(3) Medicaid Medical Home Models
CMS proposes that a Medicaid Medical Home Model must have the following elements at a minimum:

- Model participants include primary care practices or multispecialty practices that include primary care physician and practitioners and offer primary care services, and
- Empanelment of each patient to a primary care clinician.
- In addition to these elements, CMS proposes that a Medicaid Medical Home Model must have at least four of the following elements:
    - Planned chronic and preventive care.
    - Patient access and continuity.
    - Risk-stratified care management.
    - Coordination of care across the medical neighborhood.
    - Patient and caregiver engagement.
    - Shared decision-making.
    - Payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings, population-based payments).

CMS also propose to not mandate a specific method or accreditation process for recognizing Medicaid Medical Home Models.

AAFP Response
The AAFP applauds CMS for developing an appropriate, physician-friendly, and patient-centered framework for Medicaid Medical Homes. The definition incorporates elements from the Joint Principles of the Patient-Centered Medical Home, CPC, and other relevant sources. The AAFP defines an advanced primary care practice, such as a PCMH, as one that is based on the Joint Principles of the Patient-Centered Medical Home and has adopted the five key functions of the Comprehensive Primary Care (CPC) Initiative. These key functions are:

1. Access and Continuity: PCMH practices optimize continuity and timely, 24/7 access to care supported by the medical record. Practices track continuity of care by physician or panel.
2. Planned Care for Chronic Conditions and Preventive Care: PCMH practices proactively assess their patients to determine their needs and provide appropriate and timely chronic and preventive care, including medication management and review. Physicians develop a personalized plan of care for high-risk patients and use team-based approaches to meet patient needs efficiently.
3. Risk-Stratified Care Management: Patients with serious or multiple medical conditions need extra support to ensure they are getting the medical care and/or medications they need. PCMH practices empanel and risk stratify their whole practice population and implement care management for patients with high needs.
4. Patient and Caregiver Engagement: PCMH practices engage patients and their families in decision-making in all aspects of care. Such practices also integrate into their usual care both culturally competent, self-management support and the use of decision aids for preference sensitive conditions.
5. Coordination of Care Across the Medical Neighborhood: Primary care is the first point of contact for many patients and leads in the coordination of care as the center of patients' experiences with health care. PCMH practices work closely with patients' other health care providers to coordinate and manage care transitions, referrals, and information exchange.