The Medical Home Bends Cost Curve

While the Affordable Care Act is trying to manage health insurance, as well as mandating coverage, a number of projects around the country are trying to manage the underlying cost of health care. By bringing back the concept of a true primary care physician, who provides 90% of your care and coordinates with your specialists, these programs are bending the curve of health care cost trends. Most are seeing a reduction in emergency room visits and hospital days in the double digits. Others that are taking fee-for-service insurance out of the picture altogether are experiencing even higher reduction rates. The goal is to increase patient health, which includes the patient having an active role in understanding his or her condition, treatment options and self-care strategies. It is estimated that if all Americans had access to a medical home, our nation could save $37 billion annually.

by Sandra M. Wood, CEBS | Cambia Health Solutions

Do you remember going to your doctor as a kid? Not only did he or she know all about you, but the doctor also knew about your entire family. The doctor treated you for almost everything—hardly ever did you get referred to a specialist.

The days of the family doctor are coming back, in the form of medical homes. It is said that history is bound to repeat itself and, in this case, that's a good thing. Imagine having all your health care records in one place, with one team of providers reviewing your care from various sources. When you did need specialty care, your medical home would coordinate with the specialist to ensure that all your records were received and your care strategy reviewed. Also, your medical home would make sure you were getting the right aftercare, and would ensure your prescriptions wouldn't have negative interactions.

This is the brave new world of health care, or the brave old world with some new-world enhancements. A number of medical home projects are being conducted throughout the United States by health plans, employers (such as Boeing) and even major care providers (like Johns Hopkins). Some of the results include:

- Group Health Cooperative of Puget Sound in Washington saw a 29% reduction in emergency room visits under its patient-centered medical home (PCMH) project.
- Community Care of North Carolina saved $135 million in Medicaid and State Children’s Health Insurance Program (SCHIP) costs, and another $400 million in care for the blind, aged and disabled in just one year.
- Genesee Health Plan’s Healthworks PCMH model reduced inpatient hospitalizations by 15% and emergency room visits by 50%.
• Johns Hopkins’ guided care PCMH model saw an annual savings of $1,364 per Medicare patient.\(^1\)

Most of these pilot programs are still run under the traditional health insurance fee-for-service model and provide reimbursement to primary care physicians for the additional care and coordination they offer to their patients.

In 2007, Qliance was launched in Seattle, Washington.\(^2\) Qliance decided to take fee-for-service insurance out of the equation. It believed that by creating a monthly payment model, it could reap even greater savings than other medical home programs were experiencing. Qliance was right, as not only did it eliminate the need for additional billing staff to handle insurance claims, but it also reduced escalated care.

Qliance data from 2009 and 2010 are blowing the competition’s numbers out of the water, with a 65% reduction in emergency room visits and a 43% reduction in hospital days (see Table I). Qliance’s data also captured reductions in the areas of specialist visits (66%), advanced radiology (63%) and surgeries (82%). Of course, all of this did not happen without a huge increase in primary care visits—double the regional average per person. That validates the idea of a medical home—that receiving additional primary care will reduce or eliminate specialty and emergency care.

**Existing Medical Home Program Experiences**

Under Qliance, the provider team (comprised of a physician, a nurse and a medical technician) has a maximum patient load of 800 patients. Compare that to the average patient load for fee-for-service doctors of 3,000 patients. This results in patients receiving longer visits at Qliance, ranging from 30 to 60 minutes each, where the fee-for-service doctor visit is typically 15 to 30 minutes. Additional doctor visits each year, along with additional time with patients per visit, provides a more thorough vetting of all the patient’s concerns and more education of the patient regarding his or her conditions, including self-care strategies.

A detractor of the Qliance program espoused that the massive reduction in specialty and emergency care must be based on Qliance’s patient population being healthier than the average population. To determine if that was the case, Qliance conducted a review of its patients’ conditions based on medical chart notes and compared them to benchmarks (see Table II). Overall, the Qliance population’s health conditions are very similar to local, state and national benchmark data.

<table>
<thead>
<tr>
<th>Type of Referral</th>
<th>Qliance Number per Year, per 1,000 Patients</th>
<th>Regional Benchmark*</th>
<th>Difference**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2009</td>
<td>2010</td>
<td>2009</td>
</tr>
<tr>
<td>ER visits</td>
<td>60</td>
<td>56</td>
<td>158</td>
</tr>
<tr>
<td>Hospitalization (in days)</td>
<td>136</td>
<td>105</td>
<td>184</td>
</tr>
<tr>
<td>Specialist visits</td>
<td>909</td>
<td>670</td>
<td>2,000</td>
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<tr>
<td>Advanced radiology</td>
<td>414</td>
<td>300</td>
<td>800</td>
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<tr>
<td>Surgeries</td>
<td>33</td>
<td>22</td>
<td>124</td>
</tr>
<tr>
<td>Primary care visits</td>
<td>4,040</td>
<td>3,540</td>
<td>1,847</td>
</tr>
</tbody>
</table>

*Based on regional benchmarks from Ingenix and other sources.

**Based on best available internal data; may not capture all nonprimary care claims.

Source: Qliance Medical Group non-Medicare patients, 2009 (n = 2,316) and 2010 (n = 3,088).
Let’s step back for a moment and review the Qliance model. For a flat monthly fee, currently ranging from $54 to $169 based on age and level of provider coordination, a patient can visit Qliance without copays, deductibles or coinsurance. Services include office visits, medical exams, preventive care, immunizations, on-site x-ray/lab work and chronic disease management. Not included are higher level radiology tests, emergency room services, ambulance, hospital care and prescription drugs.

Qliance’s five locations offer same-day and next-day appointments, and are open seven days a week with extended hours Monday through Friday. Patients can access a doctor by phone or e-mail 24 hours a day. If a patient needs noncovered care, the providers at Qliance will coordinate with the specialist and/or hospital to provide patient medical records and coordinate aftercare.

The Qliance target market initially was the working poor and the uninsured, both of whom could not afford traditional insurance. But it now is enrolling additional members through alliances with employers that are providing high-deductible health plans to their employees. By combining the Qliance model with a high-deductible plan, employees can receive as much primary care as they need (without copays, deductibles or coinsurance), and have the insurance plan help pay for prescriptions, hospitalizations and other nonprimary care services.

Qliance isn’t the only program finding stellar results by creating medical homes for its patients. Adventist HealthCare, a self-funded employee benefit plan covering 7,200 lives, began a pilot project in late 2009. Under this program, the plan targeted 46 patients who sought care through at least 15 different providers and had at least nine prescribing physicians. The goal was to provide this segment with a medical home, including a provider who would coordinate all care a patient was receiving from various specialists.
The primary care physicians (PCPs) for these patients received access to personal health records, including information on the patients’ diagnoses, procedures, inpatient stays and prescriptions. The program also matched each PCP with a personal health nurse from Adventist HealthCare’s third-party administrator. The health nurse educated providers on how to access the online health records of the patients and provided member progress reports to the PCP. They also reached out to patients to engage them in the program and provide coaching. Each patient had unlimited access to a health nurse and could spend one hour a month with the PCP, at no charge to the patient. Adventist HealthCare paid the PCP a care management fee for the extra time spent with program participants.

After one year in the program, most of the 46 members moved from the “high-risk” category down to “moderate risk” or “low risk.” And while the pilot’s participants saw a decrease in utilization costs of 35%, those not participating in the program had a 0.9% increase. The pilot program cost $31,204, with direct savings of $87,365—resulting in a return on investment (ROI) of 2.79.

A second obstacle is online medical records. Who will pay for this service, storage of the data and the security needed? And how will patients and providers access the data efficiently?

Third are the laws on the books in each state, some of which preclude such provider practices as Qliance from doing business outside of insurance oversight.

The author has reviewed the programs offered through Qliance and Adventist HealthCare, both of which use a monthly payment model for their PCPs. Adventist was able to provide this payment in addition to its current fee-for-service insurance program because its program is self-funded. It also had the resources through its third-party administrator to collect all data on each patient and provide that data to the PCPs through an online portal. Qliance is a member-paid program, also known as a direct primary care medical home. So that care could be provided outside the realm of insurance, the Washington legislature enacted a law (Senate Bill 5958) that removed direct patient-provider primary care from the definition of health care service contractor. This meant that any direct patient-provider primary care was not deemed an insurer or a health carrier, and could practice outside of insurance regulations.

All of Qliance’s expansion has been in the state of Washington. As it looks to expand into other states, the first hurdle it must tackle is how those states regulate patient direct-pay programs. How this will play out in 2014 remains to be seen. Patient Protection and Affordable Care Act (PPACA) Section 1301(a)(3) specifically allows direct primary care medical homes to be offered in state exchanges, when coupled with a suitable “wrap-around” insurance product. Insurance carriers are already working with Qliance and other direct primary care medical homes to design these new wrap-around insurance products. The Department of Health and Human Services (HHS) will be drafting the final provisions that will regulate medical homes under the exchanges. Several providers, patients and state lawmakers are urging HHS to use Washington’s primary care law as a basis for the final regulations to ensure that these direct practices remain independent of insurance companies.

Washington’s Senate Bill 5958, passed in April 2007, removed insurance regulations from direct patient-
provider practices but had stipulations with which these direct patient-provider practices must abide. They can provide only primary care, including routine health screening, assessment, and diagnosis; treatment to promote health; and detection/management of disease or injury. They cannot accept payment for their services other than the monthly fee and cannot provide prescription drugs, hospitalization, major surgery, dialysis, high-level radiology, rehabilitation or procedures requiring general anesthesia. They must charge fees on a monthly basis, cannot change rates more than once a year and must provide a 60-day notice of rate changes to their members. Finally, they must enroll all of those who apply (assuming they have room in their practice) regardless of age or health status.

Conclusion

With the initial statistics showing the benefits of medical homes, these programs are poised to mushroom, whether through standalone models or under existing fee-for-service insurance programs. Knowledge is power and, in the case of medical homes, knowledge is power over better health. It remains to be seen how HHS will write final regulations for medical homes under PPACA, but the agency may use the Washington law as a starting point for allowing more avenues for medical homes for those entering the exchanges.

Getting providers to coordinate care and patients to take control of their conditions—with a payment structure that encourages this type of health care—could help the United States become healthier, both medically and fiscally.

Endnotes

2. Information about Qliance is available at www.qliance.com.
5. More information about direct primary care medical homes is available from the Direct Primary Care Coalition at www.dpcare.org.
7. The Affordable Care Act establishes a private health insurance market through the creation of state-based affordable insurance exchanges, which launch in 2014.