

Comments on the Medical Home Model As a Core Concept in Health Care Reform Legislation

The Medical Home Model developed by the Health Care Collaborative represents an excellent cornerstone for health care reform and a principal objective that providers should pursue. The elements of improved communication, information exchange and care coordination – guided by evidenced-based protocols – holds significant promise for improving care, increasing patient satisfaction, and controlling costs.

Because of the degree of integration of doctors and hospitals within LSU-HCSD, our system in many ways is better-positioned than others to adapt to the requirements of the Medical Home concept. In fact, improvements in this system over the past decade have followed the trajectory of change that a Medical Home Model represents. The LSU Disease Management program is a major step toward that Model. In sum, LSU is willing, able and anxious to continue its transition consistent with the Medical Home concept.

A successful transition to a Medical Home Model does not entirely depend upon work already done or upon the will to adapt. It also will be strongly affected by resources. It is significant that in the context of the Health Care Collaborative's deliberations, the Medical Home Model was to be implemented **for a population of patients with health care coverage**. The Collaborative was attempting to craft a means to extend a benefit package to the uninsured as well as to specify the care model within which covered services would be delivered, and it was assumed that a source of payment would be in place for those services.

The financial capacity to implement the Medical Home Model is a different proposition if the starting point is not a covered population but rather an uninsured group for whom funding covers only around a third of the costs that would be incurred by a like-sized population of insured individuals. Strict adherence to some aspects of the Medical Home Model would be problematic given the extent of rationing necessary at the funding levels that the state public hospital system receives through the DSH program for care to the uninsured.

A health care reform program designed to support implementation of a Medical Home Model in the safety net system would have to address several elements of cost that would be new or are presently unfunded. They include:

- **Payment for physician and related services that may be medically necessary under the Medical Home Model.** The current "unallowable" status of physician, CRNA and other "non-hospital" costs under DSH suppresses the ability of the safety net to provide the extent of timely clinic and other physician services that a Medical Home Model requires. It is not possible to both implement a Medical Home Model **and** to go unpaid for some of the most basic services that patients require.

- **Funding for personnel and space associated with the increased service levels under the Medical Home Model.** The Model represents an expansion of services over and above those typically utilized by the uninsured, as well as better coordination of those services. The Health Care Collaborative's cost figures clearly reflected the higher service levels. A health care reform program seeking to extend the Medical Home concept to the safety net should be attentive to added costs for personnel, and probably space, that will be required. Implementation of the Model by the LSU hospitals would require not only reimbursement for existing physicians, but it would necessitate funding for additional doctors, clinic and other staff to provide the extent of access envisioned under the Medical Home concept. In some cases, it may be necessary to direct patients to providers outside the LSU system, and the means to pay for that care would need to be available
- **Funding for enhancements to Information Technology infrastructure required by the Model.** The Medical Home Model involves significant improvements in the availability and sharing of patient medical information that can only be met by pursuing an Electronic Medical Record. LSU has made progress toward this end, but significant additional development costs must be incurred.

There should be no illusion that the Medical Home Model will be less costly than what Louisiana now spends on the uninsured. However, the new expenditures associated with the model will help control costs in the long run, as health conditions are prevented or detected earlier and expensive complications are avoided.

Reform legislation should be crafted with appropriate timeframes for transition of provider networks to the new Model and with sufficient opportunity for input in any rulemaking that must occur with DHH as, presumably, the agency with administrative responsibility for the reforms.

HCSD will be happy to provide whatever additional thoughts, information and assistance may be helpful as health care reform legislation is developed.