar Health System](#) established a PCMH project to continue testing the medical home model and the effect on outcomes, quality and cost for members in fully insured, ASO and Medicare product types. The success of the project will be evaluated based upon clinical, financial and satisfaction measures.

Idaho

Title 56, Chapter 2, 56-252. DEFINITIONS. *As used in sections 56-250 through 56-255, Idaho Code: [ID H 168 of 2007]*

(10) "Medical home" means a primary care case manager designated by the participant or the department to coordinate the participant's care.

Title 31, Chapter 35, 31-3502 DEFINITIONS. *[ID S 1158 of 2009]*

(14) "Medical home" means a model of primary and preventive care delivery in which the patient has a continuous relationship with a personal physician in a physician directed medical practice that is whole person oriented and where care is integrated and coordinated.

...

31-3503F MEDICAL HOME

The department shall create by rule a community-based system in which a medically indigent patient may be referred to a medical home upon discharge from hospital. The medical home shall provide ongoing primary and preventive care and case management with periodic reports to the department regarding the medically indigent patient's health status and participation in the patient's treatment plan.

Idaho's statutes place emphasis on having a personal primary care physician who directs medical care that is whole-person oriented, integrated, and coordinated. Quality and safety often coincide with these features; however, practices specific to enhancing quality and safety—such as ongoing education or use of evidence-based medicine—are not explicitly mentioned.

The Governor's Select Committee on Health Care's [October 2008 Report to Governor C.L. "Butch" Otter](#) recommends that the governor take the necessary action to ensure all Idaho citizens have a primary care medical home. This model of care is described as the entry point for patients to receive optimized care. Here a medical professional becomes a "health coach," physician, and the advocate for helping a patient who needs access to more specialized and advanced care. The core features include a physician-directed medical practice; a personal doctor for every patient; the capacity to coordinate high quality, accessible care; and payments that recognize a medical home's added value for patients. The report also provides a description of the seven PCMH joint principles.

Iowa

[Title IV PUBLIC HEALTH, Chapter 135.157](#) Definitions. [[IA H 2539 of 2008](#)]

4. "Medical home" means a team approach to providing health care that originates in a primary care setting; fosters a partnership among the patient, the personal provider, and other health care professionals, and where appropriate, the patient's family; utilizes the partnership to access all medical and nonmedical health-related services needed by the patient and the patient's family to achieve maximum health potential; maintains a centralized, comprehensive record of all health-related services to promote continuity of care; and has all of the characteristics specified in section 135.158.

...

[Title IV PUBLIC HEALTH, Chapter 135.158](#) Medical Home Purposes -- Characteristics.

1. The purposes of a medical home are the following:
 - a. To reduce disparities in health care access, delivery, and health care outcomes.
 - b. To improve quality of health care and lower health care costs, thereby creating savings to allow more lowans to have health care coverage and to provide for the sustainability of the health care system.
 - c. To provide a tangible method to document if each lowan has access to health care.
2. A medical home has all of the following characteristics:
 - a. A personal provider. Each patient has an ongoing relationship with a personal provider trained to provide first contact and continuous and comprehensive care.
 - b. A provider-directed medical practice. The personal provider leads a team of individuals at the practice level who collectively take responsibility for the ongoing health care of patients.
 - c. Whole person orientation. The personal provider is responsible for providing for all of a patient's health care needs or taking responsibility for appropriately arranging health care by other qualified health care professionals. This responsibility includes health care at all stages of life including provision of acute care, chronic care, preventive services, and end-of-life care.
 - d. Coordination and integration of care. Care is coordinated and integrated across all elements of the complex health care system and the patient's community. Care is facilitated by registries, information technology, health information exchanges, and other means to assure that patients receive the indicated care when and where they need and want the care in a culturally and linguistically appropriate manner.
 - e. Quality and safety. The following are quality and safety components of the medical home:
 - (1) Provider-directed medical practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between providers, the patient, and the patient's family.
 - (2) Evidence-based medicine and clinical decision-support tools guide decision making.
 - (3) Providers in the medical practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

(4) Patients actively participate in decision making and feedback is sought to ensure that the patients' expectations are being met.

(5) Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

(6) Practices participate in a voluntary recognition process conducted by an appropriate nongovernmental entity to demonstrate that the practice has the capabilities to provide patient-centered services consistent with the medical home model.

(7) Patients and families participate in quality improvement activities at the practice level.

f. Enhanced access to health care. Enhanced access to health care is available through systems such as open scheduling, expanded hours, and new options for communication between the patient, the patient's personal provider, and practice staff.

g. Payment. The payment system appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure framework of the medical home provides all of the following:

(1) Reflects the value of provider and nonprovider staff and patient-centered care management work that is in addition to the face-to-face visit.

(2) Pays for services associated with coordination of health care both within a given practice and between consultants, ancillary providers, and community resources.

(3) Supports adoption and use of health information technology for quality improvement.

(4) Supports provision of enhanced communication access such as secure electronic mail and telephone consultation.

(5) Recognizes the value of provider work associated with remote monitoring of clinical data using technology.

(6) Allows for separate fee-for-service payments for face-to-face visits. Payments for health care management services that are in addition to the face-to-face visit do not result in a reduction in the payments for face-to-face visits.

(7) Recognizes case mix differences in the patient population being treated within the practice.

(8) Allows providers to share in savings from reduced hospitalizations associated with provider-guided health care management in the office setting.

(9) Allows for additional payments for achieving measurable and continuous quality improvements.

Title IV PUBLIC HEALTH, Chapter 135.159. Medical Home System – Advisory Council – Development and Implementation.

3. The department [of public health] shall develop a plan for implementation of a statewide medical home system. The department, in collaboration with parents, schools, communities, health plans, and providers, shall endeavor to increase healthy outcomes for children and adults by linking the children and adults with a medical home, identifying health improvement goals for children and adults, and linking reimbursement strategies to increasing healthy outcomes for children and adults. The plan shall provide that the medical home system shall do all of the following:

- a. Coordinate and provide access to evidence-based health care services, emphasizing convenient, comprehensive primary care and including preventive, screening, and well-child health services.
 - b. Provide access to appropriate specialty care and inpatient services.
 - c. Provide quality-driven and cost-effective health care.
 - d. Provide access to pharmacist-delivered medication reconciliation and medication therapy management services, where appropriate.
 - e. Promote strong and effective medical management including but not limited to planning treatment strategies, monitoring health outcomes and resource use, sharing information, and organizing care to avoid duplication of service. The plan shall provide that in sharing information, the priority shall be the protection of the privacy of individuals and the security and confidentiality of the individual's information. Any sharing of information required by the medical home system shall comply and be consistent with all existing state and federal laws and regulations relating to the confidentiality of health care information and shall be subject to written consent of the patient.
 - f. Emphasize patient and provider accountability.
 - g. Prioritize local access to the continuum of health care services in the most appropriate setting.
 - h. Establish a baseline for medical home goals and establish performance measures that indicate a child or adult has an established and effective medical home. For children these goals and performance measures may include but are not limited to childhood immunization rates, well-child care utilization rates, care management for children with chronic illnesses, emergency room utilization, and oral health service utilization.
 - i. For children, coordinate with and integrate guidelines, data, and information from existing newborn and child health programs and entities, including but not limited to the healthy opportunities to experience success--healthy families Iowa program, the community empowerment program, the center for congenital and inherited disorders screening and health care programs, standards of care for pediatric health guidelines, the office of multicultural health established in section [135.12](#), the oral health bureau established in section [135.15](#), and other similar programs and services.
4. The department shall develop an organizational structure for the medical home system in this state. The organizational structure plan shall integrate existing resources, provide a strategy to coordinate health care services, provide for monitoring and data collection on medical homes, provide for training and education to health care professionals and families, and provide for transition of children to the adult medical care system. The organizational structure may be based on collaborative teams of stakeholders throughout the state such as local public health agencies, the collaborative safety net provider network established in section [135.153](#), or a combination of statewide organizations. Care coordination may be provided through regional offices or through individual provider practices. The organizational structure may also include the use of telemedicine resources, and may provide for partnering with pediatric and family practice residency programs to improve access to preventive care for children. The organizational structure shall also address the need to organize and provide health care to increase accessibility for patients including using venues more accessible to patients and having hours of operation that are conducive to the population served.

5. The department shall adopt standards and a process to certify medical homes based on the national committee for quality assurance standards. The certification process and standards shall provide mechanisms to monitor performance and to evaluate, promote, and improve the quality of health of and health care delivered to patients through a medical home. The mechanism shall require participating providers to monitor clinical progress and performance in meeting applicable standards and to provide information in a form and manner specified by the department. The evaluation mechanism shall be developed with input from consumers, providers, and payers. At a minimum the evaluation shall determine any increased quality in health care provided and any decrease in cost resulting from the medical home system compared with other health care delivery systems. The standards and process shall also include a mechanism for other ancillary service providers to become affiliated with a certified medical home.
6. The department shall adopt education and training standards for health care professionals participating in the medical home system.
7. The department shall provide for system simplification through the use of universal referral forms, internet-based tools for providers, and a central medical home internet site for providers.
8. The department shall recommend a reimbursement methodology and incentives for participation in the medical home system to ensure that providers enter and remain participating in the system. In developing the recommendations for incentives, the department shall consider, at a minimum, providing incentives to promote wellness, prevention, chronic care management, immunizations, health care management, and the use of electronic health records. In developing the recommendations for the reimbursement system, the department shall analyze, at a minimum, the feasibility of all of the following:
 - a. Reimbursement under the medical assistance program to promote wellness and prevention, provide care coordination, and provide chronic care management.
 - b. Increasing reimbursement to Medicare levels for certain wellness and prevention services, chronic care management, and immunizations.
 - c. Providing reimbursement for primary care services by addressing the disparities between reimbursement for specialty services and primary care services.
 - d. Increased funding for efforts to transform medical practices into certified medical homes, including emphasizing the implementation of the use of electronic health records.
 - e. Targeted reimbursement to providers linked to health care quality improvement measures established by the department.
 - f. Reimbursement for specified ancillary support services such as transportation for medical appointments and other such services.
 - g. Providing reimbursement for medication reconciliation and medication therapy management service, where appropriate.

Iowa's Title IV, Chapter 135.158 endorses each of the PCMH joint principles.

The Iowa Department of Public Health (IDPH) has been charged with developing a plan for implementation of a statewide patient-centered medical home system. The initial phase will focus on providing a patient-centered medical home for children who are eligible for Medicaid. The second phase will focus on providing a patient-centered medical home to adults covered by the IowaCare Program and to adults eligible for Medicaid. The third phase will focus on

providing a patient-centered medical home to children covered by the hawk-i program and adults covered by private insurance and self-insured adults. IDPH also will work with the Iowa Department of Administrative Services to allow state employees to use the patient-centered medical home system. To guide the Department in achieving these goals, the [Medical Home System Advisory Council](#) will make recommendations to IDPH on the plan for implementation of a statewide, patient-centered medical home system.

On April 14, 2010, Governor Chet Culver (D) signed [SF 2356](#), which requires the Department of Human Services to adopt rules in collaboration with the state's medical home advisory council, specifying requirements for medical homes, including certification. According to the [minutes](#) from the council's April 16, 2010 meeting, an interim set of minimum standards have been developed for IowaCare that the FQHC's will be required to meet the first year, which include:

1. Access to care and information;
 - Accessibility-24 hours/day, physician on call
2. Care Management
 - Comprehensive physical exam, and Personal Treatment Plan on annual basis
 - Disease Management Program
 - Wellness/Disease Prevention Program
3. Health Information Technology (HIT);
 - Demonstrate evidence of acquisition, installation and adoption of an electronic health record (EHR) system
 - Established plan for meaningful use of health information exchange (HIE) in accordance with the Federal Register requirement
 - Registry Function/Immunization Registry

The council plans to work with NCQA to create an NCQA+ to include Nurse Practitioners as Colorado did.

Kansas

[Chapter 75., Article 74., 75-7429.](#) [KS S 81 of 2008]

- (a) “Medical home” means a health care delivery model in which a patient establishes an ongoing relationship with a physician or other personal care provider in a physician-directed team, to provide comprehensive, accessible and continuous evidence-based primary and preventive care, and to coordinate the patient’s health care needs across the health care system in order to improve quality and health outcomes in a cost effective manner.
- (b) The Kansas health policy authority established under K.S.A. 2007 Supp. 75-7401, and amendments thereto, shall incorporate the use of the medical home delivery system within:
- (1) The Kansas program of medical assistance established in accordance with title XIX of the federal social security act, 42 U.S.C. 1396 et seq., and amendments thereto;
 - (2) the health benefits program for children established under K.S.A. 38-2001 et seq., and amendments thereto, and developed and submitted in accordance with federal guidelines established under title XXI of the federal social security act, section 4901 of public law 105-33, 42 U.S.C. 1397aa et seq., and amendments thereto; and
 - (3) the state mediKan program.
- (c) The Kansas state employees health care commission established under K.S.A. 75-6502, and amendments thereto, shall incorporate the use of a medical home delivery system within the state health care benefits program as provided in K.S.A 75-6501 through 75-6523, and amendments thereto. Except that compliance with a medical home delivery system shall not be required of program participants receiving treatment in accordance with a religious method of healing pursuant to the provisions of K.S.A. 2007 Supp. 75-6501, and amendments thereto.
- (d) On or before February 1, 2009, the Kansas health policy authority in conjunction with the department of health and environment and state stakeholders shall develop systems and standards for the implementation and administration of a medical home in Kansas.

The definition of “medical home” provided in Kansas statutes includes having a personal primary care physician who directs medical care that is ongoing, whole-person oriented, integrated, and coordinated. Quality and safety are promoted through the guarantee of comprehensive continuous evidence-based care in a medical home, and although care should be “accessible,” no specifics as to how a medical home should enhance communication and hours are included. Cost-effectiveness is also addressed in the definition, but details for providing appropriate payment are not.

During a March 11, 2009 meeting, the [Kansas Health Policy Authority](#) released the [Kansas Medical Home Model Draft Preamble](#), which states the Authority will build a model for the medical home from the Joint Principles of the Patient-Centered Medical Home that will be tailored to Kansas’s unique demographic and geographic profile. The state’s model will encompass the roles of physicians (both primary and specialist), midlevel practitioners, nurses, mental health providers, optometrists, podiatrists, dentists, therapists, pharmacists, and others. The medical home in Kansas should recognize the importance of mental health services and the relationship between physical, oral and mental health. In addition, addressing the appropriate setting and continuum of care from prenatal care and birth to death is essential to optimal functioning of the medical home.

The medical home in Kansas should build on the research and findings from national leaders but acknowledge the challenges and opportunities in creating a medical home in rural and urban underserved communities in Kansas. In addition, the development of a medical home in Kansas should align with national medical home model initiatives, include provider payment reforms, emphasize increased patient-provider communication and advance health information technology and exchange (to include telemedicine and telehealth) as a tool to improve coordination of care and health outcomes. Improving the coordination of health care is a key component of a medical home model and the utilization of health information technology and exchange is a primary means to improve coordination and critical to transforming medical practices and our entire health care delivery system.

Louisiana

[Title 46, Chapter 8-A, R.S. 46:978](#) Short title; legislative intent. [[LA S 1 of 2007](#)]

B. The medical home system of care shall incorporate the use of health information technology and quality measures to facilitate a safe, patient centered, quality driven, evidence-based, accessible, and sustainable health care system to Medicaid recipients and low-income uninsured citizens.

...

[R.S. 46:978.1](#) Definitions.

(3) "Medical home system of care" shall mean a health care delivery system that is patient and family centered and is guided by a personal primary care provider who coordinates and facilitates preventative and primary care that improves patient outcomes in the most cost efficient manner possible. By providing a coordinated continuum of care, the cost of the current health care delivery system shall be reduced, health outcomes shall improve, and the disparities in access to health care among the state's populations shall be reduced. The medical home system of care shall consist of an integrated system of primary care providers, specialty care groups, and hospital providers.

...

[R.S. 46:978.2](#) Health care delivery system.

A. The Department [of Health and Hospitals] shall develop and implement a medical home system of care for Medicaid recipients and the low-income uninsured citizens of the state.

The medical home system of care shall:

- (1) Coordinate and provide access to evidence-based health care services, emphasizing convenient, comprehensive primary care.
- (2) Provide access to appropriate specialty care and inpatient services.
- (3) Provide quality driven and cost-effective health care.
- (4) Promote strong and effective medical management.
- (5) Emphasize patient and provider accountability.

B. The department shall require providers who participate in the medical home system of care to adopt an interoperable electronic medical record.

C. In order to ease the cost of implementation of health information technology, the department shall avail itself of any public and private funding available.

D. The department may establish a mechanism to evaluate, promote, and improve the quality of health and health care delivered to the Medicaid and low-income uninsured populations through the use of quality performance measures, evidence-based standards of care, and other measurements that facilitate quality improvement.

E. Reimbursement for participation in Louisiana Health First shall be at a level to ensure provider participation and success. The department shall develop an enhanced Medicaid reimbursement methodology to compensate providers who participate in the medical home system of care. The department shall also apply to the Centers for Medicare and Medicaid Services for authority to develop a payment methodology to compensate providers who care for the low-income uninsured in the medical home system of care. To the extent permitted by the federal government, such reimbursement methodologies shall incorporate features of successful managed care programs, which promote the medical home system of care that is supported by the appropriate, enforceable, quality standards of evidence-based medical protocols and the necessary health information technologies.

F. Reimbursement for health care services for low-income uninsured individuals provided under the medical home system of care shall be allocated to the greatest extent possible based on the disbursement of the low-income uninsured population statewide.

The definition provided in R.S. 46:978:1 includes having a personal primary care provider who coordinates and facilitates care. The medical home shall also consist of an integrated system of primary care providers, specialty care groups, and hospital providers. Health information technology, quality measures, and evidence-based care are incorporated as well, enhancing quality, safety, and access. Reimbursement levels are required to be at a level to ensure provider participation and success.

The [Louisiana Health Care Quality Forum Medical Home Initiative](#) is a multi-stakeholder nonprofit organization—which includes the Louisiana Department of Health and Hospitals—whose mission is to lead evidence based quality improvement initiatives to improve the health of the people of Louisiana. The LHCQF’s Medical Home Committee was formed to promote the adoption of the patient-centered medical home system of care. In January 2008, the LHCQF board adopted the Joint Principles of the Patient-Centered Medical Home and the NCQA standards.

A [presentation](#) given by Gwen Laury RN, CCHC of the Louisiana Primary Care Association on December 4, 2009 provides an understanding the state’s medical home system of care and compares the NCQA recommendations with Louisiana standards.

Medical Home Concept Recommendations	Louisiana’s Federally Qualified Health Centers (FQHCs)
Personal physician provides first contact and continuous care.	Louisiana’s FQHCs employ Primary Care Physicians, Physician Assistants, Nurse Midwives and/or Nurse Practitioners.
Physician directed practice in which a personal doctor leads a team of providers.	The majority of Louisiana’s FQHCs have implemented practice care models such as the Chronic Care Management Redesign Model that create medical care teams to direct and manage the clinical care of patients.
Whole person orientation where the physician arranges for care for all stages of life.	The majority of Louisiana’s FQHCs participates in the state’s managed care program that operates the same principles.

Coordinated care across the health system.	Most of Louisiana's FQHCs have referral partnerships with their local hospitals and specialty providers.
Quality, safety, with evidence-based medicine guiding decision making.	The majority of Louisiana's FQHCs are JACHO accredited.
Enhance access to care through systems such as open scheduling and expanded hours.	Louisiana's FQHCs see walk-ins and have arrangements for care after normal business hours.
N/A	FTCA (Malpractice Immunity)
Some providers are eligible based on their location	Medicaid Prospective Payment System Reimbursement.
N/A	FQHCs provide Dental and Mental Healthcare.
N/A	Limited grant dollars to assist with the uninsured.

Maine

[ME LD 353 of 2009](#)

Provides funding to implement the patient-centered medical home initiative.

Legislation concerning the Maine Patient Centered Medical Home Pilot only includes an appropriation and does not provide a definition of “medical home.” However, a [report](#) produced by the Office of the Senate President on May 10, 2009 explains that LD 353, the 2010-2011 biennial general fund budget, “provides for the creation of a ‘patient-centered medical home’ by which a patient can obtain comprehensive medical services from a treating physician/clinic. It is an expansion of the primary care system of health care.”

In the [2008-2009 State Health Plan](#), the Governor’s Office for Health Policy and Finance identified the need to promote primary care as the foundation for our state’s health system and recommended creating a PCMH pilot in Maine based on the NCQA joint principles. The goals of pilot are to demonstrate that the patient-centered medical home can: improve the health of all patients receiving care from the practice; create a vital and sustainable practice team; reduce costs by controlling inappropriate utilization and unwarranted variations in care; promote an integrated system that supports coordinated care across settings; and be supported by an appropriate payment method that recognizes the infrastructure and systems needed to support this type of primary care.

According the pilot’s [Year One Review](#), Maine’s PCMH Working Group adopted the national PCMH principles for the PCMH Pilot, with a few adaptations. First, the Maine PCMH Pilot will be more inclusive in its vision of practice staffing and leadership, recognizing the importance of the entire practice team including nurse practitioners, physician assistants, office managers, and support staff. Second, while the original principles focus on medical care integration, the Maine PCMH Pilot will work to bring public health and behavioral health together with medical care. Finally, while the Principles recognize the need for PCMH practices to be fairly paid for all services they provide to patients, Maine PCMH acknowledges that practices must also do their part to ensure that they are as cost-effective as possible.

In October 2009, the state Department of Health and Human Services adopted a [rule](#) to add a new level of services delivered through a Patient Center Medical Home. PCMHs assure effective, efficient and accessible health care services for eligible MaineCare (Medicaid) members. Providers, who are approved to deliver this service, receive \$3.50 per member per month to deliver PCMH services. This management fee is in addition to the \$3.50 they receive for providing PCCM services for a total of \$7.00 per member per month. Providers are required to deliver additional integration of patient services, and participate in on-going educational and evaluation activities.

Quality Counts Maine—who partnered with the Dirigo Health Agency and the Maine Health Management Coalition to manage the PCMH pilot that began November 2009—recognizes the joint principles of the PCMH on the [pilot project webpage](#).

According to the [Maine Patient Centered Medical Home Pilot](#) presentation by Lisa M. Letourneau, M.D. of *Quality Counts*, the Maine PCMH Pilot Practice “Core Commitments” are:

1. Demonstrated physician leadership
2. Team-based approach
3. Population risk-stratification and management
4. Practice-integrated care management
5. Same-day access
6. Behavioral-physical health integration
7. Inclusion of patients and families
8. Connection to community / local HMP
9. Commitment to waste reduction

Maryland

Article – Insurance, Title 15 Health Insurance [MD HB 192 / SB 855 of 2010]

Subtitle 18. Exemption for a Patient Centered Medical Home Program, 15-1802.

(A) Notwithstanding any other provision of this article or the Health – General Article, a carrier that is participating in the Maryland Patient Centered Medical Home Program or a carrier that has been authorized by the commission to implement a single carrier patient centered medical home program may:

- (1) Pay a patient centered medical home for services associated with coordination of covered medical services to qualifying individuals;
- (2) Pay a patient centered medical home provider a bonus, fee based incentive, bundled fees or other incentives approved by the commission; and
- (3) Share medical information about a qualifying individual who has elected to participate in the patient centered medical home with the qualifying individual's patient centered medical home and other treating providers rendering health care services to the qualifying individual.

(B) Except as otherwise provided in this section:

- (1) An insurer or nonprofit health service plan that participates in the Maryland patient centered medical home program or that is authorized by the commission to implement a single carrier patient centered medical home program shall comply with this article; and
- (2) A health maintenance organization participates in the Maryland patient centered medical home program or that is authorized by the commission to implement a single carrier patient centered medical home program shall comply with this article, where applicable, and Title 19, Subtitle 7 of the Health – General Article.

Article – Health – General, Title 19 Health Care Facilities

Subtitle 1A. Patient Centered Medical Home Program, 19–1A–01.

(F) “Patient Centered Medical Home Program” means a primary care practice organized to provide a first, coordinated, ongoing, and comprehensive source of care to patients to:

- (1) Foster a partnership with a qualifying individual;
- (2) Coordinate health care services for a qualifying individual; and
- (3) Exchange medical information with carriers, other providers, and qualifying individuals.

...

19–1A–02.

(A) Subject to § 19–1A–03(A) of this subtitle, the commission shall establish the Patient Centered Medical Home Program to promote development of patient centered medical homes.

(B) (1) A carrier may elect to participate in the Maryland Patient Centered Medical Home Program.

(2) Notwithstanding the provisions of paragraph (1) of this subsection, a prominent carrier shall participate in the Maryland Patient Centered Medical Home Program.

(3) Subject to the limitations of the state budget, the department may:

- (I) Require that certain managed care organizations participate in the Maryland Patient Centered Medical Home Program as allowed by law; and
- (II) Notwithstanding any other provision of this article, mandate the participation in the Maryland Patient Centered Medical Home Program of Maryland Medical Assistance Program enrollees.

(4) The department shall ensure that participation in the Maryland Patient Centered Medical Home Program of managed care organizations and Maryland Medical Assistance Program enrollees shall support the quality and efficiency standards established in the HealthChoice program.

(C) The Commission may also authorize a carrier to implement a single carrier Patient Centered Medical Home Program that:

- (1) Pays and shares medical information with a patient centered medical home in accordance with § 15–1802 of the Insurance Article; and
- (2) Conforms with the principles of the patient centered medical home as adopted by a National Coalition of Physicians, Carriers, Purchasers and Consumers.

(D) Nothing in this section shall be construed to limit or prohibit a carrier from providing a bonus, fee based incentives, bundled incentives, or other incentive-based compensation:

- (1) As authorized by the Commission for a Patient Centered Medical Home; or
- (2) As allowed under § 15–113 of the Insurance Article.

19–1A–03.

(A) Notwithstanding any state or federal law that prohibits the collaboration of carriers or providers on payment, the commission may establish Patient Centered Medical Home Program, if the commission concludes that the program:

- (1) Is likely to result in the delivery of more efficient and effective health care services; and
- (2) Is in the public interest.

(B) In establishing the Patient Centered Medical Home Program, the commission, in consultation with the department, carriers, managed care organizations, and primary care practices, shall adopt:

- (1) Standards qualifying a primary care practice as a participant in the Maryland Patient Centered Medical Home Program;
- (2) General standards that may be used by a carrier or a managed care organization to pay a participating patient centered medical home for services associated with the coordination of covered health care services;
- (3) General standards to govern the bonus, fee based incentive, bundled fees, or other incentives a carrier or a managed care organization may pay to a participating patient centered medical home based on the savings from reduced health care expenditures that are associated with improved health outcomes and care coordination by qualifying individuals attributed to the participating patient centered medical home;
- (4) The method for attributing a patient to a participating patient centered medical home;
- (5) The uniform set of health care quality and performance measures that the participating patient centered medical home is to report to the commission and to carriers or managed care organizations;
- (6) The enrollment form notifying carriers or managed care organizations a qualifying individual has voluntarily agreed to participate in the Maryland Patient Centered Medical Home program; and
- (7) The process for primary care practices to commence and terminate participation in the Maryland Patient Centered Medical Home Program.

(C) In developing the standards required in Subsection (B)(1) of this section, the commission shall consider:

- (1) The use of health information technology, including electronic medical records;
- (2) The relationship between the primary care practice, specialists, other providers, and hospitals;
- (3) The access standards for qualifying individuals to receive primary medical care in a timely manner;
- (4) The ability of the primary care practice to foster a partnership with qualifying individuals; and
- (5) The use of comprehensive medication management to improve clinical outcomes.

- (D) The general standards required in the subsection (B)(2) AND (3) of this section shall:
- (1) Define the payment method used by a carrier to pay a participating patient centered medical home for services associated with the coordination of covered health services; and
 - (2) Define the methodology for determining any bonus, fee based incentive, bundled fees, or other incentives to be paid by a carrier to a participating patient centered medical home based on improvements in quality or efficiency.
- (E) (1) To commence, renew or terminated participation in the Maryland Patient Centered Medical Home Program, a qualifying individual shall complete forms adopted by the commission.
- (2) The enrollment form shall authorize the carrier, the participating patient centered medical home treating the qualifying individual, and other providers treating the qualifying individual to share medical information about the qualifying individual with each other.
 - (3) The authorization under paragraph (2) of this subsection shall be valid for a period not to exceed 1 year.
 - (4) The renewal form shall extend the authorization under paragraph (2) of this subsection for an additional period not to exceed 1 year.
 - (5) A carrier participating in the Maryland Patient Centered Medical Home Program shall accept forms adopted by the commission as the sole instrument for notification that a qualifying individual has voluntarily agreed to participate or terminate participation in the Maryland Patient Centered Medical Home Program.
- (F) (1) The commission shall conduct culturally and linguistically appropriate provider and patient educational activities to increase awareness of the potential benefits for providers and patients of participating in the Maryland Patient Centered Medical Home Program.
- (2) The commission shall ensure that a participating patient centered medical home provides, on an ongoing basis, culturally and linguistically appropriate care for the purpose of reducing health disparities.

19-1A-04.

The commission may adopt regulations to:

- (1) Establish the Maryland Patient Centered Medical Home Program; and
- (2) Authorize a carrier to implement a single carrier Patient Centered Medical Home Program.

19-1A-05.

(A) (1) The commission shall retain a consultant or consulting firm to conduct an independent evaluation of the effectiveness of the Maryland Patient Centered Medical Home Program in reducing health care costs and improving health care outcomes.

(2) A single carrier Patient Centered Medical Home Program may request to be included in the evaluation described in paragraph (1) of this subsection.

(3) In conducting the evaluation, the commission shall consider, subject to budget limitations, improvements in health care delivery, improved clinical care processes, increased access to care coordination, adequacy of enhanced payments to cover expanded services, increased patient satisfaction with care, increased clinician and staff work satisfaction, lower total costs of care, and reductions in health disparities resulting from the Maryland Patient Centered Medical Home Program and any authorized single carrier Patient Centered Medical Home Program included in the study.

...

19-706.

(CCCC) The provisions of Title 15, Subtitle 18 of the Insurance Article apply to health maintenance organizations.

Section 2. And be it further enacted, that:

(a) The Maryland Health Care Commission shall consult with the Maryland Community Health Resources Commission regarding the inclusion of federally qualified health centers and other primary care practices in the Maryland Patient Centered Medical Home Program established by Section 1 of this Act.

(b) The Maryland Community Health Resources Commission, in consultation with the Maryland Health Care Commission, may assist federally qualified health centers and other primary care practices to become patient centered medical homes as defined in § 19-1A-01 of the Health – General Article, as enacted by Section 1 of this Act, and identify ways that Maryland Community Health Resources Commission resources can leverage additional assets to support the participation of federally qualified health centers and other primary care practices in a patient centered medical home program.

Maryland statutes provide a brief yet concise definition of a patient centered medical home that emphasizes the need for a personal physician to direct medical practices, taking into account whole person orientation that is well-coordinated. Although not mandated, finding and providing proper payment for efficient and quality health care is encouraged—the details of which are to be determined and regulated by the Maryland Health Care Commission.

While the recently-enacted legislation states a PCMH can be required to uphold NCQA standards, such decisions are up also up to the Commission. The Commission can develop a uniform set of health care quality and performance measures, which should incorporate the use of health information technology, including electronic medical records, and comprehensive medication management to improve clinical outcomes. PCMHs should be evaluated based on improvements in health care delivery, improved clinical care processes, increased access to care coordination, adequacy of enhanced payments to cover expanded services, increased patient satisfaction with care, increased clinician and staff work satisfaction, lower total costs of care, and reductions in health disparities.

During the 2009 legislative session, Governor Martin O'Malley signed [MD S 627](#), which directs the Maryland Health Care Commission and the Department of Business and Economic Development to report to the General Assembly by December 1, 2009 on the feasibility of making economic development funding available for physicians practices evolving to medical homes. The [Patient Centered Medical Home Workgroup](#) developed [recommendations](#) for a multi-stakeholder PCMH demonstration, which was submitted to the Governor's Health Cost and Quality Council in October 2009.

According to a Maryland AFP [newsletter](#), the Council adopted 12 recommendations that has moved the pilot toward reality in 2010. A key recommendation was that any adult primary care and pediatric practice that endorses the PCMH Joint Principles and can attain NCQA Level 1 PPC-PCMH should be eligible to participate in the pilot; however, the Maryland Health Care Commission will select fifty practices for participation. The Council also adopted a recommendation encouraging major insurance plans (private and governmental) to participate. The new law requires all of Maryland's major private insurers to participate. Practices that join

the pilot will test a new care, delivery and reimbursement model. Reimbursement to participants will be based on fee-for-service, care coordination payments, per member per month fees and performance bonuses. On the [pilot's website](#), providers can find additional resources on the medical home, including the NCQA joint principles.

The PCMH workgroup's June 11, 2010 meeting included a [presentation](#) on the PCMH pilot and the implementation timeline. The pilot is expected to begin January 1, 2011.

Massachusetts

[MA S 2863 of 2008](#)

Section 30. Notwithstanding any general or special law to the contrary, the office of Medicaid, subject to appropriation and the availability of federal financial participation, and in consultation with the MassHealth payment policy advisory board, shall establish a medical home demonstration project. Within the demonstration project the office of Medicaid shall restructure its payment system to support primary care practices that use a medical home model and shall develop a program to support primary care providers in developing an organizational structure necessary to provide a medical home. The office of Medicaid shall work with Medicaid managed care organizations to develop and implement the project.

The office shall consider payment methodologies that support care-coordination through multi-disciplinary teams, including payment for care of patients with chronic diseases and the elderly, and that encourage services such as: (i) patient or family education for patients with chronic diseases; (ii) home-based services; (iii) telephonic communication; (iv) group care; and (v) culturally and linguistically appropriate care. Payment shall reward quality and improved patient outcomes.

The office shall identify practices, for participation in the project, that provide care to its patients using a medical home model, which at minimum shall include primary care practices with a multi-specialty team that provides patient-centered care coordination through the use of health information technology and chronic disease registries, across the patient's life-span and across all domains of the health care system and the patient's community.

The office shall promulgate regulations for the phase-in and implementation of this demonstration project.

The office, subject to appropriation and in coordination with the health care workforce center and the Massachusetts Academy of Family Physicians, shall develop a program to provide support to practices interested in developing an organizational structure necessary to provide a medical home.

The office shall conduct an annual project evaluation including documentation of cost savings achieved through implementation; health care screening rates, outcomes and hospitalization rates for patients with chronic illnesses such as pediatric asthma, diabetes, heart disease, hospitalization and readmission rates for the frail elderly. The office shall submit a report of the evaluation to the senate and house chairs of the joint committee on health care financing and the chairs of the senate and house committees on ways and means.

Massachusetts law recognizes the need to restructure the Medicaid payment system in order to support primary care practices using a medical home model. Payment rates should be based on programs' ability to coordinate care, enhance access for consumers, and promote quality and improve patient outcomes. Through health information technology, chronic disease registries, and physician directed care, a medical home ought to incorporate a whole person orientation. Although neither the NCQA nor the PCMH joint principles are mentioned in the enacted legislation, the bill directs the Office of Medicaid to coordinate efforts with the Massachusetts Academy of Family Physicians—who endorses the adoption of the joint principles.

Because the [Massachusetts Executive Office of Health and Human Services](#) (EOHHS) set the goal for all primary care practices in the state to become patient-centered medical homes by the year 2015, EOHSS created the [Massachusetts Patient-Centered Medical Home Initiative \(PCMHI\)](#). In June 2009, Secretary of the Massachusetts Executive Office of Health and Human Services (EOHHS) Judyann Bigby, invited a large group of consumer, physician, nurse practitioner, hospital, insurer, state agency and other interested stakeholder representatives to form the [PCMHI Council](#). The Council focused its efforts on developing a [framework](#) for a multi-payer Patient-Centered Medical Home (PCMH) effort involving all the major Massachusetts commercial and Medicaid payers, and a diverse group of Massachusetts primary care practices.

The Council specifically advised that a practice should possess the following core competencies in order to be recognized as a PCMH:

1. Patient/family-centeredness: This means that longitudinal care is delivered with transparency, individualization, recognition, respect, linguistic and cultural competence, and dignity. Such care also provides patients/families/caregivers with choice in all matters and possesses an ongoing focus on consumer service, with bi-directional feedback.
2. Multi-disciplinary team-based approach to care: This is a less physician-centric hierarchical model for care delivery than is found in traditional primary care practice and is one that requires effective team communication, collaboration and role definition.
3. Planned visits and follow-up care: In contrast to episodic, reactive care, this manner of primary care delivery tracks patients on an ongoing basis so that the practice is informed and ready to address the patient's needs holistically whenever the patient makes contact, and follows up with patients after encounters, as necessary.
4. Population-based tracking and analysis with patient-specific reminders: To support planned visits and follow-up care, a practice needs information tracking capacity in the form of a freestanding or Electronic Health Record (EHR) based patient registry with reporting functionality.
5. Care coordination across settings, including referral and transition management: Practices assume responsibility for tracking and assisting patients as they move across care settings, and for coordinating services with other service providers including behavioral health and social service providers.
6. Integrated care management focused on high-risk patients: For the most clinically at-risk patients in a practice, a care manager is either a) based in the practice or b) residing outside of the practice but otherwise tightly integrated with the practice team.
7. Patient and family education: The practice team educates patients and family members both on primary preventive care, and on self-management of chronic illness (i.e., secondary preventive care).
8. Self-management support by all members of the practice team: Extending beyond education, self-management support assists the patient and/or family/caregiver with the challenges of ongoing self-management, directly and/or through referral.
9. Involvement of the patient in goal setting, action planning, problem solving and follow-up: Patient-centered primary care requires care planning and related activities focused on a patient's specific circumstances, wishes and needs.
10. Evidence-based care delivery, including stepped care protocols: Care should be evidence-based wherever evidence exists, and follow stepped protocols for treatment of illness.
11. Integration of quality improvement strategies and techniques: Practices should utilize the improvement model emphasized by the Institute for Healthcare Improvement to measure performance, identify opportunities for improvement, test interventions, and reassess performance.

12. Enhanced access: Another hallmark of patient-centered primary care is the availability of easy and flexible access to the primary care team, including alternatives to face-to-face visits, such as e-mail and telephone.

The Council advised that practices will require technical support and infrastructure development to successfully implement and master them. The Council further recommended the adoption of the following strategies to facilitate practice redesign among the PCMHI participating practices:

1. Learning collaborative: This is a one-to-two year effort that brings together participating primary care practice teams to learn from faculty using a structured syllabus, and to learn from each other through sharing of experience.
2. Continuing education courses: To supplement the learning collaborative and to help clinicians meet continuing education requirements, the MassAHEC Network could offer courses on the core competencies.
3. Practice coaching: Practice coaches assist practice teams before and after learning collaborative sessions and provide both quality improvement assistance and technical direction on practice redesign and transformation.
4. Patient registry: A patient registry allows a practice to track patients for the purposes of maintaining a history of clinical values, for indicating when a patient may be due for a service, and to examine practice performance caring for like groups of patients.
5. Frequent narrative and data reports from practices and written feedback from coaches: Practices submit narrative and quantitative data monthly and receive written feedback and suggestions from a practice coach.
6. Development of relationships with hospitals in order to receive timely notification of patient hospital admission, discharge and Emergency Room (ER) use: It is difficult for primary care practices to effectively perform the care management function with high-risk patients without their receipt of timely notification of hospital admission and discharge and of ER use.
7. Provision of timely, actionable data from payers and pharmacy benefit managers: While not viewed by practices to be of the same value as real-time notification of hospitalization and ER use, retrospective data can enable practices to benchmark and identify subpopulations in need of intervention, such as high risk patients, and patients who are not adhering to chronic illness medication regimens and are frequent users of ER services. Such data can also support medication reconciliation.
8. Provision of registry data trends and benchmarks: Because participating practices are expected to report data from their patient registries to a common repository, the practices have the opportunity to benefit from cross-practice registry trend and benchmark data.
9. Web site with support for social networking: Communication among practices, and from learning collaborative faculty and practice coaches to practices, can be strengthened through a web site or listserv.
10. Patient and family education: Practice teams may find patients and families/caregivers better able to engage as partners if consumers are educated regarding the medical home and the roles of both providers and patients. To promote the patient's role as a partner in health care, practices will provide training and tools to enhance their patients' self-management skills.

A [request for responses](#) was issued in July 2010 for the multi-payer initiative. Practices selected to participate will follow a three-year transformation plan working with medical home facilitators, submitting monthly reports based on a patient registry, and applying for medical home recognition by the National Committee for Quality Assurance (NCQA) within 18 months of the start of the Initiative.

Minnesota

[Chapter 256.963](#), Sec. 3. Primary Care Access Initiative. [MN H 1078/S 967 of 2007]

Subdivision 1. Establishment. (a) The commissioner shall award a grant to implement in Hennepin and Ramsey Counties a Web-based primary care access pilot project designed as a collaboration between private and public sectors to connect, where appropriate, a patient with a primary care medical home, and schedule patients into available community-based appointments as an alternative to nonemergency use of the hospital emergency room. The grantee must establish a program that diverts patients presenting at an emergency room for nonemergency care to more appropriate outpatient settings. The program must refer the patient to an appropriate health care professional based on the patient's health care needs and situation. The program must provide the patient with a scheduled appointment that is timely, with an appropriate provider who is conveniently located. If the patient is uninsured and potentially eligible for a Minnesota health care program, the program must connect the patient to a primary care provider, community clinic, or agency that can assist the patient with the application process. The program must also ensure that discharged patients are connected with a community-based primary care provider and assist in scheduling any necessary follow-up visits before the patient is discharged.

(b) The program must not require a provider to pay a fee for accepting charity care patients or patients enrolled in a Minnesota public health care program.

...
Sec. 19. Care Coordination Pilot Projects. Subdivision 2. Requirements. In order to be designated a pilot project, health care professionals in a medical home must demonstrate the ability to:

- (1) be the patient's first point of contact by telephone or other means, 24 hours per day, seven days a week;
- (2) provide or arrange for patients' comprehensive health care needs, including the ability to structure planned chronic disease visits and train and support the caregivers to effectively monitor and manage the person's health condition;
- (3) coordinate patients' care when care must be provided outside the medical home;
- (4) provide longitudinal care, not just episodic care, including meeting long-term and unique personal needs; and
- (5) systematically improve quality of care using, among other inputs, patient feedback.

Subd. 3. Evaluation. Pilot projects must be evaluated based on patient satisfaction, provider satisfaction, clinical process and outcome measures, program costs and savings, and economic impact on health care providers. Pilot projects must be evaluated based on the extent to which the medical home:

- (1) coordinated health care services across the continuum of care and thereby reduced duplication of services and enhanced communication across providers;
- (2) provided safe and high-quality care by increasing utilization of effective treatments, reduced use of ineffective treatments, reduced barriers to essential care and services, and eliminated barriers to access;

- (3) reduced unnecessary hospitalizations and emergency room visits and increased use of cost-effective care and settings;
- (4) encouraged long-term patient and provider relationships by shifting from episodic care to consistent, coordinated communication and care with a specified team of providers or individual providers;
- (5) engaged and educated consumers by encouraging shared patient and provider responsibility and accountability for disease prevention, health promotion, chronic disease management, acute care, and overall well-being, encouraging informed medical decision-making, ensuring the availability of accurate medical information, and facilitated the transfer of accurate medical information;
- (6) fostered the expansion of a technology infrastructure that supports collaboration; and
- (7) reduced overall health care costs as compared to conventional payment methods for similar patient populations.

Chapter 256B.0751. Health Care Homes. [MN S 3780/H 3924 of 2008]

Subd. 2. Development and implementation of standards.

(a) By July 1, 2009, the commissioners of health and human services shall develop and implement standards of certification for health care homes for state health care programs. In developing these standards, the commissioners shall consider existing standards developed by national independent accrediting and medical home organizations. The standards developed by the commissioners must meet the following criteria:

- (1) emphasize, enhance, and encourage the use of primary care, and include the use of primary care physicians, advanced practice nurses, and physician assistants as personal clinicians;
- (2) focus on delivering high-quality, efficient, and effective health care services;
- (3) encourage patient-centered care, including active participation by the patient and family or a legal guardian, or a health care agent as defined in chapter 145C, as appropriate in decision making and care plan development, and providing care that is appropriate to the patient's race, ethnicity, and language;
- (4) provide patients with a consistent, ongoing contact with a personal clinician or team of clinical professionals to ensure continuous and appropriate care for the patient's condition;
- (5) ensure that health care homes develop and maintain appropriate comprehensive care plans for their patients with complex or chronic conditions, including an assessment of health risks and chronic conditions;
- (6) enable and encourage utilization of a range of qualified health care professionals, including dedicated care coordinators, in a manner that enables providers to practice to the fullest extent of their license;
- (7) focus initially on patients who have or are at risk of developing chronic health conditions;
- (8) incorporate measures of quality, resource use, cost of care, and patient experience;
- (9) ensure the use of health information technology and systematic follow-up, including the use of patient registries; and

(10) encourage the use of scientifically based health care, patient decision-making aids that provide patients with information about treatment options and their associated benefits, risks, costs, and comparative outcomes, and other clinical decision support tools.

(b) In developing these standards, the commissioners shall consult with national and local organizations working on health care home models, physicians, relevant state agencies, health plan companies, hospitals, other providers, patients, and patient advocates. The commissioners may satisfy this requirement by continuing the provider directed care coordination advisory committee.

(c) For the purposes of developing and implementing these standards, the commissioners may use the expedited rulemaking process under section 14.389.

Subd. 3. Requirements for clinicians certified as health care homes.

(a) A personal clinician or a primary care clinic may be certified as a health care home. If a primary care clinic is certified, all of the primary care clinic's clinicians must meet the criteria of a health care home. In order to be certified as a health care home, a clinician or clinic must meet the standards set by the commissioners in accordance with this section. Certification as a health care home is voluntary. In order to maintain their status as health care homes, clinicians or clinics must renew their certification annually.

(b) Clinicians or clinics certified as health care homes must offer their health care home services to all their patients with complex or chronic health conditions who are interested in participation.

(c) Health care homes must participate in the health care home collaborative.

Minnesota emphasizes that the PCMH is particularly beneficial for those with chronic illnesses but does not limit its use to only managing chronic disease. In HB 1078 of 2007, Sec. 19 establishes a care coordination project, which requires medical homes to provide physicians as the first point of contact and to enhance access to care by being available for communication 24 hours per day. Physician directed care, whole person orientation, and coordinated care are also required. Through various types of input—including patient feedback—medical homes are intended to systematically improve quality of care. Increased safety is another provided goal of the PCMH, which includes increasing utilization of effective treatments, reducing use of ineffective treatments, reducing barriers to essential care and access.

The Minnesota Department of Health (MDH) currently has two health care work groups that are charged with providing input and suggestions to the Commissioners of Health and Human Services. On July 6, 2009, the [Standards and Criteria Work Group](#) published a [proposed rule](#) developing and implementing standards of certification for health care homes for state health care programs. The purpose of the standards is to require health care homes to deliver services that:

A. facilitate consistent and ongoing communication among the health care home and the patient and family, and provide the patient with continuous access to the patient's health care home;

B. use an electronic, searchable patient registry that enables the health care home to manage health care services, provide appropriate follow-up, and identify gaps in patient care;

C. include care coordination that focuses on patient and family-centered care;

- D. include a care plan for selected patients with a chronic or complex condition, involve the patient and, if appropriate, the patient's family in the care planning process; and
- E. reflect continuous improvement in the quality of the patient's experience, the patient's health outcomes, and the cost-effectiveness of services.

Both the enacted legislation and proposed rule address each of the PCMH joint principles with the exception of payment. On January 11, 2011, the Minnesota Department of Health and Department of Human Services published an [adopted rule](#) which established certification procedures, including applications, on-site reviews and necessary documentation. Applicants interested in becoming a certified medical home must incorporate standards concerning:

Access and communication standards—applicants must:

- A. offer health care home services to all patients who:
 - 1. have or are at risk of developing complex or chronic conditions; and
 - 2. are interested in participation.
- B. establish a system designed to ensure that:
 - 1. participants are informed that they have continuous access to designated clinic staff, an on-call provider, or a phone triage system
 - 2. the designated clinic staff, on-call provider, or phone triage system representative has continuous access to participants' medical record information
 - 3. staff can schedule an appointment based on (a) the acuity of the condition and (b) application of protocol that address whether to schedule an appointment within one business day to avoid unnecessary ER visits and hospitalizations
- C. collect information about participants' cultural background, racial heritage, primary language, which will be used to improve care
- D. document that participants' preferred means of communication can be used
- E. inform participants that a specialty care resource may be chosen without regard to whether a specialist is a member of the same provider group or network
- F. establish adequate information and privacy security measures to comply with applicable privacy and confidentiality laws

Participant registry and tracking participant care activity.

Care coordination—collaboration within the health care home includes the patient, the care coordinator, personal clinician and specialists.

Care plan--establish and implement procedures to determine whether a care plan will benefit patients.

Performance reporting and quality improvement—including:

- A. establish a health care home quality improvement team
- B. establish procedures for the team to share work and elicit feedback from staff
- C. demonstrate capability in performance measurement by show measurement, analysis, and tracked changes of at least one quality indicator
- D. participate in a health care home learning collaborative
- E. establish procedures for representatives of the health home to share information learned through the collaborative and elicit feedback from staff

Recertification at the end of first year—improvements in care documented for each standard.

On August 17, 2010, MDH published a [news release](#) announcing that the first 11 health care homes in the state are certified. The Department's goal is to certify up to 150 organizations by the end of 2011. Currently, nearly 50 additional clinics from around the state, representing more than 400 clinicians, are in the process of applying for certification. In addition, about 500 people have attended certification training sessions at regional workshops around the state, and more than 30 individual clinics and health systems have received a variety of mini-grants to help them move toward certification.

The state's Minnesota [Children with Special Health Needs](#) section of the Department of Health also has been involved in the development of medical home in Minnesota since the early 1990's. This initiative defines "medical home" as an approach to primary care where primary providers, families and patients work in partnership to improve quality and value in the health care system, and improve health outcomes for individuals with chronic health conditions and disabilities. This approach improves the way the individual clinicians and the clinic systems work with and meet the needs of all individuals with chronic, complex health conditions or disabilities using the following tools and strategies:

1. Developing trusting relationships with patients/families
2. Partnering with and learning from patients and families
3. Using a team approach for the care of chronic conditions, which includes planned, proactive visits
4. Coordinating care
5. Co-managing with patients/families and specialists
6. Assisting with transitions
7. Providing connections with community organizations
8. Is satisfying for patients/families, providers and clinic staff
9. Continuously works on quality improvement

Mississippi

[2010 HB 1192](#)

Patient-centered medical homes: (1) provide whole-person orientation; (2) must have Health Information Exchange compliant records, electronic patient health records, and disease management applications; (3) actively participate in health care decision making and seek patient feedback; (4) coordinate care across all elements of the health care system; (5) reduce racial and ethnic disparities in terms of medical access; (6) in accordance to the Joint Principles of the Patient-Centered Medical Home, are recognized by the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Physicians, and the American Osteopathic Association; (7) should meet the specified criteria of the National Committee for Quality Assurance; and (8) will participate in the Federal Tax Relief and Health Care Act's three-year demonstration project across eight states.

[2005 MS 9484](#)

A medical home is defined as the usual and customary source that provides both preventive and treatment or diagnosis of a specific illness, symptom, complaint, or injury. The medical home will serve as the focal point for a beneficiary's health care, providing care that is accessible, accountable, comprehensive, integrated, and patient centered.

Mississippi adopted a definition of “medical home”—by passing HB 1192 in 2010—that explicitly mentions six of the seven PCMH joint principles in addition to stating that PCMHs should be in accordance to the joint principles and NCQA criteria. The measure also requires the State Board of Health to adopt guidelines applicable to physician practices, nurse practitioner practices and physician assistant practices in the state that incorporate the principles of the patient-centered medical home.

As early as April 2005, Mississippi's Medicaid program recognized the importance of the medical home model and created the initiative, the [Mississippi Medicaid Medical Home](#) to emphasize wellness and disease avoidance and to prevent unnecessary emergency department visits. The initiative has returned as part of the [Mississippi Coordinated Access Network](#), a coordinated care program created in 2009 for Medicaid beneficiaries. Under the new voluntary program, the state's Division of Medicaid expects Coordinated Care Organizations to connect beneficiaries to a medical home and implement comprehensive care management programs for target populations. The state recently issued a [Request for Proposals](#) from vendors to serve as an Implementation Manager for a Coordinated Care Program.

The University of Mississippi Medical Center's [Department of Family Medicine](#) recently converted to an electronic health record as part of an effort toward becoming a designated Medical Home. As the school's first department to provide PDAs to residents, the Department continues to emphasized point-of-care evidence-based medicine.

Nebraska

[Chapter 68-958 Medical Home Pilot Program Act. \[NE LB 396 of 2009\]](#)

Section 3. (2) Medical home means a provider of primary health care services to patients that meets the requirements for participation in the medical home pilot program established under section 5 of this act.

...

[Chapter 68-960.](#)

Section 5. A medical home shall:

- (1) Provide comprehensive, coordinated health care for patients and consistent, ongoing contact with patients throughout their interactions with the health care system, including, but not limited to, electronic contacts and ongoing care coordination and health maintenance tracking for patients;
- (2) Provide primary health care services for patients and appropriate referral to other health care professionals or behavioral health professionals as needed;
- (3) Focus on the ongoing prevention of illness and disease;
- (4) Encourage active participation by a patient and the patient's family, guardian, or authorized representative, when appropriate, in health care decisionmaking and care plan development;
- (5) Encourage the appropriate use of specialty care services and emergency room services by patients; and
- (6) Provide other necessary and appropriate health care services and supports to accomplish the purposes of the Medical Home Pilot Program Act.

The Nebraska statutes do not explicitly refer to the PCMH joint principles but indicate that enhanced access and integration of care is important by requiring a medical home to maintain contact with patients throughout interactions with the health care system, which includes electronic contacts and ongoing care coordination. This along with the provision concerning a focus on preventative services suggests that the medical home is responsible for whole person orientation.

In Section 5, provision (2) implies that the medical home also directs all medical care in referring a patient to appropriate specialists when needed; however, this statute does not mandate that a personal physician direct patients' care. Quality and safety are not mentioned; however, one could assume that implementing "comprehensive, coordinated health care" with "ongoing contact with patients" would lead to both improved quality and increased safety. Appropriate payment is also not discussed within the law but provision (6) does not clarify what "necessary and appropriate health care services and supports" could include.

New Hampshire

[NH H 2 of 2009](#)

144:27 Department of Health and Human Services; Medical Home Pilot Program.

The department of health and human services shall develop a medical home pilot program utilizing disease management funds available when the disease management contract ends and other such grant funds as may become available for this purpose.

Although not through legislation, the state of New Hampshire adopted the PCMH joint principles as the basis of the Multi-Stakeholder Medical Home Pilot. The [New Hampshire Multi-Stakeholder Medical Home Handbook](#) requires participants to agree to the concepts outlined in the joint principles of the patient-centered medical home.

The [New Hampshire Citizens Health Initiative website](#) explains that the goal of the Multi-Stakeholder Medical Home Pilot is to value, prescribe and reward medical care that is tightly coordinated and of superior quality and efficiency. The patient-centered medical home concept re-centers health care on the patient's needs and priorities by providing primary, preventive, and chronic condition care that is personalized for each patient. It emphasizes the use of care coordination and health information technology, including electronic health records, to help prevent and manage chronic disease. It also features consumer conveniences such as same-day scheduling and secure e-mail communications. The medical home strengthens the patient-physician relationship by allowing the doctor and team of health professionals to spend more time with each patient and to develop and follow through on an individualized plan of care.

Within the state Medicaid program under the Department of Health and Human Services is the [Enhanced Care Coordination](#) (ECC) program. This pilot program is a Medicaid initiative that offers comprehensive, patient-centered medical management and care coordination. The program works with Medicaid recipients who are Medicaid eligible through the Temporary Assistance to Needy Families (TANF) and Aid to the Permanently and Totally Disabled (APTD) categories of assistance and existing DHHS funded community based case managers. According to the [program website](#), in addition to ensuring coordinated medical and behavioral health services and individualized health care plans focused on prevention for Medicaid recipients with complex health care needs, the program components also include: fostering the concept of a Medical Home, establishing a 24-hour, seven days a week nurse call line, implementation of standardized, evidence-based clinical guidelines for decision making, provider outreach and support, client incentive programs, and quality improvement via benchmarking, establishing performance standards and outcomes measurement.

The [CIGNA and Dartmouth-Hitchcock Patient-Centered Medical Home Pilot](#) was launched in June 2008 with the goal of improving the quality, affordability and patient satisfaction with care through collaboration and aligned incentives. The program has three key components: clinical information, clinical collaboration, and a blended payment model.

New Jersey

2004 NJ 16588

“Medical Home” means an approach to providing healthcare that is defined by care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent.

Other than requiring care to be “accessible,” “continuous,” “comprehensive,” and “coordinated” the New Jersey definition is open-ended as to what a medical home can and should entail.

New Mexico

[NM H 710 of 2009](#) Section 1.

A. The "medical home" is an integrated care management model that emphasizes primary medical care that is continuous, comprehensive, coordinated, accessible, compassionate and culturally appropriate. Care within the medical home includes primary care, preventive care and care management services and uses quality improvement techniques and information technology for clinical decision support. Components of the medical home model may include:

- (1) assignment of recipients to a primary care provider, clinic or practice that will serve as a medical home;
- (2) promotion of the health commons model of service delivery, whereby the medical home tracks recipients' primary care, specialty, behavioral health, dental health and social services needs as much as practicable;
- (3) health education, health promotion, peer support and other services that may integrate with health care services to promote overall health;
- (4) health risk or functional needs assessments for recipients;
- (5) a method for reporting on the effectiveness of the medical home model and its effect upon recipients' utilization of health care services and the associated cost of utilization of those services;
- (6) mechanisms to reduce inappropriate emergency department utilization by recipients;
- (7) financial incentives for the provision of after-hours primary care;
- (8) mechanisms that ensure a robust system of care coordination for assessing, planning, coordinating and monitoring recipients with complex, chronic or high-cost health care or social support needs, including attendant care and other services needed to remain in the community;
- (9) implementation of a comprehensive, community-based initiative to educate recipients about effective use of the health care delivery system, including the use of community health workers or promotoras;
- (10) strategies to prevent or delay institutionalization of recipients through the effective utilization of home- and community-based support services;
- (11) a primary care provider for each recipient, who advocates for and provides ongoing support, oversight and guidance to implement an integrated, coherent, cross-disciplinary plan for ongoing health care developed in partnership with the recipient and including all other health care providers furnishing care to the recipient;
- (12) implementation of evidence-based medicine and clinical decision support tools to guide decision-making at the point-of-care based upon recipient specific factors;
- (13) use of comparative effectiveness to make a cost-benefit analysis of health care practices;
- (14) use of health information technology, including remote supervision, recipient monitoring and recipient registries, to monitor and track the health status of recipients;
- (15) development and use of safe and secure health information technology to promote convenient recipient access to personal health information, health services and web sites with tools for patient self-management;
- (16) implementation of training programs for personnel involved in the coordination of care for recipients;

(17) implementation of equitable financial incentive and compensation systems for primary care providers and other staff engaged in care management and the medical home model; and

(18) any other components that the secretary determines will improve a recipient's health outcome and that are cost-effective.

B. For the purposes of this section, "primary care provider" means a medical doctor or physician assistant licensed under the Medical Practice Act to practice medicine in New Mexico or a certified nurse practitioner as defined in the Nursing Practice Act who provides first contact and continuous care for individuals under the physician's care and who has the staff and resources to manage the comprehensive and coordinated health care of each individual under the primary care provider's care."

2004 NM 4018

YY. Medical home: A conceptual model that facilitates the provision of quality care that is accessible, family-centered, continuous, coordinated, compassionate and culturally competent.

Within the 18 components of the medical home under the state's law, each of the seven joint principles is addressed but not mandated. Component (2) and (11) state that patients will have a personal primary care provider (PCP) who will direct their medical care taking into consideration the whole person. However, under New Mexico law, a PCP is not necessarily a physician and could be a licensed physician assistant or a certified nurse practitioner.

The enacted legislation also states that appropriate payment should be implemented for primary care providers and staff engaged in the medical home model and financial incentives should be in-place for after-hours services. Offering late-night services, as well as implementing strategies to prevent emergency services and developing personal health information technology—all enhance a patient's access to care. Coordinated and integrated care are mentioned throughout the legislation, including components (3) and (8). From assessing patients' health risks to implementing evidence-based medicine and clinical decision support tools, quality and safety are also considered in the state's definition of a "medical home."

New York

PBH – Public Health, Article 27-L, 2799-S. Medical Home Demonstration Programs. [NY S 6807 of 2008]

1. The commissioner [of health], in consultation with the New York state chapter of the American College of Physicians and primary care physicians, shall establish two medical home demonstration programs, one to be located in the county of Nassau and the second to be located in the county of Onondaga, the purpose of which is to evaluate the effectiveness of the medical home concept in promoting health through both treatment of patients with chronic medical conditions and providing preventative care and improving health care delivery. A "medical home demonstration program," for purposes of this article, is defined as a program that incorporates the delivery of health care in a variety of settings based upon the needs of the patient and the skills of a provider, and is designed to furnish continuous, comprehensive medical care. It is facilitated through an ongoing, personal relationship between a patient and his or her primary care provider.
2. In approving such medical home demonstration programs, the commissioner shall consider the following characteristics, including but not limited to, the extent to which the program:
 - (a) uses health information technology and other innovations to support the management and coordination of care provided to patients;
 - (b) has established, where practical, effective referral relationships between the primary care provider and the major medical specialties and ancillary services in the region;
 - (c) applies standards for access to care and communication with demonstration participants for whom it provides care;
 - (d) has the ability to collect and maintain readily accessible, clinically useful information on demonstration participants that will enable the program to comprehensively and systematically treat such participants;
 - (e) can implement evidence-based guidelines and apply such guidelines to the identified needs of individual participants and the programs' patient population over time;
 - (f) assists in the early identification of health care needs; and
 - (g) provides ongoing primary care including care for acute, chronic and preventative needs.

SOS – Social Services, Title 11 – Medical Assistance for Needy Persons. 364-M Statewide patient centered medical home program. [NY A 158 of 2009]

1. The commissioner of health is authorized to certify certain clinicians and clinics as health care homes in order to improve health outcomes and efficiency through patient care continuity and coordination of health services. These providers will be eligible for enhanced payments for services provided to: recipients eligible for Medicaid fee-for-service; enrollees eligible for Medicaid managed care; enrollees eligible for and enrolled in Family Health Plus organizations pursuant to title eleven-D of this article ("Family Health Plus"); and enrollees eligible for and enrolled in Child Health Plus. As used in this section "clinic" means a general hospital providing outpatient care or a diagnostic and treatment center, licensed under article twenty-eight of the public health law.
2. By December first, two thousand nine, the commissioner of health shall develop and implement standards of certification for patient centered medical homes for Medicaid fee-for-

service and Medicaid managed care, Family Health Plus and Child Health Plus programs. In developing such standards, the commissioner of health shall:

- (a) consider existing standards developed by national accrediting and professional organizations; and
 - (b) consult with national and local organizations working on medical home models, physicians, hospitals, clinics, health plans and consumers and their representatives.
3. To maintain their certification, patient centered medical homes must:
- (a) renew their certification at a frequency determined by the commissioner of health; and
 - (b) provide data to the department of health and to health plans in which the patient is enrolled to permit the commissioner of health to evaluate the impact of patient centered medical homes on quality, outcomes and cost.
4. Subject to the availability of funding and federal financial participation, the commissioner of health is authorized:
- (a) To pay enhanced rates of payment to clinics and clinicians that are certified as patient centered medical homes under this section. Such enhancements may be tiered based on the level of standard achieved by the clinician or clinic; and
 - (b) To pay additional amounts for patient centered medical homes that meet specific process or outcome standards specified by the commissioner of health.

...

PBH – Public Health, Article 29-A, Title 2 Adirondack Medical Home Multipayor Demonstration Program.

Section 2959. 1. The commissioner is authorized to establish an Adirondack medical home multipayor demonstration program and may certify certain clinicians and clinics in the upper northeastern region of New York as medical homes eligible for enhanced payments for services provided to: recipients eligible for medical assistance pursuant to title eleven of article five of the social services law ("Medicaid fee-for-service"); enrollees eligible for medical assistance pursuant to such title and enrolled in approved managed care organizations pursuant to section three hundred sixty-four-j of such title ("Medicaid managed care"); enrollees eligible for Family Health Plus and enrolled in approved organizations pursuant to title eleven-D of article five of the social services law ("Family Health Plus"); enrollees eligible for the child health insurance program and enrolled in approved organizations pursuant to title one-A of article twenty-five of this chapter ("Child Health Plus Program"); enrollees and subscribers of commercial managed care plans operating in accordance with the provisions of article forty-four of this chapter or by health maintenance organizations organized and operating in accordance with article forty-three of the insurance law; enrollees and subscribers of other commercial insurance products; and employees of employer-sponsored self-insured plans. The purpose of this demonstration program is to improve health care outcomes and efficiency through patient care continuity and coordination of health services.

2. (a) In order to promote improved quality of, and access to, health care services and promote improved clinical outcomes to the residents in the upper northeastern region of New York, it shall be the policy of the state relating to the demonstration program to encourage cooperative, collaborative and integrative arrangements between payors of health care services and health care services providers who might otherwise be competitors, under the active supervision of the commissioner.

...

3. The commissioner, for purpose of the demonstration program, is authorized to participate in, actively supervise, facilitate and approve a primary care medical home collaborative with health care services providers, which may include hospitals, diagnostic and treatment centers, and private practices, and payors of health care services, including employers, health plans and insurers, to establish:

- (a) the boundaries of the demonstration and the providers eligible to participate;
- (b) practice standards for the medical home consistent with existing standards developed by national accrediting and professional organizations including the joint principles of the American College of Physicians ("ACP"), the American Academy of Family Physicians ("AAFP"), the American Academy of Pediatrics ("AAP"), the American Osteopathic Association ("AOA"), and as further defined by "Patient Centered Medical Home," as represented in certification programs developed by the National Committee for Quality Assurance ("NCQA");
- (c) methodologies by which payors will provide enhanced rates of payment to certified medical homes; and
- (d) methodologies to pay additional amounts for medical homes that meet specific process or outcome standards established by the Adirondack medical home collaborative.

4. Patient and health care services provider participation in the Adirondack medical home multipayor demonstration program shall be on a voluntary basis.

5. Clinics and clinicians participating in this demonstration are not eligible for additional enhancements or bonuses under the statewide medical home program, established pursuant to section three hundred sixty-four-m of the social services law, for services provided to participants in Medicaid fee-for-service, Medicaid managed care, Family Health Plus or Child Health Plus.

6. Subject to the availability of funding and federal financial participation, the commissioner is authorized:

- (a) To pay enhanced rates of payment under Medicaid fee-for-service, Medicaid managed care, Family Health Plus and Child Health Plus to clinics and clinicians that are certified as medical homes under this title; and
- (b) To pay additional amounts for medical homes that meet specific process or outcome standards specified by the commissioner, in consultation with the Adirondack medical home collaborative.

Article 27-L, 2799-S of the New York Public Health statutes state that the medical home is based on an "ongoing, personal relationship between a patient and his or her primary care provider." Ongoing primary care should include acute, chronic and preventative needs, which accounts for whole person orientation. Through health information technology and other innovations care should be managed and coordinated. When needed, the personal primary care provider should make referrals based established relationships with other specialists. Evidence-based guidelines should be implemented to promote quality and safety. Standards for access to care and communication with participants of the medical home demonstration program are to be established.

In Title 11, 364-M of the Social Services statutes, providers will be eligible for enhanced payments for services provided to recipients of certain public health plans in a health care

home. The commissioner of health is authorized (subject to availability of funding and federal financial participation) to pay enhanced rates to patient center medical homes.

Article 29-A, Title 2 of the Public Health statute authorizes the commissioner to also facilitate a primary care medical home collaborative with health care providers, which can established the practice standards for the medical home consistent with existing standards developed by national accrediting and professional organizations, including the joint principles of various organizations including the NCQA.

New York has several [PCMH pilot programs](#) in place. The CDPHP Patient-Centered Medical Home Pilot is creating a new primary care reimbursement methodology that is sustainable and scalable. The New York Hudson Valley p4p/Medical Home Project is implementing innovative programs to potentially improve quality and reduce the cost of health care. The EmblemHealth Medical Home High Value Network Project seeks to determine whether the provision of enhanced payment and support for redesign and care management results in greater transformation of supported practices to medical homes and better performance on measures of quality, efficiency, and patient experience than in comparison practices.

North Carolina

[Carolina ACCESS](#) is the state's Medicaid managed care program. It connects residents with a medical home and a primary care provider (PCP) to coordinate medical care.

According to the [Carolina ACCESS Member Handbook](#), a medical home:

- offers the very best of care for you. The staff will know you and your medical history. They will coordinate your health care with other doctors who may need to treat you.
- can be a doctor's office, a community clinic, or a local health department.
- provides a PCP you can call for help when you need to. You no longer have to go to the emergency department when your problem does not threaten your life or risk your health without immediate treatment.
- provides treatment and/or medical advice 24 hours a day, 7 days a week.

North Carolina law does not provide a definition for "medical home;" however, according to the state's Medicaid managed care program, Carolina ACCESS, enhanced access—including available treatment and medical advice 24 hours per day—should be a priority for a medical home model of care. Although nothing mentioned guarantees a personal physician, the medical home staff should provide personal, whole person care.

Oklahoma

[OK Administrative Code 310:550-1-2. Definitions](#)

"Planned Health Care Provider" or "Medical Home" means the health care provider who will be providing health care for the infant after discharge from the hospital.

[OK HCR 1058 of 2008](#)

Whereas, the patient-centered medical home provides a whole-person orientation that includes care for all stages of life, acute care, chronic care, preventive services, and end-of-life care; and

Whereas, patients in a patient-centered medical home actively participate in decision-making and feedback is sought to ensure the expectations of a patient are being met; and

Whereas, care in the patient-centered medical home is integrated across all elements of the health care system and the community of the patient to assure that patients receive the indicated care when and where they need in a culturally and linguistically appropriate manner; and

Whereas, when minorities have a medical home, racial and ethnic differences in terms of medical access disappear as noted in the publication "Closing the Divide: How Medical Homes Promote Equity in Health Care", published by the Commonwealth Fund (June 2007); and

Whereas, four national physician organizations, the American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, and American Osteopathic Association, representing more than 333,000 physicians across the country have developed joint principles that describe the characteristics of the patient-centered medical home; and

Whereas, the National Committee for Quality Assurance is developing a patient-centered medical home designation program for physician practices meeting specific criteria; and

Whereas, a patient-centered medical home for every American has a potential national savings of \$67 billion per year with improvement in the quality of health care provided; and

Whereas, the federal Tax Relief and Health Care Act calls for a three-year medical home demonstration project to be conducted in eight states with an estimated start in 2009; and

Whereas, the Council of State Governments supports the Joint Principles of the Patient-Whereas Medical Home as a guideline for states to improve the health of citizens; and

Whereas, the Council of State Governments encourages states to study programs to demonstrate the quality, safety, value, and effectiveness of the patient-centered medical home.

Now, therefore, be it resolved by the House of Representatives of the 2nd session in the 51st Oklahoma Legislature, the Senate concurring therein: that the Legislature concurs with patient-centered medical home principles and will work towards and encourage all health systems in Oklahoma to study and implement these principles.

The Oklahoma statutory definition of "medical home" only pertains to infants. In 2008, the legislature passed a house concurrent resolution acknowledging the importance of the patient-centered medical home and the joint principles of the PCMH for providing care to patients in all stages of life. HCR 1058 states that both the state House of Representatives and the Senate "will work towards and encourage all health systems in Oklahoma to study and implement these principles."

In 2007 a [Medical Advisory Task Force](#) (MAT) was formed to collaborate with the Oklahoma Health Care Authority and review the possibility of changing some of the elements of our current primary care delivery system. The MAT recommended a patient-centered medical home model—defined as an approach to providing comprehensive primary care for people of all ages and medical condition—for every SoonerCare Choice member.

Oregon

Chapter 414 – Medical Assistance. [OR SB 329 of 2007]

SECTION 4. The intent of the Healthy Oregon Act is to develop an Oregon Health Fund program comprehensive plan, based upon the principles set forth in section 3 of this 2007 Act, that meets the intended goals of the program to:

...

(7) Use proven models of health care benefits, service delivery and payments that control costs and overutilization, with emphasis on preventive care and chronic disease management using evidence-based outcomes and a health benefit model that promotes a primary care medical home.

...

SECTION 9. (2) The Oregon Health Fund Board shall develop a comprehensive plan to achieve the Oregon Health Fund program goals listed in section 4 of this 2007 Act. The board shall establish subcommittees, organized to maximize efficiency and effectiveness and assisted, in the manner the board deems appropriate, by the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research, the Health Services Commission and the Medicaid Advisory Committee, to develop proposals for the Oregon Health Fund program comprehensive plan. The proposals may address, but are not limited to, the following:

...

(b) Delivering health services in the Oregon Health Fund program, including but not limited to proposals for:

...

(B) The design and implementation of a program to create a public partnership with accountable health plans to provide, through the use of an Oregon Health Card, health insurance coverage of the defined set of essential health services that meets standards of affordability based upon a calculation of how much individuals and families, particularly the uninsured, can be expected to spend for health insurance and still afford to pay for housing, food and other necessities. The proposal must ensure that each accountable health plan:

...

(viii) Ensures that all enrollees have a primary care medical home;

Although the Legislature did not provide a comprehensive definition of “medical home” in the Healthy Oregon Act of 2007, the Office for Oregon Health Policy and Research’s [The Medical Home Model of Primary Care: Implications for the Healthy Oregon Act](#) analyzes the implications of the medical home portion of the act. The report includes the PCMH joint principles in its analyses, stating that the primary care medical home can generally be characterized as a primary care practice which provides the following to its patients: a continuous relationship with a physician; a multidisciplinary team that is collectively responsible for providing for a patient’s longitudinal health needs and making appropriate referrals to other providers; coordination and integration with other providers, as well as public health and other community services, supported by health information technology; an expanded focus on quality and safety; and enhanced access through extended hours, open scheduling, and/or email or phone visits. This document also analyzes and compares various PCMH programs and definitions, including tools developed by the NCQA.

Rhode Island

40-8.4-19. Managed health care delivery systems for families. [\[RI H 5112 of 2009\]](#)

(a) Managed health care delivery systems for families. Managed care" is defined as systems that: integrate an efficient financing mechanism with quality service delivery; provide a "medical home" to assure appropriate care and deter unnecessary services; and place emphasis on preventive and primary care.

...

40-8.5-1.1. Managed health care delivery systems.

(b) "Managed care" is defined as systems that: integrate an efficient financing mechanism with quality service delivery; provides a "medical home" to assure appropriate care and deter unnecessary services; and place emphasis on preventive and primary care. For purposes of Medical Assistance, managed care systems are also defined to include a primary care case management model in which ancillary services are provided under the direction of a physician in a practice that meets standards established by the department of human services.

Rhode Island statutes do not provide a definition of "medical home" but rather include this term in defining "managed care." According to these two statutes, medical homes assure appropriate care, deter unnecessary services, and place emphasis on preventative and primary care.

The [Rhode Island Chronic Care Sustainability Initiative](#) is a PCMH demonstration resulting from a two-year, broad multi-stakeholder process, funded by a grant from the Center for HealthCare Strategies to the RI Office of the Health Insurance Commissioner. All Rhode Island payers except FFS Medicare are participating. This program includes the NCQA PCMH standards of performance and payment.

Texas

Chapter 2203. Health Care Services. Sec. MEDICAL HOME. [TX H 3121 of 2007]

2203.003. The program must provide health care services through a primary care model, in which a physician, nurse practitioner, or physician assistant develops and directs a plan of care for the enrollee, coordinates referrals for medical testing and specialty services, and monitors the management of chronic conditions and diseases.

2004 TX 96770

(12) Medical home--A community-based system of health care delivery that provides individual patients a known resource (primary care provider or clinic) for all primary and preventive care services. It also provides continuity of care for primary acute needs 24 hours a day, and is networked to any necessary consultative, specialty, and health-related services.

2005 TX 97031

(40) Medical Home-- A PCP or specialty care Provider who has accepted the responsibility for providing accessible, continuous, comprehensive and coordinated care to Members participating in an HHSC HMO.

...

(48) Primary Care Provider-- A physician or provider who has agreed with the HMO to provide a Medical Home to Members and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

2005 TX 98979

(32) Medical home--A respectful partnership between a client, the client's family as appropriate, and the client's primary health care setting. A medical home is family centered health care that is accessible, continuous, comprehensive, coordinated, compassionate, and culturally competent. A medical home includes a licensed medical professional who accepts responsibility for the provision and/ or coordination of primary, preventive, and/ or specialty care for a client, and coordination of care with other community services providers.

...

(A) Medical home. Each CSHCN Services Program client should receive care in the context of a medical home.

(i) Comprehensive coordinated health care of infants, children, and adolescents should encompass the following services:

(I) provision of preventive care, including but not limited to, immunizations; growth and development assessments; appropriate screening health care supervision; client and parental counseling about health care supervision; and client and parental counseling about health and psychological issues;

- (II) assurance of ambulatory and inpatient care for acute illness, 24 hours a day, seven days a week (including after hours and weekends);
 - (III) provision of care over an extended period of time to enhance continuity;
 - (IV) identification of the need for sub-specialty consultation and referrals, provision of medical information about the client to the consultant, evaluation of the consultant's recommendations, implementation of recommendations that are indicated and appropriate, and interpretation of the consultant's recommendations for the family;
 - (V) interaction with school and community agencies to assure that the special health needs of the client are addressed; and
 - (VI) maintenance of a central record and database containing all pertinent medical information about the client, including information about hospitalizations.
- (ii) The CSHCN Services Program may require periodic reports from the medical home.

Texas does not require physician directed care in patient-centered medical homes but rather refers to a licensed medical professional in a primary care, preventative or specialty setting—including a physician, nurse practitioner, physician assistant, primary care provider or specialty care provider. The state's statutes emphasize access to care—requiring continuity of care for primary care acute needs 24 hours a day. A focus on whole person care is included—providing preventative services, appropriate referrals for medical testing, and specialty services, and monitoring of chronic conditions and diseases. Medical homes should also provide accessible, comprehensive and coordinated care.

The Legislature provided additional requirements for medical homes in 2005; however, these provisions only concern infants, children and adolescents. Access to ambulatory and inpatient care for acute illness 24 hours a day, coordination with school and community agencies, and maintenance of medical information of a central record and database are required.

The mission of the [Texas Patient-Centered Medical Home Demonstration Project](#) is to develop, implement, and evaluate the Patient-Centered Medical Home (PCMH) primary care delivery model in Texas in order to lay a foundation which ensures access to a Medical Home for all Texans by the year 2012. The goal is to invigorate the practice of Primary Care through development of a robust methodology in various group settings based on best practices to continually evaluate and refine the Medical Home and our patients' needs around key tenets including: focus on improved access to high quality in all care dimensions (acute, chronic, preventive); improving the patient-centered care experience; investment in a sustainable infrastructure; effective and efficient cost management; and enhanced practitioner and patient satisfaction.

Utah

2005 UT 28074 (8) “Medical home/practitioner” means a person licensed by the Department of Commerce, Division of Occupational and Professional Licensing to practice medicine, naturopathy, or chiropractic or to be a nurse practitioner, as well as the licensed or unlicensed midwife who takes responsibility for delivery or the on-going health care of a newborn.

Utah statutes do not place emphasis on personal physician directed care within medical homes. In addition to those licensed to practice medicine, the state also allows any practitioner licensed to practice naturopathy or chiropractic or to be a nurse practitioner or a midwife to direct care in a medical home. No provisions are included concerning other components of the PCMH joint principles.

The Utah Department of Health established a [Medical Home Portal](#) to provide ready access to reliable and useful information for professionals and families to help them care and advocate for children and youth with special health care needs, as partners in the Medical Home model. According to the Portal, a Medical Home is not a house, office, or hospital, but rather an approach to providing comprehensive primary care. In a medical home, a pediatric clinician works in partnership with the family/patient to assure that the medical and non-medical needs of the child/youth are met. Through this partnership, the clinician can help the family/patient access and coordinate specialty care, educational services, out-of-home care, family support, and other public and private community services that are important to the overall health of the child and family.

Vermont

VT H 631 of 2007 **Sec. 7. Integrated Early Implementation of Blueprint Programs**

(e) Medical home project chronic care management systems integration.

(1) The director, with assistance from the commissioner of health, the director of the office of Vermont health access, the commissioner of human resources, and the commissioner of banking, insurance, securities, and health care administration, shall establish a medical home project for use with Medicaid beneficiaries, Catamount Health, and the state employees' health plan. The director shall also encourage other health insurers to participate in the project and adopt and pay similar care management fees.

(2) The project shall facilitate provision of accessible, continuous, and coordinated family-centered care to high-need populations. The project shall ensure that:

(A) Medicaid, Catamount Health carriers, and the state employees' health plan pay care management fees to primary care providers providing care management under the project and in compliance with subsection (e) of this section;

(B) incentive payments for demonstrated compliance with established clinical protocols are paid to primary care providers participating in practices that provide services as a medical home.

(3) The director, with assistance from the commissioner of health, the director of the office of Vermont health access, the commissioner of human resources, and the commissioner of banking, insurance, securities, and health care administration, shall develop a care management fee schedule and shall determine the amount of care management and incentive payments.

(4) A primary care provider participating in the project shall:

(A) Provide ongoing support, oversight, and guidance to implement a plan of care that provides an integrated, coherent, cross-discipline plan for ongoing medical care developed in partnership with patients and including all other physicians furnishing care to the patient.

(B) Use evidence-based medicine and clinical decision support tools to guide decision-making at the point of care based on patient-specific factors.

(C) Use health information technology, which may include remote monitoring and patient registries, to monitor and track the health status of patients and to provide patients with enhanced and convenient access to health care services.

(D) Encourage patients to engage in the management of their own health through education and community support systems, including the blueprint healthier living workshops or similar evidence-based, self-management tools.

...

(7) (D) Medical home is defined as a primary care provider practice that is responsible for: (i) targeting patients for participation in the project; and (ii) providing safe and secure technology to promote patient access to personal health information; (iii) developing a health assessment tool for the individuals targeted; and (iv) providing training programs for personnel involved in the coordination of care.

Vermont law creates a medical home project, requiring accessible, continuous and coordinated family-centered care to high-need populations. Under the project, Medicaid, Catamount Health carriers and the state employees' health plan pay care management fees to primary care providers providing care management, and incentive payments for compliance with clinical

protocols are paid to participating primary care providers. The state does not mention personal physician-directed care but rather refers to participating primary care providers, or health care providers who: (i) are board certified, if applicable; (ii) provide first contact and continuous care for individuals under his or her care; and (iii) have staff and resources sufficient to manage the comprehensive and coordinated health care of each such individual.

In partnership with patients and other physicians, participating providers must provide ongoing support and integrated, coherent, and cross-discipline care, in addition to evidence-based medicine utilizing decision support tools and health information technology. This suggests that whole person orientation, coordinated / integrated care, quality / safety, and access to care are all key aspects of a medical home.

The [Patient-Centered Medical Home—Vermont](#) is aligned with the Chronic Care Model and the VT Blueprint for Health. The pilot program started in 2005 with diabetes and was roughly built off of the structure of the NCQA Diabetes Physician Recognition Program.

Virginia

2004 VA 521

“Medical Home” means a concept in which the child has an ongoing source of health care from a primary care physician who works together with the family to ensure that the child has accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective medical care.

Medical homes under Virginia law only provide ongoing primary care to ensure accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care to children. These terms are not expounded upon and no mention of the PCMH joint principles is included.

Washington

RCW 74.09.402. Children's health care. [[WA H 1071/S 5093 of 2007](#)]

(e) Improved health outcomes for the children of Washington state are the expected result of improved access to health care coverage. Linking children with a medical home that provides preventive and well child health services and referral to needed specialty services, linking children with needed behavioral health and dental services, more effectively managing childhood diseases, improving nutrition, and increasing physical activity are key to improving children's health. Care should be provided in appropriate settings by efficient providers, consistent with high quality care and at an appropriate stage, soon enough to avert to the need for overly expensive treatment.

...

(1) The department, in collaboration with the department of health, health carriers, local public health jurisdictions, children's health care providers including pediatricians, family practitioners, and pediatric subspecialists, parents, and other purchasers, shall identify explicit performance measures that indicate that a child has an established and effective medical home, such as:

- (a) Childhood immunization rates;
- (b) Well child care utilization rates, including the use of validated, structured developmental assessment tools that include behavioral and oral health screening;
- (c) Care management for children with chronic illnesses;
- (d) Emergency room utilization; and
- (e) Preventive oral health service utilization.

Performance measures and targets for each performance measure must be reported to the appropriate committees of the senate and house of representatives by December 1, 2007.

RCW 74.09.710. Chronic care management programs – Medical homes – Definitions. [[WA H 2098/S 5930 of 2007](#)]

(2) (a) "Medical home" means a site of care that provides comprehensive preventive and coordinated care centered on the patient needs and assures high quality, accessible, and efficient care.

WA H 2549/S 6282 of 2008

Sec. 1. A medical home is a place where health care is accessible and compassionate. It is built on evidence-based strategies with a team approach. Each patient receives medically necessary acute, chronic, prevention, and wellness services, as well as other medically appropriate dental and behavioral services, and community support services, all which are tailored to the individual needs of the patient. Development and maintenance of medical homes require changes in the reimbursement of primary care providers in medical home practices.

...

Sec. 2. (1) Within funds appropriated for this purpose, and with the goal of catalyzing and providing financial incentives for the rapid expansion of primary care practices that use the

medical home model, the department of health shall offer primary care practices an opportunity to participate in a medical home collaborative program, as authorized under [RCW 43.70.533](#).

...

(2) The collaborative program shall be structured to promote adoption of medical homes in a variety of primary care practice settings throughout the state and consider different populations, geographic locations, including at least one location that would agree to operate extended hours, which could include nights or weekends, and other factors to allow a broad application of medical home adoption, including rural communities and areas that are medically underserved.

...

Key goals of the collaborative program are to:

...

(c) Promote adoption, and use of the latest techniques in effective and cost-efficient patient-centered integrated health care.

...

(4) The department of health shall issue an annual report to the health care committees of the legislature on the progress and outcome of the medical home collaborative. The reports shall include:

- (a) Effectiveness of the collaborative in promoting medical homes and associated health information technology, including an assessment of the rate at which the medical home model is being adopted throughout the state;
- (b) Identification of best practices; an assessment of how the collaborative participants have affected health outcomes, quality of care, utilization of services, cost-efficiencies, and patient satisfaction;
- (c) An assessment of how the pilots improve primary care provider satisfaction and retention.

Sec. 3. (1) As part of the five-year plan to change reimbursement required under section 1, chapter 259, Laws of 2007, the health care authority and department of social and health services must expand their assessment on changing reimbursement for primary care to support adoption of medical homes to include medicare, other federal and state payors, and third-party payors, including health carriers under Title 48 RCW and other self-funded payors.

...

(3) The health care authority shall work with providers to develop reimbursement mechanisms that would reward primary care providers participating in the medical home collaborative program that demonstrate improved patient outcomes and provide activities including, but not limited to, the following:

- (a) Ensuring that all patients have access to and know how to use a nurse consultant;
- (b) Encouraging female patients to have a mammogram on the evidence-based recommended schedule;
- (c) Effectively implementing strategies designed to reduce patients' use of emergency room care in cases that are not emergencies;
- (d) Communicating with patients through electronic means; and
- (e) Effectively managing blood sugar levels of patients with diabetes.

[WA S 5891/H 2114 of 2009](#)

Sec. 1. The legislature declares that collaboration among public payors, private health carriers, third-party purchasers, and providers to identify appropriate reimbursement methods to align incentives in support of primary care medical homes is in the best interest of the public. The legislature therefore intends to exempt from state antitrust laws, and to provide immunity from federal antitrust laws through the state action doctrine, for activities undertaken pursuant to pilots designed and implemented under section 2 of this act that might otherwise be constrained by such laws. The legislature does not intend and does not authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of state and federal antitrust laws including, but not limited to, agreements among competing health care providers or health carriers as to the price or specific level of reimbursement for health care services.

Sec. 3. The health care authority and the department of social and health services may select a pilot site that currently employs the following activities and functions associated with medical homes: Provision of preventive care, wellness counseling, primary care, coordination of primary care with specialty and hospital care, and urgent care services; availability of office appointments seven days per week and e-mail and telephone consultation; availability of telephone access for urgent care consultation on a seven-day per week, twenty-four hours per day basis; and use of a primary care provider panel size that promotes the ability of participating providers to appropriately provide the scope of services described in this section. The reimbursement method chosen for this pilot site must include a fixed monthly payment per person participating in the pilot site for the services described in this section. These services would be provided without the submission of claims for payment from any health carrier by the medical home provider. Agreements for payment made directly by a consumer or other entity paying on the consumer's behalf must comply with the provisions applicable to direct patient-provider primary care practices under chapter 48.150 RCW. In addition, the agencies may determine that the pilot should include a high deductible health plan or other health benefit plan designed to wrap around the primary care services offered under this section.

[RCW 48.150.005](#). **Public Policy.**

It is the public policy of Washington to promote access to medical care for all citizens and to encourage innovative arrangements between patients and providers that will help provide all citizens with a medical home.

Washington needs a multipronged approach to provide adequate health care to many citizens who lack adequate access to it. Direct patient-provider practices, in which patients enter into a direct relationship with medical practitioners and pay a fixed amount directly to the health care provider for primary care services, represent an innovative, affordable option which could improve access to medical care, reduce the number of people who now lack such access, and cut down on emergency room use for primary care purposes, thereby freeing up emergency room facilities to treat true emergencies.

Initially only providing that medical homes are particularly beneficial in delivering health care to children and then adding they are suitable for managing chronic care, the definition of "medical

home” has evolved in Washington state statutes from 2007 to the most recent 2009 legislative session. Whole person orientation is incorporated into the state’s medical home standards by requiring care be tailored to each patient’s medical needs including necessary acute, chronic, prevention, wellness, dental, behavioral and other medically appropriate services.

The state also recognizes the need to appropriately alter reimbursement rates for primary care providers in medical home practices, and requires the health care authority to develop reimbursement mechanisms that would reward providers participating in medical homes. In order to promote collaboration among public payors, private health carriers, third-party purchasers, and providers in identifying appropriate reimbursement methods, the legislature provides exemption from state antitrust laws and immunity from federal antitrust laws.

Emphasis is also placed on evidence-based and integrated care, and although not required, extended hours—such as late nights or weekend hours—and adoption of health information technology are encouraged. By promoting use of email and telephone consultations, the state requires medical homes to enhance access to care for patients. The state requires a primary care provider (PCP) to lead the medical home, but providers are not exclusively personal physicians. Physicians, physician assistants, nurse practitioners and clinic are included in the definition of PCP.

The Washington State Department of Social and Health Services [Office of Quality and Care Management](#) provides the basic definition of “medical home” as an approach to delivering primary health care through a team partnership that ensures health care services provided in a high quality comprehensive manner—including acute, chronic and preventive care. A Primary Care Provider (physician, physician assistant, nurse practitioner or clinic) leads the medical home with support and direction of the client, family, clinic staff, community agencies, and specialists. The core components of a medical home are: (1) accessible and continuous; (2) coordinated and comprehensive; (3) client centered; and (4) compassionate and culturally effective. Key medical home infrastructure includes: (1) telemedicine or expert consultative support; (2) utilization and other report development; (3) reimbursement for certain services such as expanded hours or care coordination activities; and (4) infrastructure that supports or provides for care management.

The [2009-2011 Washington State Collaborative for Medical Home](#) sponsored by the state Department of Health focuses on creating medical homes within primary care settings for adults, youth and children. The Collaborative defines a PCMH as a way to provide health care for adults, youth and children with a partnership between the physician, or primary care provider, patient and family. This partnership becomes a medical home from which all care for the patient is coordinated. The Department of Health also uses the joint principles of the patient-centered medical home as a working definition of medical home, with the understanding that nurse practitioners and physician assistants also lead medical homes, particularly in rural settings.

The Washington State Department of Health also has a [medical home initiative](#) within the Children with Special Health Care Needs Program. The program defines “medical home” as an approach to delivering primary health care through a team partnership that ensures health care services are provided in a high quality and comprehensive manner. The program works to promote partnerships among families, health care providers, other professionals, and the communities to help families know about and access medical and other services for their children with special needs.

West Virginia

§16-29H-9. Patient-centered medical homes. [WV S 414/H 2743 of 2009]

(a) The Legislature finds that:

- (1) There is a need in the state to transform the health care services delivery model toward primary prevention and more proactive care management through the development of patient-centered medical homes;
- (2) The concept of a patient-centered medical home would promote a partnership between the individual patient, the patient's various health care providers, the patient's family and, if necessary, the community. It integrates the patient as an active participant in their own health and well-being;
- (3) The patient-centered medical home provides care through a multidisciplinary health team consisting of physicians, nurse practitioners, nurses, physicians assistants, behavioral health providers, pharmacists, social workers, physical therapists, dental and eye care providers and dieticians to meet the health care needs of a patient in all aspects of preventative, acute, chronic and end-of-life care using evidence-based medicine and technology;
- (4) In a patient-centered medical home each patient has an ongoing relationship with a personal physician. The physician would lead a team of health care providers who take responsibility for the care of the patient or for arranging care with other qualified professionals;
- (5) Transitioning health care delivery services to a patient-centered medical home would provide greater quality of care, increase patient safety and ensure greater access to health care;
- (6) Currently there are medical home pilot projects underway at the Bureau for Medical Services and the Public Employees Insurance Agency that should be reviewed and evaluated for efficiency and a means to expand these to greater segments of the state's population, most importantly the uninsured.

(b) The patient-centered medical home is a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patients' families and communities. A patient-centered medical home integrates patients as active participants in their own health and well being. Patients are cared for by a physician or physician practice that leads a multidisciplinary health team, which may include, but is not limited to, nurse practitioners, nurses, physician's assistants, behavioral health providers, pharmacists, social workers, physical therapists, dental and eye care providers and dieticians to meet the needs of the patient in all aspects of preventive, acute, chronic care and end-of-life care using evidence-based medicine and technology. At the point in time that the Center for Medicare and Medicaid Services includes the nurse practitioner as a leader of the multidisciplinary health team, this state will automatically implement this change.

...

(d) The four types of pilot programs shall be:

- (1) *Chronic Care Model Pilots.* -- This model shall focus on smaller physician practices. Primary care providers shall work with payers and providers to identify various disease states. Through the collaborative effort of the primary care provider and the payers and providers, programs shall be developed to improve management of agreed upon conditions of the patient. Through this model, the primary care provider may utilize

current practices of multipayer workgroups. These groups shall be comprised of the medical directors of the major health care payers and the state payers along with medical providers and others.

(2) *Individual Medical Homes Pilots.* -- These pilots shall focus on larger physician practices. They shall seek certification from the National Committee on Quality Assurance. That initial certification will be Level I certification. This would be granted by virtue of certifying the provider is in the process of attaining certification and currently have met provisional standards as set by the National Committee on Quality Assurance. This provisional certification lasts only one year with no renewal.

(3) *Community-Centered Medical Home Pilots.* -- This approach shall link primary care practices with community health teams which would grow out of the current structure in place for federally qualified health centers. The community health teams shall include social and mental health workers, nurse practitioners, care coordinators and community health workers. These personnel largely exist in community hospitals, home health agencies and other settings. These pilots shall identify these resources as a separate team to collaborate with the primary care practices. The teams would focus on primary prevention such as smoking cessation programs and wellness interventions as well as working with the primary care practices to manage patients with multiple chronic conditions. Within this pilot all health care agencies are connected and share resources. Citizens can enter the system of care from any point and receive the most appropriate level of care or be directed to the most appropriate care. Any financial incentives in this model would involve all health care payers and could be used to encourage collaboration between primary care practices and the community health teams.

(4) *Medical Homes for the Uninsured Pilots.* -- These pilots shall focus on medical homes to serve the uninsured. They shall include various means of providing care to the uninsured with primary and preventative care. Through this mechanism, a variety of pilots may be developed that shall include screening, treatment of chronic disease and other aspects of primary care and prevention services. The pilots will be chosen based on their design meeting the requirements of this subsection and the resources available to provide these services.

The West Virginia Legislature enacted legislation during the 2009 session to establish standards for the patient-centered medical homes in the state. The bill promotes personal physicians to have ongoing relationships with patients and to lead a team of health care providers to provide greater quality of care, increase patient safety, and ensure greater access to health care. Physicians are responsible for all of their patients' health care needs and should make appropriate referrals to behavioral health providers, pharmacists, social workers, physical therapists, dental and eye care providers and dieticians to meet the needs of the patient in all aspects of preventive, acute, chronic care and end-of-life care. In order to integrate care across all aspects of the health care system, evidence-based medicine and technology should also be adopted.

The Legislature also establishes four types of pilot programs in the state and provides appropriate payment structures for each. The individual medical home pilot is required to see certification from the National Committee on Quality Assurance.

Wisconsin

[2009 AB 75](#) 49.45 (24g) PHYSICIAN PRACTICE PAYMENT PILOT.

(a) The department shall develop a proposal to increase medical assistance reimbursement to providers to which at least one of the following applies:

1. The provider is recognized by the National Committee on Quality Assurance as a Patient-Centered Medical Home.
2. The secretary determines that the provider performs well with respect to all of the following aspects of care:
 - a. Adoption of written standards for patient access and patient communication.
 - b. Use of data to show that standards for patient access and patient communication are satisfied.
 - c. Use of paper or electronic charting tools to organize clinical information.
 - d. Use of data to identify diagnoses and conditions among the provider's patients that have a lasting detrimental effect on health.
 - e. Adoption and implementation of guidelines that are based on evidence for treatment and management of at least 3 chronic conditions.
 - f. Active support of patient self-management.
 - g. Systematic tracking of patient test results and systematic identification of abnormal patient test results.
 - h. Systematic tracking of referrals using a paper or electronic system.
 - i. Measuring the quality of the performance of the physician practice and of individual physicians within the practice, including with respect to provision of clinical services, patient outcomes, and patient safety.
 - j. Reporting to members of the physician practice and to other persons on the quality of the performance of the physician practice and of individual physicians.

(c) The department's proposal shall specify increases in reimbursement rates for providers and shall provide for payment of monthly per-patient care coordination fee to those providers. The department shall set the increases in reimbursement rates and the monthly per-patient care coordination fee so that together they provide sufficient incentive for providers.

The legislation, signed by Wisconsin Governor Jim Doyle (D) on June 29, 2009, qualifies Medicaid providers who either are recognized by the NCQA as a patient-centered medical home, or meet certain conditions. Such conditions mostly concern the ability to adequately record and track patients' conditions and quality reporting. Several of the PCMH joint principles—the personal physician, physician directed medical care, whole person orientation, and coordinated care—are alluded to without explicit acknowledgement. Standards for patient access and patient communication shall be adopted, but no mention of possibilities, such as open scheduling or email communication, is made. This new law also recognizes the joint principle that provider payment should be appropriate. AB 75 also requires the Department of Health Services to develop a PCMH initiative proposal for the [Joint Committee on Finance](#) to consider.

The Wisconsin Department of Health Services also participates in the [Children and Youth with Special Health Care Needs Program](#) in an effort to strengthen medical homes for children with special needs. Included in the program is the medical home initiative, which promotes patient-centered medical homes throughout the state with resources like the [Wisconsin Medical Home Toolkit](#).

ADDENDUM

Although not necessarily enacted through legislation or adopted through regulations, the following states have in some way acknowledged the importance of promoting use of the patient-centered medical home model of care. Some of these programs pertain only to particular segments of the population—such as children with special health care needs, while others currently have advisory councils or commissions developing recommendations for further implementation of the PCMH model.

Alabama

The state has employed the medical home concept since 2004. [Patient 1st](#) is a primary-care case management program that requires Medicaid beneficiaries to designate a “personal medical provider,” whose role it is to provide first contact and continuous, comprehensive care. The program expands the traditional fee-for-service reimbursement model to compensate physicians for the care coordination they provide to their patients.

Alaska

In the [FY 2010 Alaska Medicaid Program Budget Recommendation](#) released August 2008, the State of Alaska’s Medical Care Advisory Commission recommended implementing a medical home pilot program for Medicaid patients in order to improve quality and contain costs, particularly to address issues concerning disease management.

The Office of Children’s Services in the state Department of Health and Social Services is working on an [Early Childhood Comprehensive Systems Project](#) (ECCS). The medical home model is included as a primary area in which the ECCS Plan will provide direction in the state for the development of public policy for young children.

At a [Medical Care Advisory](#) meeting held on November 6, 2009, the Deputy Commissioner for Medicaid and Health Policy, Bill Streur, presented the “Alaska Healthcare Roadmap.” The presentation included the deputy commissioner’s plan to pursue a medical home program in the next year by engaging community health centers in a pilot program under the state’s Medicaid program.

Arizona

The Arizona Department of Health Services Office for Children with Special Health Care Needs established a [Medical Home Program](#) to promote and integrate family-centered, community based, culturally effective, comprehensive, coordinated health services for all children and youth with special health care needs.

The [UnitedHealth Group PCMH Demonstration Program](#) is also located in the state. Though the emphasis is on primary disease prevention and improving quality of care for chronically ill patients, the program includes an outreach to members to be more engaged in their overall health and wellness. The program provides recognition for NCQA PPC-PCMH.

Arkansas

The Arkansas Department of Human Services Division of Developmental Disabilities has a Children’s Services program. This program has a [Medical Home Arkansas](#) component, which works improve accessibility and quality of medical homes available to children in the state.

Connecticut

The Connecticut Children & Youth with Special Health Care Needs program created a [Medical Home Initiative](#) to ensure that children have access to coordinated quality health care services.

[CT H 6600](#) of 2009 requires that a [medical home advisory committee](#) be established to provide recommendations including defining medical home functions on an ongoing basis that incorporates evolving research concerning the delivery of health care services.

Delaware

[Community health centers](#) are located within each county across the state. The centers provide a medical home for people in almost all income levels.

Hawaii

In 2002, the Department of Health Children with Special Health Needs Branch joined with the Hawaii Medical Association and the Hawaii Academy of Pediatrics to establish the [Medical Home Implementation Project](#). The focus of the [Project](#) is to identify and prevent barriers that hinder children with special needs and their families from access medical homes throughout the state.

Illinois

Most individuals enrolled in the state's [medical assistance](#) programs, including [Medicaid](#), are required to have a medical home. As of July 1, 2006, Illinois has a statewide [Primary Care Case Management](#) program, through which eligible enrollees will have a medical home through their primary care provider. [Illinois Health Connect](#) (IHC)—the program created by the state Department of Healthcare and Family Services—developed a primary care provider network of over 5,600 providers with approximately 1.8 million clients enrolled. Through a bonus payment program for high performance, [IHC](#) targets five common clinical measures for quality improvement, resulting in a reduction of both inpatient hospitalizations and ER visits.

At a meeting on December 11, 2008, the Illinois Department of Public Health [State Board of Health](#) discussed the importance of the patient-centered medical home and the necessity for the Board to make recommendations to the Governor and legislature.

In June 2007, the Illinois Department of Public Health issued the [Newborn Screening Practitioner's Manual](#), which states that the Department “encourages primary care practitioners to provide medical homes, and to facilitate follow-up services for infants with abnormal newborn screening results.”

The [Quality Quest Medical Home project](#) in Illinois created a medical home model for the tri-county area, including the processes, tools, information and payer/employer benefit designs that facilitate the delivery of continuous, comprehensive care and managing and coordinating care necessary to implement a Medical Home Pilot.

Indiana

The state's Medicaid managed care program, [Hoosier Healthwise](#), provides all enrollees with a medical home. Because the program aims to help all members develop a positive patient to physician relationship, those who do not select a primary medical provider are automatically assigned one.

The Indiana State Department of Health [Sunny Start Project](#) was created in 2003 to develop a strategic plan to support a coordinated system of resources and supports for young children from birth through age five and their families in Indiana. Included in this project is the medical provider / medical home issues subcommittee; the last documented meeting of the subcommittee was held in August 2007.

Kentucky

The Medicaid primary care case management program within the state's Medicaid program, the [Kentucky Patient Access and Care System](#) (KenPAC), provides a medical home and primary care provider to all enrollees. The [KenPAC website](#), however, provides no medical home standards.

The Kentucky Cabinet for Health and Family Services Commission for Children with Special Health Care Needs established the Medical Home for Coordinated Pediatrics in 2007. This clinic provides a medical home to children in foster care in central Kentucky.

Michigan

Through the [Aligning PCMH Stakeholders in Michigan project](#), the Michigan Primary Care Consortium is convening a series of meetings for payers and professional associations to create a PCMH definition, metrics and practice process for Michigan in order to: (1.) decrease the burden that would be imposed on practices through each payer creating a PCMH plan using different assumptions and requirements, and (2.) lay the foundation for future consideration of multi-payer pilots and/or other collaborative work.

Also in Michigan is the [Blue Cross Blue Shield of Michigan—Physician Group Incentive Program](#). This incentive program connects physician organizations from across Michigan to encourage information sharing about various aspects of health care. The program is using incentives, aggregated among physicians in POs, to support infrastructure development, allowing each PO, and each physician office, to build component capabilities of the PCMH model as best they see fit, given the state of their own practice at the outset.

In October 2008, the Department of Community Health updated [March 07 Joint Principles of the Patient-Centered Medical Home with Michigan Footnotes](#). In addition to providing the seven PCMH joint principles, this document lists the state's footnotes, which include:

- (1) Patient-centered - This model of care recognizes the central role of patients (and their families, when appropriate) as stewards of their own health. In the Patient-Centered Medical Home, the team of health professionals guides and supports patients and their families to help them achieve their own health and wellness goals.
- (2) A personal physician may be of any specialty but to be considered a Patient-Centered Medical Home, the practice must meet all Patient-Centered Medical Home requirements. It shall be recognized that there may be situations in which a physician is not on-site and the patient's relationship is with a certified nurse practitioner or physician assistant who provides the principal or predominant source of care for a patient. In those instances, the NP or PA provider, in collaboration with a physician, may perform the responsibilities of first contact, continuous and comprehensive care if he or she is otherwise qualified by education, training, or experience to perform the selected acts, tasks, or functions necessary where the acts, tasks, or functions fall within the certified nurse practitioner's or the physician assistant's scope of practice.
- (3) Clinical outcomes, safety, resource utilization and clinical and administrative efficiency are consistent with best practices.
- (4) Transformational change in healthcare financial incentives should occur simultaneously with, proportionally to, and in alignment with Patient-Centered Medical Home adoption.

Missouri

The Department of Health and Senior Services' [Healthy Children and Youth Administrative Case Management Program](#) assists families in meeting their child's needs to function at an optimal level. Among the services for which assistance is provided is the establishment of a

medical home. The program is available to all MO HealthNet (Medicaid) eligible children (birth to age 21) residing in Missouri who are in need of medically necessary services.

Montana

The [Montana Early Childhood Comprehensive System](#) (ECCS) is the synchronization and improved collaboration of all existing pertinent services at the state and local level for children aged 0 – 5 and their families. Through a federal grant, the program will build on existing information and infrastructure in the state and create a strategic plan to support a coordinated system of services for young children and their families. Included in these services is the medical home model of care.

The ECCS [Strategic Plan for Implementation 2009/2010](#) includes providing information on medical homes in orientation training, health and safety training, and on-site individual training for child care providers. The ECCS plans to contact the American Academy of Pediatrics for information on medical homes to use in early childhood training. The program will also work with the Early Childhood Services Bureau to include medical home materials in the early childhood training, on the website, and in provider mailings.

North Dakota

Increasing access to medical homes is a goal for the North Dakota [Children with Special Health Care Needs Service System](#) in order to achieve a community-based system of services for all families of children and youth with special health care needs by 2010.

The Patient-Centered Medical Home—Diabetes Management program in North Dakota involved patients with diabetes, hypertension and coronary artery disease. In January 2009, this project expanded to become the [MediQhome Quality Project: Patient-Centered Advanced Medical Home Quality Improvement Initiative](#). The project now involves the deployment of a web-based patient-centered information support and decision to all primary care physicians offices across the state and providers are reimbursed for use of the portal. Care suites are being developed for diabetes mellitus, hypertension, coronary artery disease, asthma, ADHD, chronic heart failure, preventive cancer screening, and immunizations.

Ohio

In December 2006, the Ohio Medical Home Focus Group Project released a [Summary Report](#) providing recommendations to provide health care services to children with special health care needs through a medical home and to ensure all young children and adolescents have access to preventative health care services.

Also in Ohio, the [Cincinnati Medical Home Pilot Initiative](#) continues to test the Medical Home model and the effect on outcomes, quality and cost for members in fully insured, ASO and Medicare product types, and the Greater Cincinnati Aligning Forces for Quality Medical Home Pilot will be launched fall 2009.

Pennsylvania

The [Pennsylvania Medical Home Program](#) is administered by the Department of Health in collaboration with the Pennsylvania Chapter of the American Academy of Pediatrics. This project works to provide comprehensive health care to children with special health care needs.

The [Southeastern Pennsylvania Rollout of the Chronic Care Initiative](#) is led by the Governor's Office of Health Care Reform and involves strong collaboration by providers, payers and professional organizations. The initiative incorporates the Patient-Centered Medical Home

standards as a validation tool that practices are transforming their care delivery to effectively manage chronically ill patients.

South Carolina

The South Carolina Department of Health and Environmental Control, through its Division of Women and Children's Services, supports and encourages the expansion of medical homes (i.e., care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent) for children and their families through the development of [public/private partnerships](#). In these partnerships, the medical primary care provider assumes the medical aspects of care and the public health partner provides the services that augment and enhance primary medical care.

Tennessee

The state Department of Health is currently accepting applications for grants from faith-based, community-based, rural health, and federally funded centers [excluding Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes] willing to provide primary care services to uninsured adult Tennesseans 19 to 64 years of age in a medical home. According to the [application procedures](#), the "primary care medical home" is not a temporary or interim provider-patient arrangement. The primary care safety net provider assumes overall and ongoing responsibility for health maintenance and disease management, emphasizing continuity of care over the entire spectrum of health care services.

The [Memphis Multi-Payer Patient-Centered Medical Home](#) is working to develop a multi-payer approach to the Patient-Centered Medical Home in the Memphis area. Because there is no predominant payer in most primary care practices, the multi-payer demonstration is essential to the transformation of a typical primary care practice into a Medical Home.

CONTACT

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