

# Disease Management and the Medical Home Model

## Competing or Complementary?

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### Abstract

For the past decade, US physicians have failed to embrace disease management (DM) approaches offered by private DM companies and health plans. Until recently, physicians have not offered an alternative, systematic approach to caring for patients with chronic illnesses and conditions.

The medical home model has become the centerpiece of reforms proposed by associations that represent family medicine physicians (the American Academy of Family Physicians [AAFP]) and general internal medicine physicians (the American College of Physicians [ACP]). In February 2007, the AAFP and the ACP were joined by the American Academy of Pediatrics and the American Osteopathic Association in issuing joint principles for the patient-centered medical home. While the medical home model is promoted primarily as a comprehensive approach to primary care reform, there is one aspect where the medical home and DM overlap: care coordination.

Medicare has been exploring alternative mechanisms to manage and reimburse chronic care and care-coordination activities. In 2003, the US Congress passed legislation to require pilot projects for chronic care improvement programs; the program implementing this legislation is Medicare Health Support (MHS). To date, very little information has been available about the progress of MHS projects. The three early announcements about MHS progress have not been encouraging: the expected financial results are not being achieved.

In December 2006, Congress passed legislation authorizing the Medicare Medical Home Demonstration (MMHD) project. MHS and MMHD are directed at similar patient populations: high-cost, frail, elderly patients with multiple co-morbid conditions. The medical home concept being advanced by primary care physicians has the potential to be competitive with DM companies. Health plans that have built their own DM programs are more likely to be supportive of the medical home model. Do physicians have the *ability* to compete at providing care-coordination services? There are strong arguments suggesting 'no' and strong arguments suggesting 'yes'.

While the medical home model is focused on primary care reform, its effect could be competitive to DM companies and others. The medical home model could affect the flow of hundreds of billions of dollars – money that over time might flow either to physicians or to private companies.

For the past decade, US physicians have failed to embrace disease management (DM) efforts of private DM companies and health plans.<sup>[1-4]</sup> However, until recently, physicians have not offered an alternative, systematic approach to caring for patients with chronic illnesses and conditions. All of this changes with the introduction of the medical home model.

This article poses and discusses important questions relating to the medical home model and DM:

- How have physicians viewed DM?

- What is the medical home model?
- How does the medical home model relate to DM?
- What alternatives is Medicare exploring for chronic care and care coordination?
- What is the Medicare Medical Home Demonstration (MMHD) project?
- Will the medical home model be competitive with DM?
- Can physicians compete effectively?

## 1. How Have Physicians Viewed Disease Management (DM)?

The Disease Management Association of America (DMAA) has provided a detailed definition of DM; the introduction to that definition notes that DM “is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant.”<sup>[5]</sup>

DM in the US has been performed primarily by DM companies and health plans. The Disease Management Purchasing Consortium estimated that the size of the DM outsourcing market was approximately \$US1.5 billion in 2006 (Lewis A, personal communication). Christobel Selecky, a former President of the DMAA, shared a DMAA projection of a potential \$US30 billion-a-year market.<sup>[6]</sup>

Physician objections to DM include the lack of financial incentives, the lack of technology that facilitates DM-physician communications, and the need for a practice-based champion that physicians trust.<sup>[1]</sup> The DM model has also been criticized as bypassing physicians.<sup>[2]</sup>

## 2. What is the Medical Home Model?

Primary care physicians experience challenges and frustrations in their profession. The American College of Physicians (ACP) has described a wide range of problems in the US healthcare system:

- Healthcare costs are growing faster than the economy.
- There are significant gaps in the quality of healthcare that patients in the US receive. Healthcare outcomes in the US contrast poorly with those of other industrial countries, despite the highest level of spending.
- Patients are reporting dissatisfaction with the care they receive.
- Primary care physicians are dissatisfied with the practice of medicine as a result of the financial, administrative, and increasingly technical demands under the current care system.
- The current healthcare payment and delivery system is particularly poor at providing care for the chronically ill.<sup>[7]</sup>

The medical home model has become the centerpiece of reforms proposed by associations that represent family medicine (the American Academy of Family Physicians [AAFP], which represents 94 000 family medicine physicians) and general internal medicine physicians (the ACP, which represents 120 000 internists). The AAFP and the ACP initially developed distinct models of the medical home.<sup>[8,9]</sup> However, in February 2007, the AAFP and the ACP were joined by the American Academy of Pediatrics and the American Osteopathic Association (representing a collective 330 000 physicians), in issuing joint principles of the patient-centered medical home (PC-MH).<sup>[10]</sup> These principles de-

scribed the characteristics of a practice-based care model for providing comprehensive primary care in a healthcare setting. Under these principles, each patient will have an ongoing relationship with a personal physician who will:

- provide first contact, continuous, and comprehensive care (‘Personal Physician’);
- lead a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients (‘Physician-Directed Medical Practice’);
- take responsibility for providing for all of the patient’s healthcare needs or arrange for that care with other qualified professionals (including acute, chronic, preventive, and end-of-life care) [‘Whole-Person Orientation’].

Care will be coordinated and/or integrated across all elements of the healthcare system and the patient’s community, and will ensure that patients get the indicated care when and where they need and want it, and that it is culturally and linguistically appropriate.

The Joint Principles also spell out a proposed payment framework for the PC-MH. This framework reflects the value of work that falls outside a face-to-face visit, including care coordination and the adoption and use of health information technology. It also recognizes the value of work associated with remote monitoring of clinical data using technology, and adjusts for case-mix differences in the patient population being treated within the practice.

## 3. How Does the Medical Home Model Relate to DM?

The medical home model is a comprehensive approach to primary care reform. However, there is one aspect where the medical home model and DM overlap: care coordination. The ACP version of the advanced medical home specifically discusses the term ‘care coordination’:

“The literature has correctly indicated that the term ‘care coordination,’ which is often used interchangeably with the term ‘care management,’ refers to a variety of activities. These include managing the transition of care across settings, the use of patient registries to allow for population-based care protocols, the use of frequent follow-up with patients to promote treatment plan compliance and to obtain healthcare data, the use of clinical practice guidelines, including feedback to the physician regarding their degree of compliance with the guidelines, and the teaching of disease self-management skills to patients... *These care coordination activities are at the core of what defines a primary care physician*” [emphasis added].<sup>[9]</sup>

The ACP discussion of care coordination is remarkably similar to the DMAA’s introduction to the definition of DM (see section

1). The ACP discussion of care coordination describes the type of activities that DM companies and health plans have been performing for the past decade. In turn, the medical home model not only advocates that physicians should be responsible for care-coordination activities but that they should also be paid for these activities.<sup>[10]</sup>

#### 4. What Alternatives is Medicare Exploring for Chronic Care and Care Coordination?

In the US, Medicare is a federal government program that pays for the vast majority of medical expenses for patients aged >65 years; Medicare is the single largest and most influential payer in the US. Medicare has been exploring alternative mechanisms to manage and reimburse chronic care and care-coordination activities. Congress passed Section 721 of the Medicare Modernization Act of 2003 to require pilot projects for the “development, testing, evaluation, and implementation of chronic care improvement programs.”<sup>[11]</sup> This legislation *mandates* expansion if the programs prove successful: “if the Secretary finds that the results of the independent evaluation ... have been met by a program (or components of such program), the Secretary shall enter into agreements ... to expand the implementation of the program (or components) to additional geographic areas ... which may include the implementation of the program on a national basis”.<sup>[11]</sup>

The program implementing this legislation has been named Medicare Health Support (MHS). MHS pilots are structured to run for 4 years, with one exception that allows a quicker rollout if success is demonstrated after only 2 years. Implementation of MHS has occurred methodically. The Centers for Medicare and Medicaid Services issued a formal request for proposals in April 2004. While a diverse range of participants were encouraged to apply for MHS projects, the project awards announced in December 2004 were heavily dominated by DM companies and health plans. Eight MHS projects began program operations between August 2005 and January 2006.<sup>[12]</sup>

Two aspects of MHS are worth noting. First, MHS patients are challenging: they are high-cost, frail, elderly patients typically with multiple co-morbid conditions; prior to MHS, DM companies and most health plans had very limited experience with this population. Second, the contract terms of MHS are challenging. As measured against a control group, MHS awardees are required to guarantee a 5% savings of total medical costs to Medicare; the penalty for not achieving savings results in having to pay back up to 100% of the program fees advanced by Medicare.

Early announcements about MHS progress were not encouraging: programs were having difficulties in achieving financial goals. In October 2006, LifeMasters Supported SelfCare, Inc.,

announced its withdrawal from the Oklahoma MHS project.<sup>[13]</sup> Healthways, Inc., acknowledged that it did not achieve projected MHS results.<sup>[14,15]</sup> McKesson Corporation announced that its MHS program in Mississippi would end as of 31 May 2007.<sup>[16]</sup>

The first official findings of MHS program progress were released in a report delivered to CMS in June 2007.<sup>[17]</sup> While based on only 6 months of data, the findings continue to raise doubts about the potential for MHS programs to achieve financial success: “... fees paid to date far exceed any savings produced. The negotiated MHSO [Medicare Health Support Organization] monthly fees are a much higher percentage of the comparison groups’ PMPMs [Per Beneficiary Per Month] than the percentage savings on payments through the first 6-month pilot period. Fees negotiated by the MHSOs with CMS have not been covered by reductions in Medicare expenditures, let alone an additional 5% savings in Medicare payments. Without a substantial reduction in each MHSO’s monthly fee, budget neutrality after the first year is questionable.”

While MHS has received worldwide attention, it is just one of a range of pilot and demonstration programs being conducted by Medicare; Medicare’s web site describes projects in various stages of completion.<sup>[18]</sup> Many of these projects have aspects that deal with chronic and/or high-cost patients; for example, the Care Management for High Cost Beneficiaries, Special Needs Plans, and Physician Group Practice demonstrations. It is unclear how Medicare will ultimately decide to structure programs and funding for chronic care and care coordination. Early results from the MHS projects only cloud the issue further.

#### 5. What is the Medicare Medical Home Demonstration?

On 9 December 2006, the US Congress passed legislation authorizing demonstration projects to evaluate the medical home model.<sup>[19]</sup> Figure 1 presents a synopsis of the MMHD legislation.

How does MMHD compare with MHS? First, the patient populations are similar: high-cost, frail, elderly patients with multiple co-morbid conditions. Second, the contracting and financial requirements of MMHD are much less stringent. MMHD awardees are not required to guarantee 5% savings; in fact, participants will be allowed to keep 80% of documented savings, most of which is likely to occur from reduced hospitalizations and emergency room visits.

#### 6. Will the Medical Home Model Be Competitive with DM?

The word ‘competition’ is not often used in a physician’s vocabulary. Doctors relate much more to a culture rooted in

### Medicare Medical Home Demonstration Tax Relief and Health Care Act 2006; Sec. 204

The Secretary of Health and Human Services will establish a medical home demonstration project to redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high-need populations.

- Care management fees will be paid to personal physicians, and
- Incentive payments will be paid to physicians participating in practices that provide services as a medical home.

'High-need population' means individuals with multiple chronic illnesses that require regular medical monitoring, advising, or treatment.

The project will operate for a period of three years and will include urban, rural, and underserved areas in a total of no more than 8 States.

A personal physician will perform or provide for the performance of at least the following services:

- Advocates for and provides ongoing support, oversight, and guidance to implement a plan of care developed in partnership with patients, other physicians furnishing care to the patient, and other appropriate medical personnel or agencies
- Uses evidence-based medicine and clinical decision support tools to guide decision-making at the point-of-care based on patient-specific factors.
- Uses health information technology, which may include remote monitoring and patient registries, to monitor and track the health status of patients and to provide patients with enhanced and convenient access to health care services.
- Encourages patients to engage in the management of their own health through education and support systems.

A 'medical home means a physician practice that:

- is in charge of targeting beneficiaries for participation in the project; and
- is responsible for:
  - providing safe and secure technology to promote patient access to personal health information;
  - developing a health assessment tool for the individuals targeted; and
  - providing training programs for personnel involved in the coordination of care.

The project will provide for payment of a care management fee to personal physicians.

80 percent of the reductions in expenditures resulting from participation of individuals that are attributable to the medical home (as reduced by the total care management fees paid to the medical home under the project) will be paid to the medical home. The amount of such reductions in expenditures will be determined by using assumptions with respect to reductions in the occurrence of health complications, hospitalization rates, medical errors, and adverse drug reactions.

**Fig. 1.** Summary: Medicare Medical Home Demonstration Project.<sup>[20]</sup>

service and professionalism rather than business competition. Physicians also read the reports that predict that DM has the potential to grow to become a \$US30 billion-a-year market. They are understandably asking "Is some of that coming out of our pockets? How do we get our share and retain the bread and butter activities that define the physician of the future?"

The medical home concept being advanced by primary care physicians has the potential to be competitive with DM companies. Ironically, this occurs at a time when most DM companies are working hard to improve relationships and communications with doctors.<sup>[21]</sup> The recent MHS pilot projects underscore the urgency felt by DM companies to integrate with doctors. These projects focus on frail, elderly patients who are particularly dependent on their relationship with their primary care physician. The medical home model puts DM companies in an awkward position. On the one hand, DM companies have been working hard to improve their relationships and workflow integration with physicians, on the other hand, the medical home model could put doctors into direct competition with DM companies.

While competition is a possibility, it is also possible to envision a range of collaborative scenarios. DM companies holding con-

tracts could subcontract with physicians for their services; physicians who have signed up medical home patients could subcontract with DM companies for services, IT support, and other infrastructure. It is possible that varying collaborative models could emerge in different geographical regions, different delivery systems, and/or different financing systems.

How will health plans view the medical home model? This issue will be more complicated for health plans to evaluate as the medical home model proposes a broad restructuring of care delivery and financing – certainly beyond just the issue of care coordination. However, as the medical home model relates specifically to DM and care coordination activities, health plans that have built their own DM programs are likely to be supportive of the medical home model. These health plans will view DM as a cost center, unlike DM companies, which view their services as a profit center. Most health plans are likely to be receptive to physicians increasing their involvement with care coordination. Finally, many health plans are working on other fronts to improve their relationships and workflow with physicians; the opportunity to support physician care coordination efforts will likely be seen as a means toward better overall relationships with physicians.

## 7. Can Physicians Compete Effectively?

Do physicians have the *ability* to compete at providing care coordination services? There are strong arguments suggesting ‘no’ and strong arguments suggesting ‘yes’. It is important to examine various perspectives.

From the perspective of the arguments leaning towards ‘no,’ what is the rationale suggesting that physicians *cannot* be effective competitors at providing care coordination and chronic DM?

- Individual physicians cannot be cost effective at care coordination. The use of expensive physician time is not economical; a mix of nurses, other professionals, lay persons, and technology will be much more cost effective.
- Physicians lack training and experience at care coordination. DM companies and health plans have spent the past decade developing their care-coordination capabilities.
- The medical home model does not have a mechanism to provide financial guarantees for purchasers. Many DM purchasers require guaranteed financial savings; these guarantees are typically backed by reinsurance and/or a very strong balance sheet. For example, as discussed in section 4, the current MHS projects require contractors to guarantee 5% savings. Guaranteed savings for purchasers is not an integral part of the medical home model.
- Physicians lack capital. They will not be able to scale their operations.
- Physicians lack management expertise. Physicians are trained in medicine, not management or business. Most physicians work in small groups or alone. They do not have the ability or interest to take on the broader care-coordination functions required by the medical home model.

For the arguments leaning towards ‘yes’, there is also a strong rationale suggesting that primary care physicians *can* be effective competitors at providing care coordination and chronic DM:

- The medical home is a better clinical model. The medical home approach incorporates the Chronic Care Model.<sup>[22]</sup> It provides for more comprehensive delivery of primary care, better integration of local care providers, and strengthens the doctor-patient relationship; DM companies and health plans have been viewed as operating parallel to the doctor-patient relationship or as getting in between doctors and their patients. Initiatives to develop and validate the Chronic Care Model have been supported by the Robert Wood Johnson Foundation,<sup>[23]</sup> the Institute for Healthcare Improvement,<sup>[24]</sup> and the RAND Corporation.<sup>[25]</sup>
- Technology levels the playing field. Physicians can provide DM services efficiently. They can subcontract with DM companies or other specialized vendors to gain access to appropri-

ate call center services, health coaching, and other technologically supported interventions. Doctors can compete in a “flat world”.<sup>[26]</sup>

- Physicians can leverage their grass roots connections. Primary care physicians live everywhere in the US; physicians are often influential citizens in their local communities and will have broad access to all members of Congress. Working with their national organizations, they will be able to influence passage of legislation favorable to the medical home model.
- Doctors have trusting, personal relationships with patients. How might you expect the doctor and the patient to respond at the *moment of truth* in the privacy of the exam room when the patient asks “Doctor, should I sign up for this DM program being offered by ABC Company or should I sign up for your ‘medical home’ program?” Physicians could have a powerful influence over patient decisions.

Overall, there are strong points on both sides – arguments suggesting that doctors *can* be effective competitors and arguments suggesting that they *cannot* be effective competitors. This promises for an interesting future as the medical home model unfolds.

## 8. Discussion and Conclusions

There is much at stake. While the medical home model is focused on primary care reform, the effect of the medical home model could be competitive to DM companies and others. The medical home could affect the flow of hundreds of billions of dollars – money that over time might flow either to physicians or to private companies.

Many aspects of the medical home model are still unclear and will take time to evolve. Some issues and questions remain:

- Do the national physician organizations speak for individual member physicians in advocating the medical home?
- Can physicians gain and sustain political support for the medical home model?
- Beyond Medicare, can physicians get other payers interested in the medical home model?
- Can physicians develop evidence to support the clinical and cost effectiveness of the medical home model?
- How will the MMHD be evaluated against MHS and other Medicare pilot and demonstration projects?

These and other issues relating to the medical home model are worth considering and monitoring over time.

Will the medical home model be competing or complementary to disease management? While the potential for competition is evident, there is also great potential for collaboration. It is too soon

to tell and it is definitely worth watching the unfolding of developments.

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