

Written Testimony for Committee on Energy and Commerce, U.S. House of Representatives

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Good morning. My name is Bruce Nash and I am the Chief Medical Officer of Capital District Physicians' Health Plan which is based in Albany, New York. CDPHP, as we are known, is a not-for-profit, physician-sponsored, network model health plan with close to 400,000 members who live in 24 counties in upstate New York. We are the Capital District's largest provider of managed Commercial, Medicare, and Medicaid products. I also serve as the chairman of the Medical Directors' Council for the Alliance of Community Health Plans (ACHP) – whose members include 22 of the nation's leading non-profit, regional health plans, who share our commitment to the Triple Aim –working to enhance our members' experience of health care while improving their health and keeping it affordable.

CDPHP was founded by the physicians of the Albany County Medical Society 28 years ago and to this day is governed by a Board whose majority are practicing physicians who are elected by their peers. Our Board chair is also required to be a practicing physician. As a consequence, we have enjoyed a close relationship with our provider community, enabling us to deploy market-leading initiatives that improve care delivery for our members, despite not directly employing any of the clinicians. This has led to us being recognized as a top-ranked health plan, in the state and the nation, for our member satisfaction and quality metrics.

Four years ago, our Board emerged from a strategic planning session with a directive for management to address the impending primary care crisis. It was noted that our local medical school was no longer graduating significant numbers of new physicians who were choosing primary care as a career. While the causes for this were multiple, we chose to focus on improving a primary care physicians' income potential. It was clear that for this to be accomplished it would have to be funded by changing the way physicians practice with more effective, efficient care as a result. This began the program that we later labeled our Enhanced Primary Care program or EPC.

Over the ensuing years, CDPHP invested over \$10 million assisting practices with transformation to this patient-centered medical home model of care, the acquisition of electronic medical records, and their achievement of meaningful use. CDPHP also deployed on a selective basis its nurse care managers, pharmacists, and behavioral workers directly in EPC practices.

We began with an initial pilot of three practices, and over a two-year period of time were able to demonstrate an improvement in 14 of 18 specific quality metrics; a 15% reduction in hospital utilization; a 9% reduction in emergency department usage; and a 7% reduction in the use of advanced imaging<sup>1</sup>. All of this resulted in an \$8 per member per month savings in total health care costs.

On the strength of these early data, CDPHP expanded its EPC program by establishing training programs for selected practices lasting 12 months and requiring significant commitment of time and effort as they learned the basics of Enhanced Primary Care. We currently have 75

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<sup>1</sup> The utilization reductions all reached statistical significance at  $p < .1$  level.

such practices, representing 384 providers and almost 100,000 members. We are now launching our next cohort which will add an additional 70 practices to the program.

While much of what I have described is common to many successful patient-centered medical home initiatives nationally, we believe our unique contribution to this effort has been the creation and deployment of a novel reimbursement methodology.

This model involves a risk-adjusted global payment for all services that the physician provides, in conjunction with a significant bonus focused upon elements of the Triple Aim. The combination of these two creates an opportunity for a physician to enhance his or her reimbursement by an average of 40%. A fundamental characteristic of the model is that it provides higher rewards specifically for better care of the sicker patients who consume the greatest amount of our health care dollars.

Our base payment is a unique global payment to the practice for each of their patients. This is driven by a severity factor that was developed for our use by the scientists associated with Verisk Health, Inc.<sup>2</sup> This severity score predicts the amount a primary care physician should be paid for a specific patient based upon the diagnoses of that patient. This score is then multiplied by a conversion factor to determine the payment for that given patient based upon their plan type – i.e. Commercial, Medicare, or Medicaid. We pay this to the practice on a monthly basis.

We still pay fee-for-service for a small subset of physician services (15%). These payments represent things that we would like to incent the primary care physicians to do in their office as opposed to referring to a specialist (e.g., minor skin biopsies) or for the acquisition cost of things like immunizations.

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<sup>2</sup> Ash, Arlene S., Ellis, Randall P. Risk Adjusted Payment and Performance Assessment For Primary Care. Medical Care 50(8) August 2012. 643-6653. DOI: 10.1097/MLR.0b013e3182549c74

The bonus or pay-for-performance aspect of the model is focused on the Triple Aim. We measure the satisfaction of the practice's patients to determine bonus eligibility. Currently we utilize HEDIS<sup>3</sup> metrics to measure the quality of care delivery. A weighted average of 18 distinct metrics creates a quality score for the practice. Our efficiency metric is an output of our Impact Intelligence software which accomplishes the required risk adjustment across the total cost of care.

The annual bonus payout to a practice is determined in a manner that has been described as a "tournament" system – simply said, practices need to perform better than other practices in the network to achieve their optimal payout.

Our initial data for the EPC program was based on a population of only 12,000 members. We are fortunate that the Commonwealth Fund has provided a grant to an external evaluator, Dr. David Bates of the Brigham and Women's Hospital, to evaluate our 2012 experience. These data will become available in the latter half of 2013.

CDPHP has also been active in the development of alternative reimbursement models for certain specialist and hospital partners. While we have yet to develop the experience that we have with the EPC program, we firmly believe that all components of the delivery system need to engage with us in payment models that align financial incentives with the needs of our communities.

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<sup>3</sup> HEDIS – Healthcare Effectiveness Data and Information Set: a set of standardized performance measures on health plan quality and service