

The term Medical Home pertains to a physician practice that has sufficiently documented the capabilities to function as a Medical Home in either Tier 1 or Tier 2. However, each physician who practices in a Medical Home as a personal physician is expected to provide a higher level of care and care management to participating Medicare beneficiaries under their care.

The description of services below indicate what personal physicians who practice in a qualified Tier 1 and Tier 2 Medical Home should be providing to all their Medical Home patients.

Medical Home Demonstration (Tier1)

MEDICAL HOME INCLUDED SERVICES

Direct physician supervision and management of the comprehensive and coordinated health care of a patient having one or more chronic conditions or prolonged illnesses as included on the CMS eligible disease list. These services are separate from and in addition to those provided as part of E/M services that may occur during the service period. Coordination of care across all of a patient's healthcare needs and responsibilities will occur whether or not an E/M service is provided and reported during the service period. Services include all of the following as necessary within a calendar month:

- Obtains mutual agreement on role of medical home between physician and patient
- Ongoing support, oversight, and guidance by a physician-led health care team
- Integrated coherent planning for ongoing medical care including communication and coordination with other physicians and healthcare professionals furnishing care
- Regular physician development and/or revision of documented care plans, including integration of new information and/or adjustment of medical therapy
- Approval and tracking of medication changes initiated by pharmacy benefit plans
- Medication reconciliation
- Review of reports of patient status from other physicians or health care professionals
- Review results of laboratory and other studies
- Documented use of evidence-based medicine and clinical decision support tools to facilitate diagnostic test tracking, pre-visit planning, and after-visit/test follow-up
- Seven day per week, 24-hour access to phone triage
- Communication (including telephone calls, secure web sites, etc.) with the patient, family, and caregivers for purposes of assessment or care decisions
- Use of patient self-management plan (including end-of-life planning, home monitoring)
- Patient, family, and caregiver education and support
- Use of health assessment to characterize patient needs and risks
- Monitoring, arranging, and evaluating appropriate and/or evidence informed preventive services
- Organizes and trains staff in roles for coordination of care across all of a patient's healthcare needs (including staff feedback)

Medical Home Demonstration (Tier 2)

MEDICAL HOME INCLUDED SERVICES

Direct physician supervision and management of the comprehensive and coordinated health care of a patient having one or more chronic conditions or prolonged illnesses as included on the CMS eligible disease list. These services are separate from and in addition to those provided as part of E/M services that may occur during the service. Coordination of care across all of a patient's healthcare needs and responsibilities will occur whether or not an E/M service is provided and reported during the service period. Services include all of the following as necessary within a calendar month:

- Obtains mutual agreement on role of medical home between physician and patient
- Ongoing support, oversight, and guidance by a physician-led health care team
- Integrated coherent planning for ongoing medical care including communication and coordination with other physicians and healthcare professionals furnishing care
- Regular physician development and/or revision of documented care plans, including integration of new information and/or adjustment of medical therapy
- Tracking of hospital, and other facility admissions, with appropriate follow-up after discharge
- Approval and tracking of medication changes initiated by health plans or pharmacy benefit plans
- Medication reconciliation to avoid interactions or duplications. Review of medication changes occurring outside of an E/M visit, including all prescriptions and related communication with other physicians and health care professionals.
- Review of reports of patient status from other physicians or health care professionals
- Review results of laboratory and other studies
- Staff monitoring to ensure use of evidence-based medicine and clinical decision support tools to facilitate diagnostic test tracking, pre-visit planning, and after-visit/test follow-up
- Seven day per week, 24-hour access to phone triage
- Communication (including telephone calls, secure web sites, etc.) with the patient, family, and caregivers for purposes of assessment or care decisions
- Use of patient self-management plan (including end-of-life planning, home monitoring)
- Patient, family, and caregiver education and support

- Use of health assessment to characterize patient needs and risks
- Use of health information technologies, such as patient registries, to monitor and track patient health status or generate point of care clinical reminders
- Use of secure systems that provide for patient access to personal health information
- Use of secure electronic communication between the patient and the healthcare team
- Use of an electronic health record
- Use of an electronic prescribing system
- Measuring performance regarding clinical quality and patient experience and taking action to improve care and processes
- Monitoring, arranging, and evaluating appropriate evidence based and/or evidence informed preventive service
- Organizes and trains staff in roles for coordination of care across all of a patient's healthcare needs (including staff feedback)