

## **Redesigning Federal-State Health Programs Around the Medical Home**

The Medicaid Commission, in its December 2006 report to HHS Secretary Leavitt, recommended that “states should place all categories of Medicaid beneficiaries in a coordinated system of care premised on a medical home for each beneficiary, without needing to seek a waiver or any other form of federal approval”. The Commission defined a “medical home as a source of primary health care that provides accessible, comprehensive coordinated care . . . Care should be delivered or directed by well-trained physicians who provide primary care services and who manage and facilitate essentially all aspects of care.” Several states have already begun to redesign Medicaid and other state programs around a medical home:

*Louisiana* - After Hurricane Katrina, the Louisiana Health Care Redesign Collaborative was created to revitalize health care in the New Orleans region (Jefferson, Orleans, Plaquemines, and St. Bernard parishes). Driven by quality and incorporating evidence-based practices and accepted standards of care, the Collaborative adopted the following vision: “*Health care in Louisiana will be patient-centered, quality-driven, sustainable and accessible to all citizens.*” The backbone of a redesigned system of care put forward by the Collaborative is the “medical home.” Louisiana is seeking a federal waiver for broad system redesign based on the medical home.

*Missouri* - Governor Matt Blunt (MO) proposed the creation of Missouri HealthNet, in his 2007 State of the State address, as a way to guarantee that every participant has access to primary and preventative care. The focal point of HealthNet is the medical home. Under HealthNet proposal, all Missourians will have “one central point of contact and a doctor who knows them personally. HealthNet provides this access by empowering participants to choose their health care home.” It will use a health risk assessment to develop a plan of care for improved health and, help to avoid unnecessary emergency room visits and unnecessary hospitalizations. HealthNet also will embrace HIT to ensure that all health care information is available to patients and providers in a secure system. Unlike the old Missouri Medicaid system, HealthNet will pay providers for results, not just visits or tests.

*North Carolina* – The North Carolina State Medicaid program, Community Care of North Carolina (CCNC), pays primary care physicians in a “medical home” a monthly care coordination fee plus performance based bonuses. Practices are supported by a community network model that includes disease management, nurse educators, and case managers to outreach to sicker and more costly patients. The annual cost of CCNC is \$8.1 million with a savings of \$60 million (compared to FY 2002) and a savings of \$203 million (compared to fee-for-service). North Carolina is currently seeking a federal waiver to incorporate dual-eligibles.

### **Congress Should Encourage States to Restructure Plans Around the Medical Home**

Congress can support such state efforts by: (1) including language in the SCHIP reauthorization that encourages states to organize health care around a medical home model as part of a broader quality program; (2) providing funding to states to redesign Medicaid, SCHIP, and programs for the uninsured around a medical home and easing or eliminating federal waiver requirements for such programs; and (3) encouraging HHS to grant waivers to states seeking to make the medical home part of their health care programs. Funding should be targeted to ensure the medical home’s success, with savings devoted to quality improvement and/or an expansion of coverage.