



<u>Alabama</u>	<u>Kentucky</u>	<u>North Dakota</u>
<u>Alaska</u>	<u>Louisiana</u>	<u>Ohio</u>
<u>Arizona</u>	<u>Maine</u>	<u>Oklahoma</u>
<u>Arkansas</u>	<u>Maryland</u>	<u>Oregon</u>
<u>California</u>	<u>Massachusetts</u>	<u>Pennsylvania</u>
<u>Colorado</u>	<u>Michigan</u>	<u>Rhode Island</u>
<u>Connecticut</u>	<u>Minnesota</u>	<u>South Carolina</u>
<u>DC</u>	<u>Mississippi</u>	<u>South Dakota</u>
<u>Delaware</u>	<u>Missouri</u>	<u>Tennessee</u>
<u>Florida</u>	<u>Montana</u>	<u>Texas</u>
<u>Georgia</u>	<u>Nebraska</u>	<u>Vermont</u>
<u>Hawaii</u>	<u>Nevada</u>	<u>Virginia</u>
<u>Idaho</u>	<u>New Hampshire</u>	<u>Washington</u>
<u>Illinois</u>	<u>New Jersey</u>	<u>West Virginia</u>
<u>Indiana</u>	<u>New Mexico</u>	<u>Wisconsin</u>
<u>Iowa</u>	<u>New York</u>	<u>Wyoming</u>
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[Alabama](#)

None

[Alaska](#)

No official definition, but the Alaska Health Care Commission recommended that the Governor aggressively pursue the creation & implementation of a medical home model in their [2010-2014 Strategic Plan on Primary Care Innovation](#). Their definition is as follows:

The “Medical Home Model” is a term meant to describe the ideal concept for how primary care should be provided, but the Commission felt as though this term has become too much of a buzz word in the health care reform debates and that for many it simply implies paying primary care practitioners more for working in the same way. And so the Commission is avoiding use of that term, and is focusing on key characteristics of a modernized high quality primary care model:

Patient and family centered;

- Stable trusting relationship between care team and patient/family that continues over time;

- Comprehensive, coordinated, and accessible care provided by integrated multidisciplinary teams
- Focus on health and wellness (physical, behavioral, social) rather than disease care

Arizona

Arizona does not have PCMH in their code or legislation, but the DHHS has this definition listed on their [website](#):

“Medical Home is a family-centered approach to providing comprehensive primary care. Our office promotes best practice around medical home through education, training and partnerships with state agencies, community-based organizations which provide services, care or health plans for children with special health care needs and their families.”

Arkansas

None

California

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

(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. [2007 CO S 130]

(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 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.

Connecticut

State of Connecticut Department of Social Services

Acronyms, Abbreviations, and Definitions:

13. Person-Center Medical Home (PCMH) - A Person-Centered Medical Home is a health care setting that facilitates partnerships between individual patients, their personal physicians, and when appropriate, the patients' families. Care is facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. The provider is required to provide this coordination

and is encouraged to improve practice infrastructure in order to qualify as a medical home.

19a-710 Selection text – Definitions:

Sec. 17b-263c. Medical homes. Regulations. (a) The Commissioner of Social Services may establish medical homes as a model for delivering care to recipients of assistance under medical assistance programs administered by the Department of Social Services.

Delaware

Department of Health and Social Services - [Dialogue on Healthcare Reform Implementation in Delaware](#)

The medical home is an approach to providing primary care services that is team-based, whole-person, comprehensive, ongoing and coordinated patient-centered care. The “patient centered medical home” model establishes teams that comprehensively attend to multiple needs of patients, aiming to provide more coordinated care, promote prevention and reduce health care costs. The American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics and the American Osteopathic Association have jointly defined the medical home as “a model of care where each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care. The physician-led care team is responsible for providing all the patient’s health care needs and, when needed, arranges for appropriate care with other qualified physicians.

DC

2006 DC B 2 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.

Georgia

Georgia Department of Human Resources, Division of Public Health, Family Health Branch – [Status of Georgia's Children – May 2006](#) – Page 8

“The American Academy of Pediatrics defines a medical home as the provision of care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent. The medical home implies joint accountability between the physician and the family. Providing a medical home means addressing the medical and non-medical needs of the child and family. For the primary care physician, this role may involve identifying and making referrals to community, state, and federally funded resources that will benefit the child and family.”

Hawaii

Hawaii Department of Health – [“Every Child Deserves a Medical Home”](#)

“A Medical Home is not a building, house, or hospital, but rather an integrated and trusted partnership to provide health care services in a high quality, cost effective manner.

Pediatric care professionals and parents act as partners in a Medical Home to identify and access all medical and non-medical services needed to help children and their families achieve maximum potential.

Medical Home promotes community-based primary care that is accessible, comprehensive, continuous, and coordinated, delivered in family-centered, compassionate, and culturally effective ways.”

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.

Illinois

Illinois Department of Health – [Illinois Health Connect](#)

“What is a Medical Home?

A medical home is the place you go for healthcare. Your medical home is where all of your records are kept. You and your family will go to your medical home to see your Primary Care Provider (PCP) when you are sick or due for a checkup.

- All your medical records are kept there in one place.
- Your primary care provider gets to know you well.
- You get better health care because your personal doctor knows all of your health care needs.
- You and your family get the top quality health care you need to stay healthy.

Even if you are healthy and never get sick, it is good to have a medical home.”

Indiana

Indiana State Department of Health – Community Integrated Systems of Services

“What is a Medical Home?

As we quickly move past the first decade of the twenty-first century, health care reform and the need to transform primary care practice has never been more urgent. The health care reform bill contains Medical Home as the model of primary care needed to improve patient care and stop spiraling costs. A medical home is the working relationship between a child's family and a physician's practice that supports both excellent health care and family satisfaction. It includes good communication at office visits, between office visits and regarding visits to other specialists as well as oral health, health education, family support and anything else important to a child's overall health. Medical Homes are accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. The Institute of Medicine and others have stated that system change is needed to make this transformation. System change within a practice is best done through quality improvement processes. Experiences by members of the AAP have demonstrated that "learning collaboratives" help start and maintain this process.”

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.

Kentucky

Cabinet for Health and Family Services - [Public Health Accreditation Board Definition](#)
“A medical home is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.”

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.

Maine

Maine Department of Health and Human Services, Office of MaineCare Services
[MaineCare Benefits Manual, Chapter VI, Primary Care Case Management](#)
“The Department of Health and Human Services is proposing changes to Chapter VI, Primary Care Case Management (PCCM) to add a new level of services, Patient Centered Medical Home. Patient Centered Medical Home services will assure effective, efficient and accessible health care services for eligible MaineCare members. Provider requirements are included in the proposed rule. Providers who are approved to deliver this service will receive \$3.50 per member per month to deliver patient centered medical home services. This management fee is in addition to the \$3.50 they have received for providing PCCM services for a total of \$7.00 per member per month. Providers will be required to deliver additional integration of patient services, and participate in on-going educational and evaluation activities. The Department also added language to clarify what groups may not be required to participate in PCCM or PCMH services to be in compliance with federal guidelines and updated sections that have been revised or consolidated in the MaineCare Benefits Manual.”

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.

Also defined in a [Maryland Department of Health and Mental Health Brochure](#) "The PCMH is a model of practice in which a team of health professionals, guided by a personal physician, provides continuous, comprehensive, and coordinated care in a culturally and linguistically sensitive manner to patients. The PCMH provides for all of a patient's health care needs, or collaborates with other qualified health professionals to meet those needs.

In Addition, PCMH provides patient centered care though:

- Evidence-based medicine
- Expanded access and communication
- Care coordination and integration
- Care quality and safety”

Massachusetts

Executive Office of Health and Human Services – Patient Centered Medical Home Initiative Definition:

“In a Patient-Centered Medical Home practice, staff work together to provide care that meets patients' needs and results in the best health outcomes. Being "patient- centered" means that practices recognize the patient as an individual, respect the patient's values, language and culture, and support a thorough exchange of information about care and options between patient and providers.

- Care is delivered by a team that includes health care providers from multiple disciplines and involves the patient and family. The team members work as partners to ensure that decisions about care include the patient's wants, needs and preferences and to ensure that the patient has easy and flexible access to the team.
- Patients are active participants in their care. Health care providers and patients share responsibility for setting goals and making decisions about care, treatment and follow-up care.
- Clear communication occurs within the team and across disciplines and systems, ensuring integrated care for all patients, including high-risk patients who have complex medical and psycho-social conditions. Coordinated care- includes community-based providers and services and appropriate, accessible patient education on health promotion, including disease prevention and self-management for patients, especially of chronic conditions.
- Technology, including electronic medical records and resources, such as appropriate payment systems, support clinical practice with care management, patient follow-up and reminders, and ongoing quality improvement and evaluation.”

Michigan

Department of Community Health – Michigan Definition for Patient-Centered Medical Home

“The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth and adults. The PC-MH is a health care

setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patient's family.**

*the document then lists all of the principles developed by the AAP, AAFP, ACP and APA to describe the characteristics of the PCMH.

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

Title 41. Public Health

Chapter 3. State Board of Health; Local Health Boards and Officers in General
2011 Miss. Code Ann. § 41-3-61

“(a) There are patient programs that provide a whole-person orientation that includes care for all stages of life, including acute care, chronic care, preventive services and end-of-life care;

(b) A patient-centered medical home must have Health Information Exchange compliant records, electronically integrated with electronic patient health records, and use practice-based disease management applications to facilitate and measure quality of care at the point of care;

(c) A patient in a patient-centered medical home actively participates in health care decision making, and feedback from the patient is sought to ensure that the expectations of the patient are being met;

(d) Care in a patient-centered medical home is coordinated across all elements of the health care system and the patient's community to assure that the patient receives the indicated care when and where the patient needs the care in a culturally appropriate manner;

(e) Multiple studies have demonstrated that when minorities have a medical home, racial and ethnic disparities in terms of medical access disappear and the costs of health care decrease;

(f) The American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Physicians, and the American Osteopathic Association, representing more than three hundred thirty thousand (330,000) physicians across the country, have developed Joint Principles of the Patient-Centered Medical Home that describe the characteristics of the patient-centered medical home;

(g) The National Committee for Quality Assurance is developing a patient-centered medical home designation program for physician practices that meets specified criteria; and

(h) The Federal Tax Relief and Health Care Act calls for a three-year medical home demonstration project to be conducted in eight (8) states.

(2) The State Board of Health shall adopt guidelines applicable to physician practices, nurse practitioner practices and physician assistant practices in Mississippi that incorporate the principles of the patient-centered medical home, using all resources available to the board.”

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.

[Missouri](#)

[Department of Health & Senior Services – Medical Home Definition](#)

“A medical home is not a building, house, or hospital, but rather an approach to providing health care services in a high-quality and cost-effective manner. Individuals who have a medical home receive the care they need from a health care provider whom they know and trust. Individuals and their health care providers act as partners in a medical home to identify and access all the medical and non-medical services needed to achieve maximum potential. A medical home should be accessible, family-centered, continuous, coordinated, comprehensive, compassionate, and culturally competent.”

[Montana](#)

[Department of Public Health and Human Services - Medicaid Primary Care Services Subchapter 52 – 37.86.5201 Health Improvement Program Definitions](#)

“(6) "Medical home" means one primary care provider or clinic that delivers the majority of all ambulatory health care services to each client. The medical home is the client's source for routine or preventive health care.”

[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 decision making 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.

Nevada

Department of Health and Human Resources – Division of Health Care Financing and Policy – [Medical Homes Collaborative](#)

“Patient Centered Medical Home (PC-MH) - This builds upon the original Primary CareCase Management concept and was most recently defined in the Joint Principles for Patient Centered Medical Home. A physician, or in some states, a nurse practitioner, is responsible for coordinating most aspects of a patient’s care and receives additional compensation for doing so. The benefit to this model is that physicians already have the medical skills, expertise, and patient relationships to coordinate care. Potential challenges include a provider’s lack of time and resources to coordinate care and limited knowledge about community resources.”

*further review of this document has the state refer to the ncqa.org website for more information on PCMH.

New Hampshire

(Chp. 177:123, NH Laws of 2005) “medical home” is mentioned [4 times](#) in the statutes, yet there is no clear definition available online through the NH state government website.

New Jersey

New Jersey Administrative Code – N.J.A.C. 8:19-1

"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.

Title 30 – Institutions and Agencies

30: 4D-17.33 Medicaid medical home demonstration project; terms defined

1. a. The Division of Medical Assistance and Health Services in the Department of Human Services, subject to federal approval and the availability of federal financial participation under Title XIX of the Social Security Act, shall establish a three-year Medicaid medical home demonstration project as provided in this act. The demonstration project shall be developed in consultation and implemented with the managed care organizations that contract with the Medicaid program to provide health care services to Medicaid recipients or with other appropriate vendors that contract with the Medicaid program to provide health care services to general public assistance recipients.

b. The Medicaid program shall:

(1) 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: (a) patient or family education for patients with chronic diseases; (b) home-based services; (c) telephonic communication; (d) group care; (e) oral health examinations, when applicable; and (f) culturally and linguistically appropriate care. In addition, the payment system shall be structured to reward quality and improved patient outcomes;

(2) Develop a system to support primary care providers in developing an organizational structure necessary to provide a medical home; and

(3) Identify primary care providers for participation in the demonstration project that provide care to their patients using a medical home model, **which at a minimum shall include primary care providers utilizing a multi-disciplinary 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.**

c. Nothing in this act shall be construed to limit the choice of a Medicaid or general public assistance recipient who is participating in the medical home demonstration project to directly access a qualified health care provider for family planning services who is not participating in the demonstration project.

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.

New York

PBH – Public Health, Article 27-L, 2799-S. Medical Home Demonstration Programs.

* § 2799-s. Medical home demonstration programs. 1. The commissioner, 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 relationship 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.

4. The commissioner is authorized and directed to promulgate such rules and regulations as are necessary to implement the provisions of this article.

5. The department shall evaluate the programs' effectiveness in promoting health through improving health care delivery, and promoting participants' and physicians' satisfaction with the medical home model, and shall issue a report of its findings and recommendations to the governor and legislature on or before April thirtieth, two thousand twelve.

*** NB Repealed January 1, 2012**

[\[NY S 6807 of 2008\]](#)

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.

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(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.

North Carolina

House Bill 2436 – Session Law 2008-107 – Page 62

“CCNC CHRONIC DISEASE/MEDICAL HOME AND PATIENT MODEL PROGRAM SECTION 10.10C. Of the funds appropriated in this act to the Department of Health and Human Services, Division of Medical Assistance, the sum of five hundred thousand dollars (\$500,000) for the 2008-2009 fiscal year shall be used to develop a plan for the implementation of a medical home and patient-centered collaborative model program. The model program will build on and enhance CCNC's success in reducing the cost of treating chronic disease among Medicaid enrollees through its initial implementation in six to eight counties. The model program will also allow CCNC to implement its disease management, patient-centered, medical home model to a greater number of patients, including those who will be included in the pending Medicare 646 waiver.”

North Carolina Healthy Start Program

“What is a Medical Home?”

A Medical Home is the one place you take your child for all your child's health care.

- checkups
- sick visits
- accidents
- special health needs
- immunizations (shots)

A Medical Home is a doctor's office, a community clinic, or a local health department. The staff there knows you, your child, and your child's health history. Remember you can call 24 hours a day.”

North Dakota

“A medical home is not a place, like an office or a hospital. Rather, the family or patient-centered medical home is a team-based approach to care that promotes coordinated acute, preventive and chronic care for all life stages. In a quality medical home, the clinical team partners with the patient or family to assure that all medical and non-medical needs are met.

According to the American Academy of Pediatrics, a medical home provides well-child and preventive care.

1 A medical home ensures care for its patients that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. A medical home assists in the early identification of special health-care needs, provides routine primary care and coordinates with a broad range of other specialty, ancillary and related services. During the 2011 Title V MCH Needs Assessment, the priority needs statement and performance measure for North Dakota were identified as follows:
Priority Needs Statement: Support quality health care through medical homes.

2 State Performance Measure: The percent of children birth through age 17 receiving health care that meets the American Academy of Pediatrics definition of medical home.

2. [North Dakota's Title V MCH performance measures are consistent with applicable national Healthy People 2020 objectives.](#)”

*ND doesn't have definitions of Medical Home in state statute, but on the department of health website, [this pamphlet informally explains the PCMH model](#)

Ohio

Ohio Administrative Code >> 5101:3 Division of Medical Assistance >> Chapter 5101:3-35 Medicaid School Program

51-1:3-35-01 Definitions

“(11) Medical home: a physician, physician group practice, or an advanced practice nurse with a current medicaid provider agreement, or a provider with a contract with an Ohio medicaid managed care plan. This provider serves as an ongoing source of primary and preventive care and provides assistance with care coordination for the patient.”

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.

Oregon

*OR's state code website was down for 2 days, but their office of health affairs did have a pdf from December 2007 – [The Medical Home Model of Primary Care: Implications for the Healthy Oregon Act](#). This printout defined medical home in various ways (See Appendix A – p.27).

Pennsylvania

*PA doesn't define "medical home" in their posted online statutes, but they do define it on their [Department of Health Website](#) as follows:

“What is a Medical Home?

A medical home is an approach to providing comprehensive health care to children with special health care needs. Health professionals and families work together as partners to identify and arrange all of the services needed to help the child with special health care needs to reach his/her potential. A medical home is patient-centered and accessible; provides comprehensive, continuous, coordinated services; has compassionate staff and is community-based and culturally competent.

A joint statement issued by the American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, and the American Osteopathic Association (March 2007) identified the following core principles of the medical home:

- Personal physician

- Physician directed medical practice
- Whole person orientation
- Care coordination across multiple systems
- Quality and safety
- Enhanced access
- Appropriate payment for services”

Rhode Island

Chapter 42-14.6. Rhode Island All-Payer Patient-Centered Medical Home Act

"Patient-centered medical home" means a practice that satisfies the characteristics described in § 42-14.6-2, and is designated as such by the secretary, or through alternative models as provided for in § 42-14.6-7, based on standards recommended by the patient-centered medical home collaborative.

"Patient-centered medical home collaborative" means a community advisory council, including, but not limited to, participants in the existing Rhode Island patient-centered medical home pilot project, and health insurers, physicians and other clinicians, employers, the state health care program, relevant state agencies, community health centers, hospitals, other providers, patients, and patient advocates which shall provide consultation and recommendations to the secretary and the commissioner on all matters relating to proposed regulations, development of standards, and development of payment mechanisms.

§ 42-14.6-2 Legislative purpose and intent. – (a) The general assembly recognizes that patient-centered medical home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. The patient-centered medical home is a health care setting that facilitates partnerships between individual patients, and their personal physicians, physician assistants and advanced practice nurses, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. The goals of the patient-centered medical home are improved delivery of comprehensive primary care and focus on better outcomes for patients, more efficient payment to physicians and other clinicians and better value, accountability and transparency to purchasers and consumers. The patient-centered medical home changes the interaction between patients and physicians and other clinicians from a series of episodic office visits to an ongoing two-way relationship. The patient-centered medical home helps medical care providers work to keep patients healthy instead of just healing them when they are sick. In the patient-centered medical home patients are active participants in managing their health with a shared goal of staying as healthy as possible.

(b) The patient-centered medical home has the following characteristics:

(1) Emphasizes, enhances, and encourages the use of primary care;

(2) Focuses on delivering high quality, efficient, and effective health care services;

(3) Encourages patient-centered care, including active participation by the patient and family, or designated agent for health care decision-making, as appropriate in decision-

making and care plan development, and providing care that is appropriate to the patient's individual needs and circumstances;

(4) Provides 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) Enables and encourages 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;

(6) Focuses initially on patients who have or are at risk of developing chronic health conditions;

(7) Incorporates measures of quality, resource use, cost of care, and patient experience;

(8) Ensures the use of health information technology and systematic follow-up, including the use of patient registries; and

(9) Encourages the use of evidence-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.

(c) The general assembly recognizes that Rhode Island is a national leader in all-payer patient-centered medical homes through a model developed by providers and financed through the voluntary participation of insurers. The continuation of this model, developed by the Rhode Island chronic care sustainability initiative, is recognized as critical to the future structure of the Rhode Island primary care delivery system. The general assembly also recognizes that the model created through this legislation is not the only model for patient-centered medical homes and in no way seeks to limit the innovation of providers and insurers in the future.

[§ 42-14.6-7 Alternative models.](#) – Nothing in this section shall preclude the development of alternative patient centered medical home models by an insurer for its group and/or individual policies, or by the secretary, the commissioner or other state agencies or preclude insurers, the secretary, the commissioner or other state agencies from establishing alternative models and payment mechanisms for persons who are enrolled in integrated Medicare and Medicaid programs, are enrolled in managed care long-term care programs, are dually eligible for Medicare and Medicaid, are in the waiting period for Medicare, or who have other primary coverage.

[South Carolina](#)

*SC doesn't seem to have a definition for PCMH in their statutes, but they do have a definition on the Department of Health & Human Services website, in the form of a print-out "manual" for providers.

[South Carolina Healthy Connections \(Medicaid\) – Provider Manual Supplement](#)

“Managed Care is a health care delivery model implemented by the South Carolina Department of Health and Human Services (SCDHHS) to establish a medical home for all Medicaid Managed Care eligible beneficiaries. The goals of a medical home include:

- Provide accessible, comprehensive, family-centered coordinated care
- Manage the beneficiary’s health care, perform primary and preventive care services, and arrange for any additional needed care
- Provide beneficiaries access to a “live voice” 24 hours a day, 7 days a week, to ensure access to appropriate care
- Provide beneficiary education about preventive and primary health care, utilization of the medical home, and the appropriate use of the emergency room

Enrolling in a managed care plan does not limit benefits. Benefits offered under fee for service (FFS) Medicaid, as well as additional or enhanced benefits are provided by all health plans.

These additional benefits vary from plan to plan according to the contracted terms and conditions between SCDHHS and the managed care entity. Beneficiaries and providers should contact the health plan with questions concerning additional benefits.

Examples of additional benefits include:

- 24-hour nurse advice line
- Care coordination
- Health management programs (asthma, diabetes, pregnancy, etc.)
- Unlimited office visits
- Adult dental services”

South Dakota

*SD doesn’t seem to have a definition for PCMH in their statutes, but they do have a definition on the Department of Social Services website, in the form of a RFI word document:

Medicaid Solutions Initiative: Improving Care Management for High Need, High Cost Medicaid Consumers – Page 5

“B. HEALTH HOME INITIATIVE

As a result of the Work Group analysis and activities, DSS intends to move forward to implement a Medicaid “Health Home” initiative. A “Health Home” is an alternative approach to the delivery of primary care services that promises better patient experience and better results than traditional care. The Health Home has many characteristics of the Patient-Centered Medical Home (PCMH), but is customized to meet the specific needs of low-income patients with chronic medical conditions. Pursuant to this model, a team of healthcare professionals partners with the patient to create an individualized plan of care. Patients are provided with all the support needed to follow their treatment plans and to adopt healthy habits. The medical home model is expected to lower healthcare costs by preventing costly complications and hospitalizations. Payment policies generally provide fee-for-service payments with add-ons for coordination and shared savings or bonuses for quality outcomes and reductions in ED and hospital utilization.

Since 2006, more than 30 state Medicaid programs have adopted medical home initiatives with some level of enhanced payments, shared savings, and/or bonus

payments. Recent changes to federal law provide states with a new Medicaid option to provide "health home" services for enrollees with chronic conditions. To encourage states to take up the new option, federal legislation authorized a temporary 90% federal match rate (FMAP) for health home services specified in the law. The health home option became available to states on January 1, 2011. Planning is underway in South Dakota to design and implement a Health Home option in pilot areas with the State. Implementation is anticipated within the next year."

Tennessee

*TN doesn't seem to have a definition for PCMH in their statutes, but they do have a definition on the Governor's Office of Children's Care Coordination website:

"What is the Medical Home Approach?"

The "medical home" is not a single person, place or building. It is an approach to health care for your child and your family.

The parts of the medical home approach are explained below:

Accessible care: Your health provider's office can accommodate any special physical needs your child may have. You can find a provider who is close to your home and can take different kinds of insurance. You can reach your provider in a number of ways-in person, by phone or maybe even by email.

Compassionate care: Your child's health providers try to understand your feelings and what you are going through.

Comprehensive care: Your child's health providers are well-trained to take care of children and families. Your provider is available to help you 24 hours a day, 7 days a week-this may mean in person or by phone.

Coordinated care: All the different health providers who care for your child talk to each other. This way, everyone knows about the plan for your child. Your health providers can connect you with community resources to help your child and family.

Continuous care: The same provider can take care of your child from birth until young adulthood. Your regular health provider can help with your child's care if your he or she has to be in the hospital.

Culturally effective care: Your providers consider your family's beliefs when making a plan for your child's care, and he or she communicates with you in a language you can understand.

Family-centered care: Your provider knows that you are the expert in caring for your child. You help the provider develop a plan to take care of your child.

When you build a home, there are many different parts. A home has doors, windows, a roof and furniture. The same is true with the medical home approach.

A medical home has many different parts. There are health providers who take care of your child, such as doctors, nurses, therapists and others. There are also insurance companies who help pay for your child's health care. The community is a big part of the medical home approach - places like schools and community agencies help children and

families to be healthy. The most important part of the medical home is the child and family. Everyone works with the family to help meet its needs.

Only having a primary care provider (a pediatrician or a family doctor) doesn't mean you have a medical home. All of the parts in the system must work together. Families have a part, too! The medical home has tasks just like any other home. Some of the tasks for families in a medical home are:

Share any questions with your child's primary care provider.
Tell your provider about your family's needs and main concerns.
Keep up with important information like shot records, test results and appointment times.
Work as a team with your child's providers to make a plan that meets your family's needs.”

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.

[*The Texas Department of State Health Services also dedicates a page to defining Medical Homes:](#)

“What is a Medical Home?

A medical home is not a place like a clinic or a hospital.

A medical home is a partnership between a child, the child's family, and the place where the child gets primary health care. At a medical home, the child's family and health care experts are a team. They work together to find and get all the services the child and family need, even if they are not medical services.

In other words, "medical home" is a name for a special kind of health care.

What is special about the medical home?

The medical home is health care that is:

Accessible

- provides health care in the community at times that best serve the community's families;
- accepts Medicaid, Children's Health Insurance Program (CHIP), Children with Special Health Care Needs (CSHCN) Services Program, and private insurance.
- Family-centered

- sees the family as the expert in their child's care;
- offers a safe place for families and professionals to discuss health care issues as partners.
- Continuous

- ensures that a child sees the same doctor over time;
- provides help with the transition to adult or specialty care.

Comprehensive

- provides a full range of care:
- preventative;
- primary;
- specialized care.
- works together with specialists and other service providers;
- shares information about insurance and other resources with the family.

Coordinated

- doctor, family, and child develop a plan of care as a team;
- offers support and links to schools and community-based services.
- Compassionate
- shows concern for child and family.
-

Culturally competent

- acknowledges and respects every family's cultural and religious beliefs”

Utah

*UT does not define “medical home” in their statutes, but it does dedicate a page to defining the medical home model on the [Utah Department of Health website](#).

“Medical Home

A medical home is not a hospital a home or a place. It is the way your doctor gives medical care to you or your family. In the Medical Home, you are the most important person in your child's life and your doctor listens to you because you know what your child needs. You are a partner in the care of your child's special medical needs and are entitled to receive correct information about health concerns and make health care choices for your child. The Medical Home is:

- Family Centered: you are a partner with the doctor.
- Consistent: the same doctor sees your child all the time.
- Complete/Comprehensive Support: Someone is always there any time, day or night, to take care of your child.
- Coordinated Care: The doctor talks to specialists your child sees, helps with school plans and gives referrals when needed.
- Concerned: Your doctor is concerned about you, your child and family
- Culturally Aware/Sensitive: Your doctor includes your religious and cultural needs in planning with you the care of your child
-

The Medical Home benefits children with special health care needs and their families by creating a place for families to go for ideas and help to solve problems about the child's health or other issues while they grow. It also provides someone to help manage and sort the services a child needs and gets. Health care proceeds more smoothly when parents, doctors and medical home staff work together”

Vermont

Title 18: Health – Chapter 13: Chronic Care Infrastructure and Prevention Measure 18 V.S.A. § 704. Medical Home

“§ 704. Medical Home

Consistent with federal law to ensure federal financial participation, a health care professional providing a patient's medical home shall:

- (1) provide comprehensive prevention and disease screening for his or her patients and managing his or her patients' chronic conditions by coordinating care;
- (2) enable patients to have access to personal health information through a secure medium, such as through the Internet, consistent with federal health information technology standards;
- (3) use a uniform assessment tool provided by the Blueprint in assessing a patient's health;
- (4) collaborate with the community health teams, including by developing and implementing a comprehensive plan for participating patients;
- (5) ensure access to a patient's medical records by the community health team members in a manner compliant with the Health Insurance Portability and Accountability Act, 12 V.S.A. § 1612, sections 1852, 7103, 9332, and 9351 of this title, and 21 V.S.A. § 516; and
- (6) meet regularly with the community health team to ensure integration of a participating patient's care. (Added 2009, No. 128 (Adj. Sess.), § 13.)

2007 VT H 631

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

*VA government websites were having trouble with the search function while updating this document, but as far as we could see, there isn't a viable definition for PCMH other than the standard AAP definition that is referred to in a couple docs.

Washington

RCW 74.09.010

Definitions (as amended by 2011 c 316)

“(8) "Health home" or "primary care health home" means coordinated health care provided by a licensed primary care provider coordinating all medical care services, and a multidisciplinary health care team comprised of clinical and nonclinical staff. The term "coordinating all medical care services" shall not be construed to require prior authorization by a primary care provider in order for a patient to receive treatment for covered services by an optometrist licensed under chapter 18.53 RCW. Primary care

health home services shall include those services defined as health home services in 42 U.S.C. Sec. 1396w-4 and, in addition, may include, but are not limited to:

- (a) Comprehensive care management including, but not limited to, chronic care treatment and management;
 - (b) Extended hours of service;
 - (c) Multiple ways for patients to communicate with the team, including electronically and by phone;
 - (d) Education of patients on self-care, prevention, and health promotion, including the use of patient decision aids;
 - (e) Coordinating and assuring smooth transitions and follow-up from inpatient to other settings;
 - (f) Individual and family support including authorized representatives;
 - (g) The use of information technology to link services, track tests, generate patient registries, and provide clinical data; and
 - (h) Ongoing performance reporting and quality improvement.
- (9) "Internal management" means the administration of medical assistance, medical care services, the children's health program, and the limited casualty program."

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]

(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.

Wisconsin

*The WI department of Health Services links to a "[medical home toolkit](#)" on the AAP website to define medical home.

"What is a Medical Home?"

A "great" medical home declares itself to be a medical home, and

- knows its patients and patient populations;
- partners with and learns from youth and families;
- uses a proactive team approach to chronic care management, including planned visits, coordination of complex services, co-management with specialists, and assistance with transitions - especially to adult services;
- connects with other community-based organizations;
- offers safe, efficient care while preventing unnecessary or duplicative services, thus reducing health care costs.¹

Wyoming

[2009 introduced in the Senate – 09LSO-0235 - SF0024](#)

“(vi) "Medical home" means a service provided by a physician, advanced practice registered nurse or physician assistant serving as the principal provider of primary care and the initial point of contact with the medical system for the patient. The medical home shall seek to strengthen the provider-patient relationship by replacing episodic care based on illnesses and patient complaints with a broad array of prevention, screening exams, advice on avoiding illness and, as needed, urgent care with referral to specialists as indicated. When appropriate, the medical home shall involve a plan of care for each individual and include teaching the individual to assist in the management of his health. Reimbursement for medical home services shall include reimbursement to the health care professional for patient care management”

CONTACT US

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