Healthcare BUSINESS STRATEGY™

Health Plans, Providers Testing Medical Home Concept

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by Hazel Becker

Amidst the turmoil of healthcare reform, fortunately the quest for real solutions to control rising healthcare costs is still alive. Several industry leaders are gaining support for reviving an innovative model called the Patient-Centered Medical Home (PCMH) that dates back to the 1960s. On the surface, the model appears to resemble the health maintenance organization (HMO) and is based on similar principles of coordinated care. On closer examination, it is clear that the PCMH is far less restrictive than traditional HMOs and could very well emerge to play a key role in the next generation of healthcare.

Although the medical home concept shares some characteristics with the HMO model, there are key differences. A very important difference is the fact that there is no gatekeeper. Patients do not need a referral from a primary care doctor to see a specialist. In a PCMH, the primary care physician advises patients and may arrange for specialty care but the patient retains control of the decision. The primary care physician's role is to coordinate care by making sure patient information is appropriately shared with clinicians to result in a consistent, integrated plan of treatment. Pay-for-performance strategies are also an integral component of the medical home model.

In our current system of fragmented services based on diagnoses and procedures provided largely by specialists, this concept sounds revolutionary. However, the medical home concept is not new — the American Academy of Pediatrics coined the phrase in the 1960s in seeking a high level of care coordination for children with special needs. More recently, policymakers and industry innovators have advocated providing coordinated primary care for all Americans to reduce emergency room visits and minimize unnecessary or duplicative tests and hospitalizations. The key objective of the PCMH movement is to develop a healthcare delivery system in which individuals and their primary care providers truly collaborate to provide for the patient's health and well-being.

To deliver the required integrated care, medical homes rely heavily on advanced technology to implement electronic medical records (EMRs), keep and access disease and condition registries, implement evidence-based diagnosis and treatment guidelines, and provide secure email and phone communication systems. Additional staffing with nurses, physician assistants, pharmacists, dieticians, and other health professionals allows practices to offer extended hours, 24/7 phone coverage, follow-up, and outreach to help patients carry out prescribed treatment and monitoring regimes.

This may sound like an optimal primary care delivery system that is "too good to be true." However, with considerable help and endorsement from nonprofit organizations and employers, medical homes are taking hold. The modern-day PCMH concept resulted from the efforts of several large national employers that brought together primary care physicians, health plans, and consumer groups in 2006 to flesh out the idea through the Patient-Centered Primary Care Collaborative (PCPCC). The group's Joint Principles of the Patient-Centered Medical Home, released in 2007, became the core of a recognition program carried out by the National Committee for Quality Assurance (NCQA). According to NCQA, a PCMH is "a health care setting that facilitates partnerships between individual patients, and their personal physicians, 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."

Since the guidelines were released, NCQA has recognized more than 265 primary care practices with nearly 1,450 physicians as patient-centered medical homes. Many of those practices and physicians are involved in more than 30 demonstration and pilot projects, working with the nation's leading health insurers, several smaller health plans, state and regional agencies, and other sponsoring organizations to test various care delivery approaches and funding mechanisms to provide high-touch, coordinated care.

When all is said and done, medical homes must deliver improved health outcomes while demonstrating real cost savings. This requires a high level of collaboration from provider to provider as well as provider to payer. Results from several demonstration and pilot programs are promising. A review prepared by the PCPCC for a White House meeting in September 2009 presented positive outcomes from a number of PCMH pilots and concluded that quality of care, patient experiences, care coordination, and access are demonstrably better at facilities participating in the demonstration projects.

Positive outcomes noted in the review included:

- a 29% reduction in emergency room (ER) visits, 11% reduction in ambulatory sensitive care admissions, and statistically significant decrease in total costs at a Group Health Cooperative clinic in Seattle;
- a 40% decrease in asthma hospitalizations and 16% lower ER visit rate at Community Care of North Carolina in a project that linked Medicaid and state children's health insurance program (SCHIP) beneficiaries to medical homes, resulting in an estimated savings of $535 million per year to the state programs;
- an estimated savings of $3.7 million over two years and statistically significant quality improvements in preventive, coronary artery disease, and diabetes care for Geisinger Health System after it implemented its PCMH model;
- significantly lower median annual costs for Medicaid and SCHIP beneficiaries in a Colorado pilot ($785 for PCMH children, compared with $1,000 for controls) ; and
- a 24% reduction in hospital inpatient days, 15% fewer ER visits, and a 37% decrease in skilled nursing facility days among Medicare beneficiaries in the top health-risk quartile at the Johns Hopkins PCMH in Baltimore.

Pilot Projects Address Business Questions

One aim of the pilots and demonstration programs is to address the obstacles medical homes must overcome to succeed, one of which is the cost. Upfront costs include systems and technology, while ongoing costs include the additional staff needed for extended hours and reduced physician case loads. In some cases, health plans and sponsoring organizations are helping providers defray the upfront costs as well as the operating costs.

Harriet Walsh, RN, CIGNA HealthCare's business lead for medical homes, said the company's participation in a variety of pilots and demonstration programs gives it "the opportunity to look at many models to see what's most effective. That will inform how we support medical homes in the future." In a project that began September 1, 2009 CIGNA will provide upfront funding for Medical Clinic of North Texas (MCNT) to establish a process for coordinating patient care. Care coordination will be led by a registered nurse, working with a team of professionals supported by MCNT and CIGNA data and clinical tools. The clinic's primary care physicians will be paid as usual for medical services they provide and also may be rewarded through a pay for performance (P4P) structure for improving quality and enhancing access to appropriate care.

Walsh said most of CIGNA's PCMH programs rely on a blended payment methodology that includes compensation according to the provider's existing fee schedule as well as supplemental payments of a per-member-per-month (PMPM) fee for care coordination. The PMPM fees, generally paid twice a year, are based on a system of "virtual patient alignment" that ties each plan member to a primary care-giver based on the patient's past claims. In CIGNA's newest medical home pilot, with ProHealth of Farmington, Conn., compensation will include a P4P component in addition to the fee-for-service and PMPM payments. According to Walsh, the company will look at outcomes and costs each year and then adjust PMPM payments accordingly. CIGNA's pilot project with Dartmouth-Hitchcock Medical Center, announced in June 2008, also includes a P4P component. The company is now collecting information from the pilot's first year and hopes to have data to evaluate by the end of 2009, she said.

A Collaborative Process

CIGNA also is using the demonstration projects and pilots to work out its relationship with providers and devise reports providing "actionable data" to help providers coordinate care. For example, Walsh said, the company sends each physician in its network a report that identifies gaps in a patient's treatment, such as prescriptions that were not filled and follow-up visits that were not scheduled. While she said CIGNA is not certain how much providers use the reports, it is delivering gap information electronically to its PCMH practices and working with care coordinators to help them use the reports, along with evidence-based care guidelines, to provide improved care.

The relationship between providers and health plans is not the only interaction that needs to be worked out for patient-centered medical homes to work. Reports on the early PCMH pilots indicate that some providers have had trouble adjusting to working collaboratively with a group of professionals and the patient. This is a particularly important finding, according to Dr. Paul Grundy, PCPCC's president and IBM's director of healthcare, technology, and strategic initiatives. "Nobody teaches doctors how to work in teams," Grundy said. For the PCMH movement to succeed, he said, healthcare providers need to go through a fundamental change in which they learn to deliver comprehensive, integrated, coordinated care to everyone, with the aim of controlling patients' health and "keeping them away from being high-end need." This means treating chronic and emerging conditions before they require more intervention, procedures, and hospitalizations. "The biggest bang for the buck is keeping patients out of the hospital," Grundy said.

Physicians, other health professionals, hospitals and clinics, and health plans are all working out what their roles will be in the healthcare delivery system of the future. Grundy believes that health plans have a place in that system as "more than just a network provider, more than just a payer of bills. Hopefully, they will make it so that data begins to flow — they will provide quality guidance to members about where they can get care in a more transparent way. And, they will develop mechanisms of how they pay around quality of care and outcomes. This is an extremely valuable role for health plans to play," he said.

However, not all primary care physicians believe health plans need to — or should — be involved in creating patient-centered medical homes. One Seattle company, Qliance Medical Group, has set up two clinics where it charges patients a monthly fee for primary care. The payments are generally not reimbursed by health insurance companies, and Qliance recommends that its patients maintain insurance to pay for care that would be required in the event of a serious accident, illness, or emergency. The company markets its plan to individuals and employers as a means of bringing healthcare costs down by combining its capitated primary care coverage with lower cost, high deductible health plans and health savings accounts (HSAs) or health reimbursement arrangements (HRAs).

Dr. Erika Bliss, Qliance's director of clinical operations, said the company aims to address the same problems in the primary care system that the PCMH program targets. Although Qliance follows many of the principles outlined in the PCPCC guidelines, it decided not to seek NCQA recognition because the measures it requires are focused more on the medical practices than on the patients. Further, she said, the company believes that the healthcare system's reliance on fee-for-service and insurance is detrimental to physicians' efforts to provide the quality, coordinated primary care.

The original HMO model also saw many of the same challenges that medical homes are facing. In particular, healthcare providers must go through a fundamental change to focus on delivery of comprehensive, integrated, coordinated care to everyone, with the aim of cultivating patients' health. In the current environment, technological and data advances in electronic medical records (EMRs), disease and condition registries, evidence-based diagnosis and treatment guidelines, and secure email and phone communication systems may advance this model a few steps further toward developing a healthcare delivery system in which individuals and their primary care providers truly collaborate to improve everyone's health and well-being.

Medical Homes are a health care delivery system model, not an insurance (i.e. health plan) model. The types of health plans involved are irrelevant in this model. Pilots involve all the leading health insurers and all segments of the population, including commercial, Medicaid and Medicare as well as special needs plans. CIGNA, with its limited Medicare and no Medicaid membership, is actively involved in medical homes not only because the company believes in the concept but also because self-insured employers, such as IBM, are interested in this model. IBM, as a producer of system solutions for electronic records integration, management, analysis, and communication across the healthcare ecosystem, also has a commercial interest in PCMH success. The role between provider and health plan has not been worked out in the medical home model perhaps because health plans are not essential participants. Clayton M. Christensen, Harvard University business professor and author of several books on disruptive technologies (defined as innovations that improve a product or service in ways the market doesn't expect), suggested PCMH as a possible disruptive technology at the America's Health Insurance Plans' (AHIP) annual meeting last year. It certainly bears watching.

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