Primary-care companies cut costs through preventive models

By Harris Meyer | October 20, 2018
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For most Americans, it's not easy to schedule an appointment to see a primary-care physician or speak to one by phone. When patients can get in for a visit with a doctor, they're lucky to get 15 minutes of their time.

That's not the case at a JenCare primary-care center in Chicago's South Side Ashburn neighborhood. Executives for JenCare and its parent, ChenMed, urge doctors and staff to get their senior patients in often and spend as much time as they need with them. Patients there average more than three hours of face time a year with their primary-care doctor.

“Ask yourself, am I seeing patients frequently enough?” Dr. Gordon Chen, chief medical officer of Miami-based ChenMed, told the company's more than 200 doctors and care coordinators across the country during a video conference late last month. “If we could increase the average number of visit slots used to 18 a day per physician, think of what would happen to our outcomes and how many lives we could save.”

ChenMed operates 53 clinics in seven states, including this JenCare facility in Chicago's Ashburn neighborhood. (Harris Meyer)

That admonition isn't because the company, privately owned by the Chen family, makes more money by seeing patients more often. On the contrary, ChenMed, which operates 53 clinics in seven states, serves most of its patients under a fixed per-member, per-month payment from Medicare Advantage plans.

So its intense focus is on keeping its elderly patients, who average five chronic conditions, as healthy as possible and avoiding expensive emergency room and hospital stays. That means

investing heavily in prevention and getting patients, particularly higher-risk people, in at least once a month and spending lots of time with them.

Otherwise, the company loses money, as Chen pointed out, citing negative results for the first quarter of 2018 due to a bad flu season. “We are behind budget; we have to catch up for all those hospital days,” he told the assembled doctors. “If we could touch our top 30 (high-risk) patients, our admissions would go down.”

Indeed, ChenMed's approach has resulted in 50% fewer hospital admissions compared with a standard primary-care practice, 28% lower per-member costs, and significantly higher use of evidence-based medications, according to a new study in the American Journal of Managed Care.

Dr. Gordon Chen (on screen), chief medical officer at ChenMed, addressing the company's doctors via videoconference (Harris Meyer)

ChenMed is one of a growing number of companies using intensive, team-based primary care to improve patient outcomes and the overall patient experience while reducing healthcare costs. Other players in this “high-touch” primary-care space—many of which are backed by venture capital investors—include CareMore Health System, Iora Health, Oak Street Health and One Medical. In addition, UnitedHealth Group's Optum, Humana and other insurers have invested heavily in coordinated primary-care groups.

Some of these firms, like ChenMed, Iora Health and Oak Street Health, focus on Medicare Advantage. Some, like Cerritos, Calif.-based CareMore, which is owned by Anthem, target high-needs patients in managed-care plans serving patients eligible for both Medicare and Medicaid. Others, like One Medical, target younger commercial members and employer groups. These companies often employ their own physicians and contract with specialists like cardiologists at some sites.

The companies have big expansion plans, with ChenMed having opened 10 clinics this past summer, while Iora Health has 10 practices about to open and aims to double in size each year.

Insurers offering Medicare Advantage plans like working with these primary-care groups because they've learned how to make money under risk-based payments by keeping patients out of the hospital and ER. Plus, they tend to produce high patient satisfaction, with Net Promoter Scores in the 80s and 90s, far above scores for insurers and hospitals.

“Because they've got a stable payment, these groups can do the things you can't do in fee for service—addressing social determinants of health such as transportation, food security, social isolation and housing,” said Dr. Roy Beveridge, chief medical officer at Humana, which serves nearly two-thirds of its Medicare Advantage members through value-based provider groups including ChenMed and Iora Health.

“We think what's missing in healthcare is there isn't an agent out there taking full responsibility for the health of patients and all the stuff that influences their health,” said Dr. Neil Patel, a regional medical director at Boston-based Iora Health, which mainly serves Medicare Advantage and traditional Medicare patients at 25 practices in seven states. “Primary care is the right seat. We're the ones to do it.”

COMMON FEATURES OF TEAM-BASED PRIMARY-CARE MODELS

- **Multidisciplinary care teams** with doctors, nurses and care coordinators assigned to each patient.
- **Smaller patient panels** allowing staff to see patients more often and spend more time with them.
- **Same-day** or next-day appointments.
- **A focus on working closely with patients** to meet their personal health goals, including addressing social determinants of health.
- **Tight coordination of care** in the hospital and during transitions between care settings. **Integration of behavioral healthcare** into primary-care delivery.
- **Customized electronic health record systems** that focus on clinical issues rather than billing.

Source: Modern Healthcare reporting

These companies' innovative, population health-style efforts are being emulated by some hospital systems, including Stanford Medicine and Johns Hopkins Medicine.

But experts say this primary-care transformation by health systems has been slow and spotty, limited by the sluggish shift from fee for service to capitation and other value-based pay models. That leads systems to view primary-care physicians as feeders to their specialists and inpatient facilities, which undermines primary-care improvement as an end in itself.

Another reason is that Medicare's facility-based payment system makes it easier for hospitals to operate primary-care practices profitably under the old model, compared with the hard work of redesigning care and taking risk in a value-based model.

“It may be that hospitals won't reach for more intensive primary-care models until they either are under greater margin pressure or they decide they want to go all in for accountability on population health,” said Dr. Arnold Milstein, director of the Stanford Medicine Clinical Excellence Research Center.

Beyond that, there are questions whether the companies have developed business models that can be rolled out profitably on a mass scale. A key challenge is finding enough high-needs patients in each of their locations who require their brand of resource-intensive care—while providing an appropriate, less-costly level of care for patients at lower health risk.

“I absolutely love this model, but a lot of folks don't need intensive monitoring or a multidisciplinary team,” said Jeff Goldsmith, a national adviser to Navigant Healthcare. “How do you target it to the populations that really need it?”

At ChenMed, each team, consisting of a physician, nurse and care coordinator, reaches out to the 40 highest-risk patients on its panel of about 400 patients, urging them to come in every few weeks to check up on medication adherence and vital signs for chronic conditions such as urinary tract infection and heart failure. The clinics dispatch their own vans and drivers to pick up patients who lack transportation. They also dispense prescriptions at their own pharmacies.

When Gwendolyn and Ron Shields, retired educators who are both 73, saw Dr. Kimberly Webb last month at the JenCare clinic in Chicago, Webb talked with them about their recent tests, asked if they needed any prescription refills, and arranged a urologist appointment for Ron and a vein clinic visit for Gwendolyn. And Webb urged them to take advantage of their Medicare Advantage plan's no-cost gym membership.

After the visit was done, the couple praised JenCare, where they have been seeing Webb for two years, for the personal attention and detailed follow-up. “Where we went before, I had to ask the doctors if we needed something,” Mrs. Shields said. “Here they check everything.”

Webb, who left private practice to join JenCare three years ago, said she had to shift her mindset to a more preventive approach. “I spend more time with patients and get to know them a lot better,” said Webb, whose performance has earned her a partnership share in the clinic's profits. “In private practice, I previously would see my diabetic patients once every three months. But a lot can happen in that time.”

While CareMore offers a similar high-touch, team-based model, it primarily serves the high-cost, high-needs patients in Anthem's Medicare Advantage plans and its plans serving poor and disabled patients who are dually eligible for Medicare and Medicaid. CareMore, which serves about 150,000 patients in 10 states, assigns a team consisting of a physician, nurse, dietitian, social worker and pharmacist to each patient's care. For Medicaid patients, it adds a behavioral health specialist. It deploys physicians it calls extensivists to follow patients throughout the care continuum.

“A lot of healthcare organizations think about restricting care to drive profitability,” said Dr. Sachin Jain, CareMore's CEO. “We invest heavily in chronic disease management and prevention to take great care of patients. We're a spend-to-save organization.”

Integrating mental healthcare, meeting patients' social needs, and using extensivist physicians to follow them through the continuum of care helped lead to 26% fewer hospital admissions and up to 29% fewer ER visits among CareMore's Medicaid patients in Tennessee and Iowa over the past year, according to a new article in the Harvard Business Review.

San Francisco-based One Medical is one of several primary-care companies targeting the younger commercial market. The company, with about 70 offices in eight big U.S. cities, shares some features of the team-based, patient-centered model but operates mainly through fee-for-service payment.

Another difference is patients pay a $199 annual membership fee, similar to but smaller than the fees charged by so-called concierge physician practices. That fee helps pay for video visits with nurses and physician assistants, which are available to members 24/7 at no additional charge. The company also distinguishes itself from concierge practices with its focus on providing cost-effective, evidence-based care.

Dr. Helen Xenos, the company's medical director for its three Chicago offices, said she finds practicing at One Medical to be more satisfying than her previous experience working in academic medical centers and urgent-care centers, largely because she can spend more time with patients. “It's a huge difference,” she said. “At those other places it was difficult to get patients what they needed quickly. Here if I have a patient who needs to see a gastroenterologist in the next week, I talk to the administrative staff and they make it happen. It's wonderful.”

There's a lot of agreement that the U.S. healthcare system needs to move toward this type of patient-centered primary-care model for everyone. The question is how long it will take for policymakers, providers and insurers to figure out how to make it work financially.

“My sense is that over the next 10 to 20 years, out of trial and error, American health systems will learn how to dial up and dial down the intensity of primary care to create better, more affordable forms of primary care,” Stanford's Milstein said.