Strengthening Primary Care for Patients:

Capital District Physicians' Health Plan, Inc. | Albany, N.Y.

Background

Capital District Physicians' Health Plan, Inc. (CDPHP®) has over 400,000 members who reside in 24 counties throughout New York state. The goal of its Enhanced Primary Care (EPC) initiative is to build interest in the field of primary care by increasing physician compensation and implementing a new care delivery model. The EPC program combines practice transformation with payment reform to effect real change in the delivery of primary care in a sustainable way.

Initiative Title: Enhanced Primary Care
Start Date: 2008
Practices: 160
Physicians: 723
Covered Lives: 181,012

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Implementation

The EPC initiative was developed in partnership with practices and patients; the plan contracted with an outside vendor who worked with the health plan's strategic coordinators to conduct practice site visits and hold collaborative meetings, and involved patients and family members in practice focus groups and learning collaboratives throughout the EPC pilot.[1]

Supporting Practice Transformation

With its EPC model, CDPHP aims to provide comprehensive payment for comprehensive care. Its payment model, described in the Sustainability section, enables primary care physicians to increase their reimbursement by up to 40 percent. CDPHP understands, however, that in order for its payment model to be effective, and for practices to adjust to risk-adjusted capitation model instead of fee-for-service (FFS) reimbursement, providers must transform the way they deliver care.

The plan therefore supports practice transformation at the administrative and clinical levels. The goals of this transformation are to improve patients' access to care, improve health IT capabilities with a focus on evidence-based standards, improve care coordination between sites of care and improve patient, staff and physician experience.

The plan offers EPC sites a 12-month practice transformation process that includes consulting resources; adoption of health information technology with a specific focus on meeting Centers for Medicare & Medicaid Services meaningful use requirements; and connection to local Regional Health Information Organizations, such as the Massachusetts e-Health Collaborative and the Health Information Xchange of New York (HIXNY).

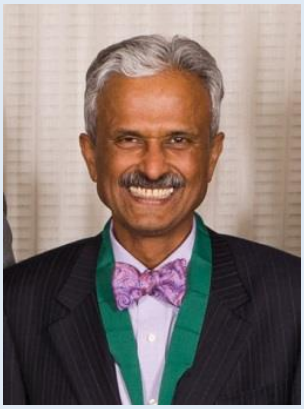
Clinical and Staff Support

Practices have the option of accepting health plan case managers, who are embedded within the practices and typically assist with care management two or more days per week.[2] CDPHP has placed these case managers in 14 of its 160 EPC practices with the most complex populations. The case managers work on care teams and partner with physicians to coordinate care for chronically ill and at-risk patients and help them understand how they can better self-manage their illness. All practices continue to have access to CDPHP's telephonic care managers.

Case managers ensure patients at high risk for hospitalization or with gaps in care receive the support they need with the help of predictive modeling reports and physician referrals. These tools allow CDPHP to identify members who are appropriate for outreach efforts. Case managers have access to the practices' electronic medical records (EMR) to validate referrals, update patient profiles, see patients after their appointment and schedule individual appointments.

Pharmacists are another critical part of the EPC team, as CDPHP is integrating pharmacy services into the care management of its high-risk, complex patients. Health plan pharmacists educate clinicians, share trending reports and help providers with adherence and generic utilization rates. One EPC practice has

Patient Story: Plan-Provider Collaboration



Kallanna Manjunath, M.D., at the CDPHP Physicians' Academy™ awards, 2012.

The chief medical officer of Whitney M. Young, Jr. Health Services in Albany, N.Y., can tell you that change is not easy. In fact, when Kallanna Manjunath, M.D., (left) embarked on a journey to change the way his practice did business, he was met with skepticism, doubt and even resistance. Two years later, the practice and its clinicians are seeing the fruits of their labor.

In 2010, Whitney Young began the process of practice transformation as part of CDPHP's Enhanced Primary Care model. Within one year, Dr. Manjunath began noticing tangible results.

"We were stunned by the progress being made in the area of diabetes management," says Manjunath. "Specifically, we were able to significantly decrease no-show rates and increase adherence to medical and diet management." Pre-visit planning and care coordination allowed the practice to decrease no-show rates among diabetes patients by nearly 60 percent.

But the rewards extend far beyond statistics. Dr. Manjunath, who has been practicing medicine for 30 years, says being a physician now has new meaning for him. "Yes, I'm working harder but I'm more satisfied and excited about the renewed opportunity to engage with my patients," he says. "As a provider of an underserved and uninsured community, I have a unique set of challenges, but I believe those challenges create a greater opportunity for change."

"The EPC program has really provided us with significant opportunities to implement long-lasting changes to improve access to quality health care for our patients," says Manjunath. "On a personal level, this is the most exciting and rewarding work I've done in my three decades as a physician."

even embedded a full-time pharmacist into its office. CDPHP also supports practices by providing access behavioral specialists; the plan hired four behavioral health specialists who work in a subset of EPC practices to discover which practices and patient populations would benefit most from behavioral health support.

The roles of clinic staff members have changed in EPC practices as well. Receptionists have taken a more active role in deciding when patients are seen, freeing up nurses' time. Nurses, in turn, are able to handle visits for patients with minor complaints and address patient education, both of which were formerly the responsibility of physicians.

Access to Data and Analytics

CDPHP provides its EPC practices with Medical Intelligence, a risk-adjusted predictive modeling tool that shares quality and utilization data. More specifically, it provides information on patients with gaps in care, potential emergency department or inpatient admissions and high-utilizing patients. The health plan also supplies practices with pharmacy drill-down data, which includes detailed information on prescribing patterns, cost comparisons and generic prescribing opportunities. In addition, CDPHP faxes daily patient discharge reports to the practices; these reports identify members who have been discharged in the previous 48 hours, along with the name of the discharge facility and their diagnoses.

> CDPHP provides its Enhanced Primary Care practices with quality and utilization data, including information on patients with gaps in care, prescribing patterns and daily discharge reports.

Sustainability

CDPHP ensures the sustainability of its EPC program through its payment model, a risk-adjusted capitation model that holds primary care physicians responsible for services they provide and includes opportunities for substantial performance-based bonuses. Providers can earn a bonus of up to $5.32 per member per month (PMPM) by meeting efficiency (total cost of care), quality (HEDIS®) and patient experience (CG-CAHPS®) measures. These bonuses drive transformation at each practice while ensuring high patient satisfaction.

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Practices are given the opportunity to participate in the payment model after their 12-month practice transformation period. Bonus payments are then given out yearly, with a lag due to collection of HEDIS® data. Once providers are eligible for participation in the payment model, CDPHP re-contracts with them to move them off of FFS.

Under the EPC payment model, primary care physicians are given a 23 percent increase in reimbursement for codes covered under the capitation arrangement for their practice's patients. Practices, however, continue to be paid under a FFS model for services that are outside the capitation code list. Combined with the 20 percent bonus payments, practices can earn up to 40 percent more under the EPC model than under the FFS model.

By reimbursing primary care physicians at a higher rate, CDPHP aims to make primary care more appealing to medical school students, thus encouraging more students to enter primary care.

Outcomes

Practices are measured on 18 HEDIS® quality measures, which are reported on annually. The health plan meets quarterly with each practice to discuss and define areas of opportunity based on HEDIS® reports. Practices are also measured on utilization, efficiency and episodic medical costs. CG-CAHPS® surveys are used to assess patient satisfaction, which is the basis of a plan-developed PCMH-specific patient satisfaction scoring methodology.

An independent analysis by Verisk, an external analytics corporation, found that over a two-year study period (2009-2010), practices in the EPC pilot saw a savings of $8 per member per month (PMPM) in total medical costs, a 15 percent reduction in hospital inpatient admissions, a 9 percent reduction in emergency department visits and a 7 percent decrease in the use of advanced imaging. During the same time period, the health plan also improved the quality of care for 15 out of 18 specific HEDIS® measures.

Scale

The EPC model has spread rapidly throughout its four phases between 2008 and 2012, from the initial pilot of three practices to its current 161 practices (see Table 1).

Pilot practices were initially given a $6,000 monthly stipend for the first eight months of the pilot from May to December 2008. In 2009 and 2010, physicians were additionally reimbursed $35,000 per year on top of their FFS income and had the opportunity to receive bonuses up to $50,000 based on outcomes data. A retrospective analysis revealed that during the pilot, physicians typically saw salary enhancements ranging from $10,000 to $30,000.

Year	Phase	New practices	New members	New clinicians
2008-2009	Pilot	3	12,032	30
2010	II	23	40,672	149
2011	III	50	45,542	230
2012	IV	85	82,766	314
TOTAL		**161**	**181,012**	**723**

Table 1: Spread of the Enhanced Primary Care Model

In Phases II, III and IV, practices received a $20,000 infrastructure grant in their first 12 months. This money came in two installments, with the first $10,000 being dependent upon meeting process metrics and the remaining $10,000 based upon continued participation with CDPHP and progress in the transformation.

CDPHP is encouraged by early returns on investment but realizes that the PCMH model is still being tested and modified in order to improve its sustainability. In 2011, the board of directors approved its newest payment model, a global payment and pay-for-performance hybrid. In January 2012, the EPC model moved off the pilot platform and is now available as a contract for eligible practices (those which have gone through transformation). CDPHP's goal is to include 80 percent of eligible primary care practices in this payment model by 2014.

[1] Feder, Lester. "A Health Plan Spurs Transformation of Primary Care Practices Into Better-Paid Medical Homes." *Health Affairs*. 30.3 (2011): 397-399.
[2] Grumbach, Kevin; Bodenheimer, Thomas; Grundy, Paul. "The Outcomes of Implementing Patient-Centered Medical Home Interventions." *PCPCC*. 2009.

A copy of the full ACHP report on strengthening primary care for patients, supplementary profiles on member plan initiatives, a one-page fact sheet and other resources are available online at www.achp.org or by emailing innovations@achp.org.

MAKING HEALTH CARE BETTER
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