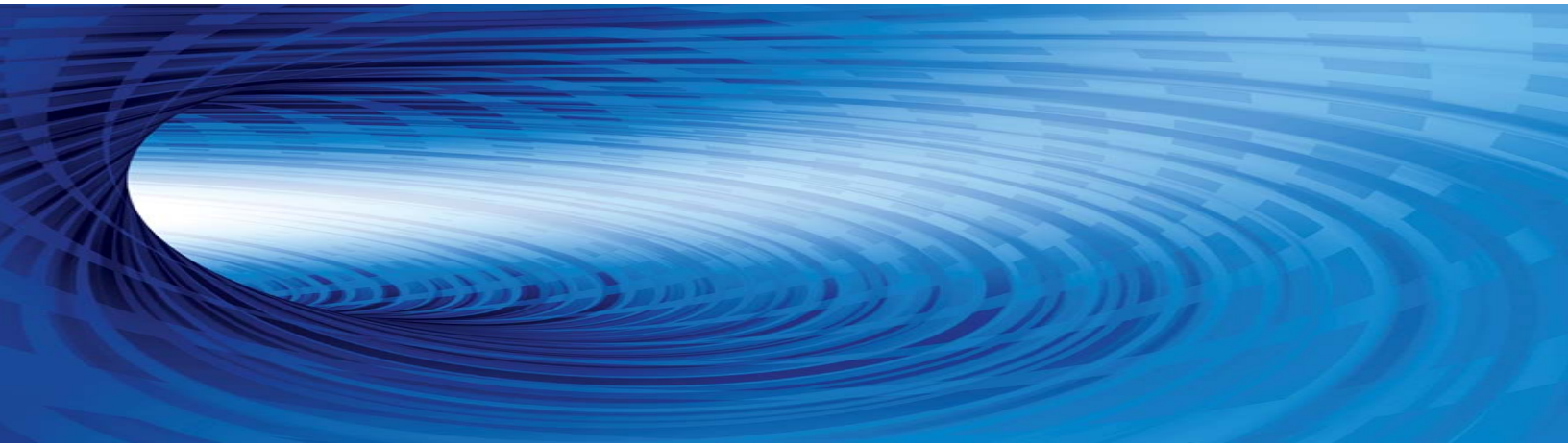
Patient Centered Medical Home:
An Approach for the Health Plan

By Marissa A. Harper and JoAnn E. Balara



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The Medical Home Concept Works

Recent Medicare demonstration projects on Patient Centered Medical Home (PCMH) illustrate a savings of $20-40 million for the Medicare Trust Fund, confirming that this model does have the potential to decrease overall health care costs [1]. For the first time, health care administrators are able to demonstrate positive results with the implementation of a Medical Home model. The PCMH model is based on data that suggests people tend to utilize health care in predictable ways. While some people use it too much, often times, others don't utilize it at all - until it's too late and they end up in the hospital – costing the healthcare system billions of dollars each year. This inappropriate method of care consumption contributes to increasing health care costs, unnecessary hospital admissions, duplicate procedures and a decrease in quality care. Whatever the level of use may be, one thing is certain, the solution may very well depend on care coordination, access to care, risk stratification, provider partnerships and the use of unique reimbursement strategies – all elements of the PCMH.

The Medical Home Model represents a paradigm shift, where the health plan's essential role is to improve access to care and assist with coordination of that care by ensuring members are placed in a medical home with a primary care physician (PCP). One study done by the *Annals of Family Medicine* showed that implementing medical homes would likely decrease health care costs by 5.6% resulting in a savings of $67 billion dollars each year[2]. These cost savings rely on preventive medicine and provide a means for physicians to be the true coordinators of the member's care. The provider's focus shifts from the episodic treatment of the disease to the holistic care of the member, enabling a proactive rather than reactive approach to medicine. This proactive approach includes the collecting and exchanging of electronic member information.

"The basic premise of the medical home concept is continuous, uninterrupted care that is managed and coordinated by a personal provider with the right tools that will lead to better outcomes." [3]
... Patient-Centered Primary Care Collaborative

Information technology (IT) is the engine of making the PCMH approach successful. In order to realize the full potential impact that PCMH can have in our health care system, the medical team needs to be able to collect, store, mine, and exchange member-specific electronic health data – none of the proactive approaches to care below are possible without IT.

Reactive Approach to Care	Proactive Approach to Care
Member only calls the doctor when ill.	Member sees their PCP/specialist regularly.
Member is admitted to the hospital because of lack of preventive office visits and due to having little knowledge of his or her disease process. Multiple inpatient events occur in one year for chronic conditions.	Member has few or no hospital admissions.
Member is not engaged in their care.	Member seeks and is supported in ways to become more involved in their care.
Low member satisfaction with care.	High satisfaction with care because the member is educated and knows how to manage their condition(s).
Member takes a passive approach to their health.	Member takes an active role in their own health.

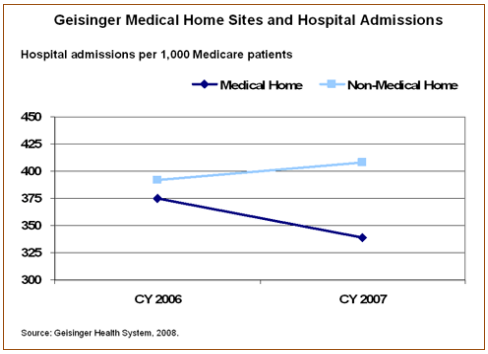
To help understand the PCMH model better, this paper addresses two key components of the health plan approach to the patient centered medical home: (1) Reasons for adoption of a PCMH Model (2) High-level considerations for implementation of a PCMH Model.

Reasons for adoption of a PCMH model

While there are a range of approaches to establishing PCMH, the health plan is at the center of making a Medical Home program work. Payers are a major component of the process, driving changes in reimbursement as they move away from a Fee for Service (FFS) episodic model and into one that offers risk adjusted reimbursement. Health plans also have access to a large amount of data, giving them the ability to provide all health care constituents access to data across multiple platforms – from care coordination to closure in care gaps.

Access to care is a critical component of managed care. Ensuring the member has access to their provider through open scheduling, extended hours, and new options such as e-visits and communication via email can greatly decrease utilization costs at the health plan. It is also critical to develop innovative and integrated delivery systems to improve the quality of health care. When a relationship is established between the provider, payer, and member, the chance that the member will turn to their physician for their medical needs first versus going directly to the emergency room is more likely; thus improving health plan performance.

Health plans are sponsoring pilots and driving the strategies to create an integrated PCMH model. Geisinger Health System in Pennsylvania reduced hospital admissions by 20 percent and saved 7 percent in total medical costs by providing a PCMH model of care that included around the clock access to primary and specialty care along with physician and patient access to electronic health records (EHRs).[4]



The PCMH model is gaining momentum on a national level, with many health plans looking for ways to improve their results by leveraging technology, partnering with providers, improving quality of care and delivering more cost effective care… all of this in the wake of healthcare reform.

The PCMH implementation means round-the-clock access to primary and specialty care, enhanced through the use of nurse care coordinators, care management support and home-based monitoring… Geisinger provides practice-based monthly payments per physician and stipends per 1000 Medicare members to help finance additional staff. [4]

Understanding Solutions to Implementing PCMH

Without question, healthcare reform is going to fundamentally change how health plans approach care management and interoperability. It is going to force the health plan to engage members like never before. Solutions need to be well planned and executed.

First, health plans need to understand what the right strategy is for their population. Many different PCMH models exist for both commercial and government payers – the approach and strategy may be different for government payers because of high risk populations. Health plans need to develop a picture of their abilities with regard to the necessary characteristics of a PCMH. If the overall goal for the health plan is to have a physician who is connected to their member, tools should be in place such as Patient Registries, Provider Portals and Care Management (CM) systems. CM systems especially need to have the ability to collaborate with the provider and member, provide strong, reliable reporting, and have the ability to identify and act on clinical alerts.

Second, the health plan needs to determine its own role in bringing care management closer to the member via the PCP. Plans may do this by facilitating information exchange, providing risk stratification and analytics, and by engaging the member. Some member engagement tools include Health Risk Assessments (HRAs), disease and case management, consumer decision support tools and member education.

Desired outcomes of a Health Plan PCMH initiative:

- **Improvement in quality of care**
- **Improvement in member and physician satisfaction**
- **More cost effective care**
- **A maintainable reimbursement model**

Essential Activities for Health Plan PCMH Development

PCMH Activity	Example/Description
Information exchange and patient registries	Inpatient discharge lists, ER utilization, provider portals
Access to care	Goal setting for ER and inpatient post-discharge follow up by providers, open access scheduling, same day appointments, secure e-visits, phone visits
Population risk stratification and analytics	Care opportunities, gaps in care, identification of chronic conditions
Partnership with providers	Identify large groups via stratification and utilization reporting
Provide selected practices with technology support	Provider practice EMR assistance, NCQA certification activities
Member engagement	Personal health records, HRAs, consumer decision support tools, secure e-visits, member educational materials
Payment schemes and incentives for providers	Pay for performance (P4P), care coordination payments, risk adjusted fee for service

Finally, plans need to adopt a technology infrastructure which can support the essential activities for the health plan PCMH model. The health plan claims system needs to have the ability to support alternative reimbursement structures for the various risk adjusted payments. For example, a multi-stakeholder pilot in Colorado chose to adopt a three-tiered payment structure which included FFS, care management fees, and a P4P methodology.[5] In addition to this tiered payment structure, additional incentives are provided by the payers for achieving higher levels of PCMH NCQA certification. This capability often includes upgrades in technology infrastructure.

Conclusion

Health plans have a choice when it comes to improving member outcomes. Most models typically focus on the provider-patient relationship. While creating that relationship is extremely important, the model proposed in this paper encompasses the member-provider-payer relationship and puts the health plan at the forefront of driving PCMH. The concept of integrating payers into PCMH can be the foundation for modifying the nation's healthcare system. Research shows that the PCMH model can be successful both financially and in terms of quality of care. In studies done by the Patient-Centered Primary Care Collaborative (PCPCC), which included 10 PCMH projects in nearly every part of the country, the projects created better coordination and more effective upstream care, leading to fewer hospitalizations and emergency room visits with a corresponding reduction in costs.[6] These cost reduction activities have been experienced first-hand by HTMS clinical consultants who have led PCMH initiatives and include reductions in ER cost and utilization at a health plan. This was primarily achieved by implementing a data exchange process between a large hospital system, the health plan, and the PCP. The health plan drove the data exchange which resulted in real-time registries of members who went to the ER (the previous day), including data such as the member's ER diagnosis and their PCP. The health plan was then able to communicate the registry "real time" to the PCP as well as facilitate post ER discharge follow-up appointments and member engagement.

Many health plans have also turned to technology to assist them with implementing PCMH models – from risk stratification, to developing patient registries and care opportunities, to creating provider incentive models. Models have shown that developing and implementing a PCMH model can provide successful outcomes. Robert VanWhy, M.D., senior vice president for primary care at HealthPartners Medical Group, a Minneapolis-based not-for-profit integrated health care system (including a health plan, medical group, and a hospital), attributes the success of the system to a combination of factors, including standardized workflows, the integration of health IT and a culture that emphasizes continuous quality improvement.[6] By integrating a technology infrastructure with PCMH, health plans can achieve a decrease in overall medical costs while improving the

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HTMS clinical consultants can enhance the provider-member-payer relationship by helping your team design and implement a PCMH model that:

- Drives cost reduction activities in Utilization Management (ER and inpatient utilization)
- Improves member outcomes and member access to care
- Engages technology to improve care coordination
- Uses risk stratification to supply providers with gaps in care and outcomes metrics
- Partners with providers and aligns providers with transformational practices
- Applies unique reimbursement strategies like Pay for Performance, Care Coordination payments, risk adjusted Fee for Service and other Physician Incentive Programs
- Creates a solid foundation for HIE initiatives

HTMS clinical consultants assist health plans to meet the challenges of the new consumer-centric environment, control healthcare costs, and improve the quality of care. Our engagements result in alignment of business priorities, greater operational efficiency, lower cost of healthcare, improved consumer engagement, and improved compliance.

overall delivery of healthcare services. The push to moving towards a PCMH model can represent great things for the health plan and is a means to really engage consumers in their care.

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Marissa Harper, RN, BSN, CMCN, has more than 12 years practical experience in hospital, physician office, and managed care environments. She is an experienced Project Manager with expertise in clinical system implementations, data analysis, clinical compliance, and provider profiling. Ms. Harper has successfully designed and implemented PCMH activities at the health plan level and is highly experienced in CMS guidelines, Milliman Care Guidelines, current managed care trends, and quality improvement initiatives. Marissa is a licensed Registered Nurse (RN) and holds a certification in Managed Care Nursing (CMCN).

JoAnn Balara, RN, BSN, CPEHR, is the Director of the Care Management Practice with HTMS. She has over 25 years of experience in the health care industry focused in the development of market driven care management strategies and the creation of care management software products. Ms. Balara assists health plans to meet the challenges of the new consumer centric environment, control healthcare costs, and to improve the quality of care. JoAnn is a Licensed Registered Nurse (RN) and she has served as a Board Member for the Case Management Society of America (CMSA). She holds certification in Pragmatic Marketing and Professional Electronic Health Records (CPEHR).

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317.381.0941
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