



American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

Children and the Medical Home

It is the position of the American Academy of Pediatrics that payers should be incentivized to adequately finance the medical home as the primary model of health care delivery for infants, children, adolescents and young adults. Payment and delivery systems should be reformed based on the principles of the patient-centered medical home agreed upon by physicians, family leaders, patient advocates and purchasers.

First pioneered by the Academy in the late 1960s, the medical home has become accepted by primary care medical associations, patient and family groups, and purchasers of health care as the standard for the delivery of primary health care services. A medical home is not a particular place, but an approach to providing primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective.

Through successful partnerships between families and providers, medical homes can provide the best care for children, appropriately utilizing limited resources and remaining responsive to health care costs. Major demonstration projects are under way in the public and private sectors. Many state Medicaid programs are also adopting incentive structures based on the patient-centered medical home model. The new health reform law will give states the opportunity to expand upon current medical home efforts. It is critical that states create medical home programs that meet the needs of children and pediatricians, including ensuring coverage of necessary services, better coordination between state programs and pediatric primary care providers, and payment for care coordination and other services provided in a medical home.

The Health Reform Law:

- Creates a Medicaid state option to provide medical assistance in a medical home (deemed “health home” in the law’s provision) to individuals with chronic conditions. An individual may select a physician, a team of health care professionals operating with a physician, or a health team as their designated health home. The payment methodology for the program can be determined by states and may be tiered to reflect the severity or number of a patient’s chronic conditions and the specific capabilities of the health home. Payment models are not limited to per-member per-month structures. Those who may enroll include individuals eligible under the state plan or waiver with (1) at least two chronic conditions, (2) one chronic condition and a risk of developing a second, or (3) one serious and persistent mental health condition. Chronic conditions include, but are not limited to, a mental health condition, a substance use disorder, asthma, diabetes, heart disease and obesity.
- Provides grants to states or state-designated entities to establish community-based interdisciplinary, inter-professional health teams to support primary care practices and provide capitated payments to primary care providers. Health teams may include medical specialists, nurses, pharmacists, nutritionists, dietitians, social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians’ assistants. These planning grants will be made available to states, but the total funding for the grants will not exceed \$25,000,000.