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October 22, 2010

## Washington Gov Asks HHS To Embrace Flat-Fee Primary Care Practices In Exchanges

Washington Governor Christine Gregoire (D) is urging HHS to “pay special attention” to a provision in the health reform law that allows direct pay primary care medical home practices to participate in the health insurance exchanges. The provision — championed by members of the state’s congressional delegation — was “designed to encourage the growth of a promising new health care delivery system that is proving beneficial not only to the state of Washington, but also throughout the country,” she told HHS Secretary Kathleen Sebelius in a recent letter urging her to embrace the model when she writes reform regulations.

Under the health reform law, such practices would be allowed to be one of several options under the new exchanges, as long the patient is offered wrap-around insurance coverage that meets the essential benefits package. Direct pay primary care medical homes are facilities that charge a flat monthly fee, typically for unlimited access to primary care services.

In a Sept. 13 letter to Sebelius, Gregoire points out that Washington has been an “incubator” for development of direct pay primary care medical homes and has passed several laws that enabled the model to flourish. “Our state law ensures that the services provided by these medical homes run the gamut from routine primary care and preventive care to urgent care and from chronic disease management to wellness education and specialist/hospital care coordination,” she writes. “There are no pre-existing condition exclusions, no disagreements over covered treatments or insurance forms to be filled out, and no deductibles or co-pays. Instead a single low monthly fee covers all costs.”

The provision in the reform law is strongly supported by Qliance, a primary care medical home practice that has several facilities in Washington and is considering an expansion into other regions. Qliance President and CEO Norman Wu says the company is also already in discussions with insurers on creating wrap-around options.

In addition, the company has been partnering with employers due to a new state law that allows employers to contribute to the flat fee for their employees. So far 80 employers have signed on and more have expressed interest. New York State is also considering a similar law, Wu says.

In terms of improving care, Wu says that the direct pay model has already proven successful. The company recently conducted a “downstream” study and came up with results that even Qliance physician Erika Bliss found surprising.

Bliss, who is also Qliance’s vice president of medical care & quality, listed the results in a interview with *Inside Health Policy* late last month. According to the results — which Gregoire also mentions in her letter to HHS - Qliance patients visited emergency rooms 62 percent fewer times than the benchmark per 1000 patients (60 visits compared to the 158 visit benchmark).

In addition, hospitalization days were reduced by 26 percent, specialist referrals by 55 percent, advanced radiology by 48 percent, surgeries by 73 percent and surgery days by 51 percent.

The hope is that the savings achieved by the model can help promote the bundling of their services with insurance policies that would be competitively priced within the exchanges, Wu says.

**Wu says primary care models like Qliance can also impact which hospital a patient chooses to receive referred services,** which can also help save the system money.

In Seattle, the price for certain procedures can be twice as much at some hospitals than others and in Massachusetts it could be put to a 3 to 1 difference, he says.

All insurers know this, but they are often wary about directing patients to one facility or specialist over another due to worries that the patient may think that the insurer is simply trying to save money, Wu says.

But, he continues, because Qliance is a medical home and has nothing to gain or lose — since it’s totally independent and not affiliated with other facilities — the doctors are willing and able to discuss pricing information with patients. Most plans require a 20 percent co-insurance so less money the hospital charges, the less a patients has to cover as well. Today, with the frenetic pace of primary care doctors don’t have time to review patients information and help them navigate the system. “We have the time,” he says. Doctors would never suggest that patients go to a lower quality hospital, but if the care is comparable the physicians would inform the patients of the option.

Wu is obviously hopeful that HHS regulation on the exchanges will be written in a way that allows practices like Qliance — which currently exist in 21 states and serves about 50,000 patients — to grow.

Gregoire is also hopeful CMS will embrace the approach. “If implemented correctly,” she writes, “this provision will be able to provide the same health care improvements being witnessed in Washington.”

She also states that in addition to providing improved care and potentially saving money, the model may help boost recruitment of primary care physicians. Primary care doctors are advocates of the model because it offers more personalized patient panels, lower overhead and predictable monthly fees, she says. — *Amy Lotven*