A Health Plan Spurs Transformation Of Primary Care Practices Into Better-Paid Medical Homes

Health Affairs, 30, no.3 (2011):397-399


Cite this article as:

J. Lester Feder

The online version of this article, along with updated information and services, is available at:

http://content.healthaffairs.org/content/30/3/397.full.html

For Reprints, Links & Permissions:

http://healthaffairs.org/1340_reprints.php

E-mail Alerts : http://content.healthaffairs.org/subscriptions/etoc.dtl
To Subscribe: http://content.healthaffairs.org/subscriptions/online.shtml

Health Affairs is published monthly by Project HOPE at 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133. Copyright © 2011 by Project HOPE - The People-to-People Health Foundation. As provided by United States copyright law (Title 17, U.S. Code), no part of Health Affairs may be reproduced, displayed, or transmitted in any form or by any means, electronic or mechanical, including photocopying or by information storage or retrieval systems, without prior written permission from the Publisher. All rights reserved.
INNOVATION PROFILE

A Health Plan Spurs Transformation Of Primary Care Practices Into Better-Paid Medical Homes

SYSTEM Capital District Physicians’ Health Plan is a not-for-profit, network-model, physician-guided health plan with 350,000 members in 29 counties in upstate New York.

KEY INNOVATION By introducing a risk-adjusted capitated payment model, the health plan worked with three pilot provider practices to establish patient-centered medical homes.

COST SAVINGS In 2009 the rate of cost growth among pilot medical homes was 67 percent that of control practices in the Capital District Physicians’ Health Plan network.

QUALITY IMPROVEMENT RESULTS The practices demonstrated improvement on many Healthcare Effectiveness Data and Information Set metrics, with consistent improvement for all pilot practices on two measures: the use of antibiotics and performing diabetic eye exams.

CHALLENGES The health plan cites the stigma of capitated payment and says it must work with physicians to design a compensation structure that overcomes their suspicion of being paid on a capitated basis. It also worries about “change fatigue”—anticipating that as practice changes roll out, staff may push too hard too fast and become overwhelmed with the pace of change.

Capital District Physicians’ Health Plan wanted to pay primary care physicians more. In 2007 the organization’s board became concerned about the declining number of general practitioners graduating from Albany Medical College, the major medical school in the plan’s part of upstate New York. The local experience tracked a nationwide trend of most medical students’ opting to become specialists. One obvious factor contributing to this trend—one that a health plan could do something about—is that primary care physicians earn far less than specialists. So the health plan’s leadership team informally surveyed area doctors on how much more they would they need to earn in order to level the financial playing field. The team concluded that if the plan could increase primary care doctors’ annual incomes by $85,000, to around $250,000, more students would be attracted to enter primary care.

This was a noble objective, recounts the plan’s chief medical officer, Bruce Nash, but it had to be paid for: “I couldn’t go talk to employers in our marketplace and say, ‘Gosh, we have a great idea! We want to pay the primary care docs $85,000 more. Would you accept a 2 percent increase on your premium?’” The only viable way to increase physicians’ pay was to find savings in the system. “There had to be a mode of value creation—better
quality at lower cost,” Nash says, “for us to be able to fund that $85,000 and not only to make it sustainable, [but also] to make it scalable.”

In response, Capital District Physicians’ Health Plan launched a primary care pilot that would promote medical homes, increase primary care physicians’ income, and align incentives to improve quality. Each primary care practice in the project registered improvement in the number of diabetic eye exams and in the use of antibiotics.

Redesigning Compensation
Following a model proposed by Harvard’s Alan Goroll, the plan set about designing a capitated payment model that could overcome doctors’ aversion to such a system—and also address the concern that capitated payments could encourage doctors to “cherry-pick” healthier patients.

The result was a system of risk-adjusted capitation. Payments are set using what is called a Primary Care Activity Level score. “The measure uses historical diagnoses to predict the amount of primary care resources to manage that member for a year,” explains Lisa Sasko, the plan’s director of transformation. “A sicker member equates with more moneys coming in” to cover the cost of care. For example, a doctor may be compensated $18 per member per month for caring for a healthy twenty-five-year-old, but $44 for a twenty-five-year-old with diabetes.

The plan also eased physicians’ concerns by keeping in place “shadow” fee-for-service billing as it tried the new capitated approach. It also promised to keep doctors whole if their costs were higher than the Primary Care Activity Level score predicted. And it gave them an added incentive to reduce costs: If the practice billed less than what the model predicted, the health plan gave the difference to the practice. In the end, the scoring method proved to be accurate: The model predicted costs within 2.6 percent of what the practices actually billed.

For participating in the new payment system, the physicians received a stipend of $35,000 to encourage practice transformation and were eligible for up to $50,000 in bonuses. Their bonus amount was calculated through a two-part formula. The maximum that doctors could receive was based on their performance on HEDIS quality measures, but the percentage of that amount that they actually received was based on efficiency measures such as rates of hospitalization, emergency department visits, and imaging use.

The reason for this two-step calculation is to ensure that cost savings are being achieved by actually changing the way in which primary care practices deliver care. “We don’t pay out our bonus unless we see differences in the way they are delivering care,” says Sasko. “It’s not just pay-for-performance, so it’s sustainable.”

Even though just 40 percent of patients seen in these practices actually belong to the health plan, Capital District Physicians’ Health Plan did not base its contributions on the plan’s share of a practice’s patients. This is because plan officials feared undermining the movement for change on the scale they hoped to see; worried that it would take too long to convene all payers to agree on a common pilot approach; and assumed that it would be impossible for a practice to operate one way for the health plan’s patients and another way for everyone else. Thus, they
regard their approach as a “virtual all-payer” system, and the innovations it promotes touch all patients in a practice.

At the end of 2009, the experiment’s first year, the health plan found that each practice had made quality improvements in different areas, although only two measures—diabetic eye exams and the use of antibiotics—improved in all three practices. No doctor earned the full $50,000 in bonuses the first year, but the practices did see bonuses ranging from $10,000 to $30,000, reflecting improvements that the health plan welcomed in the first year of the trial. When the bonus was combined with the $35,000 practice transformation stipends, providers’ salaries were enhanced by $45,000–$65,000 in 2009.

In July 2010 the plan began preparing twenty-one more practices to transform to medical homes. These practices will probably move to the risk-adjusted capitated model in 2012.

Transforming Practices
To help doctors transform their practices into medical homes, the health plan brought in TransforMED, a nonprofit organization launched by the National Academy of Family Physicians (see People & Places, p. tk). TransforMED conducted site visits with the primary care practices, led collaborative meetings, and supplied coaches to work with clinic staff.

In addition to their expertise, TransforMED personnel also created a layer between the practices and the health plan that helped promote trust in reevaluating their internal workings. “As some of my physician friends remind me,” jokes Nash, “we’re just the health plan they hate the least. It’s really important to them that there was a firewall between them [and] opening their closet of skeletons in regard to the problems they might have with their practice.”

The shift to a medical home model requires retooling procedures and changing practice culture and mind-set, explains TransforMED’s president and chief executive officer, Terry McGeeney. “They had the pieces of the puzzle, but they needed to put them in a new order,” he says of the practices in the pilot. Staff members saw their job descriptions change: Receptionists have taken on a more active role in deciding when patients were seen—a responsibility that used to fall to a registered nurse. Nurses are now doing a lot more education or seeing patients with simple complaints, which used to be in the hands of a physician. The practices also have added an entirely new position, the care manager, to serve as an intermediary between patients and providers.

Rommel Tolentino, a physician in one of the pilot practices, says that his practice runs much more smoothly now and that he has much more time to work with patients. But the transition was not an entirely easy process. His practice, like many that TransferMED works with, experienced “change fatigue” several months into the process. “The very first year, we tried to tackle too many changes at the same time,” he says, explaining that they were working on establishing the new team model and reconfiguring the office simultaneously during the holiday season.

“The first hurdle [to this transformation] is getting people to want the change, and the next hurdle is to stop it when it’s going too fast.”

Today, Tolentino’s office is divided into three teams, each with two physicians, one midlevel provider, and two nurses. And instead of asking for support from whichever staff person happens to be on hand, there is an established support procedure: “Everybody has a definite role now.”

The result, Tolentino adds, is that his office is run more cost-effectively and provides higher-quality care—and his own professional satisfaction has improved. “Doctors by nature are all trained to be in control...[but] we’ve come to realize we can’t do our jobs alone,” he observes. “The reluctance to give up control is more than outweighed by getting the help from others to do my job.”

Improved satisfaction has been reported by several doctors in the pilot. One had stopped acting as a preceptor for medical students because she was so discouraged at the professional life of a primary care doctor, but she became a preceptor again after participating in the pilot. These innovations, says TransforMED’s McGeeney, were risky for a health plan, especially since the plan guaranteed that it would keep pilot providers financially whole. But Capital District Physicians’ aggressive approach has garnered national attention. “Even though they’re a relatively small health plan, they’ve really positioned themselves as a leader,” McGeeney says. Further results are anticipated as the pilots proceed and spread.