



State Definitions of the Medical Home

Government Relations Division • 2021 Massachusetts Avenue, NW • Washington, DC 20036

[California](#)

[Maryland](#)

[Texas](#)

[Colorado](#)

[Minnesota](#)

[Utah](#)

[DC](#)

[Mississippi](#)

[Vermont](#)

[Florida](#)

[Nebraska](#)

[Virginia](#)

[Idaho](#)

[New Jersey](#)

[Washington](#)

[Iowa](#)

[New Mexico](#)

[West Virginia](#)

[Kansas](#)

[New York](#)

[Louisiana](#)

[Oklahoma](#)

California

[Welfare and Institutions Code. Section 15904.](#) [[CA S 1039 of 2007](#)]

(d) (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.

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.

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.

Florida

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

- (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.

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.

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.

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.

Louisiana

[Title 46, Chapter 8-A, R.S. 46:978.1 Definitions.](#) [LA S 1 of 2007]

(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 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.

Maryland

[Article – Health – General, Title 19 Health Care Facilities](#) [MD HB 192 / SB 855 of 2010]

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.

Minnesota

[Chapter 256.963](#), Sec. 19. Care Coordination Pilot Projects. [[MN H 1078/S 967 of 2007](#)]

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.

Mississippi

([HB 1192 of 2010](#)) 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.

Nebraska

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

(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.](#)

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.

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.

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.

(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.

New York

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

1. A medical home is 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. 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.

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](#)) 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; 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; 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 when minorities have a medical home, racial and ethnic differences in terms of medical access disappear.

Texas

Chapter 2203. Health Care Services. MEDICAL HOME. [[TX H 3121 of 2007](#)]

Sec. 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.

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.

Vermont

[\(VT H 631 of 2007\)](#) **Sec. 7. Integrated Early Implementation of Blueprint Programs**

(e) (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.

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.

Washington

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.

West Virginia

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

(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 dietitians 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.

CONTACT US

Notice errors or request additions/revisions? Please contact us at capitol@aafp.org.