The Medical Home Project

Building the Patient-Centered Practice

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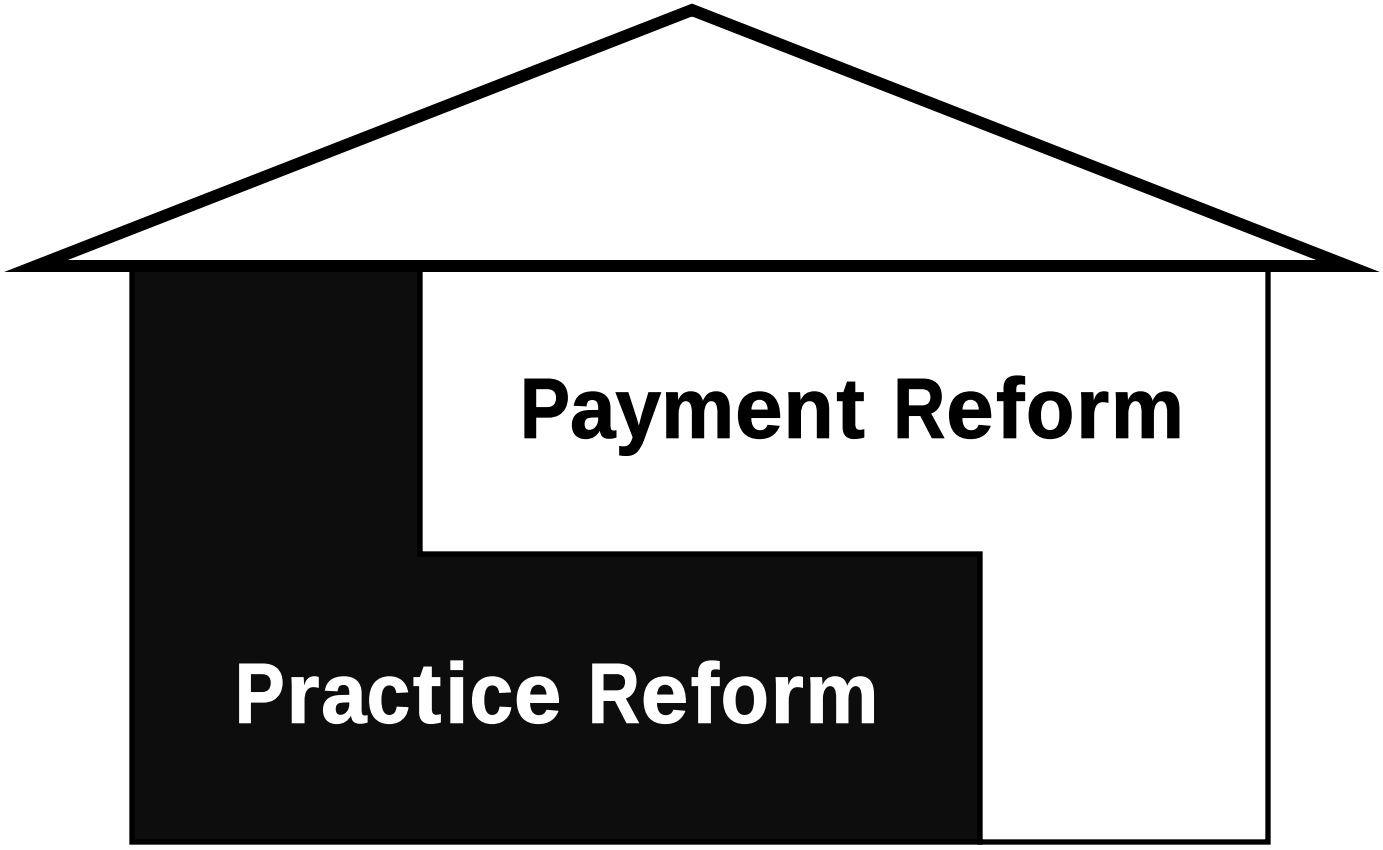
CDPHP Pilot



Resources

- **TransforMed**
- **Payment Reform**
  - DxCG/Verisk: Arlene Ash, PhD ; Randy Ellis PhD (Boston University)
  - Ingenix: Dogu Celebi, MD, MPH
  - Bridges to Excellence: Francois de Brantes, MBA
- **Evaluation**
  - Allan Goroll, MD (Massachusetts General Hospital)
  - David Bates, MD (Brigham & Women's Hospital)

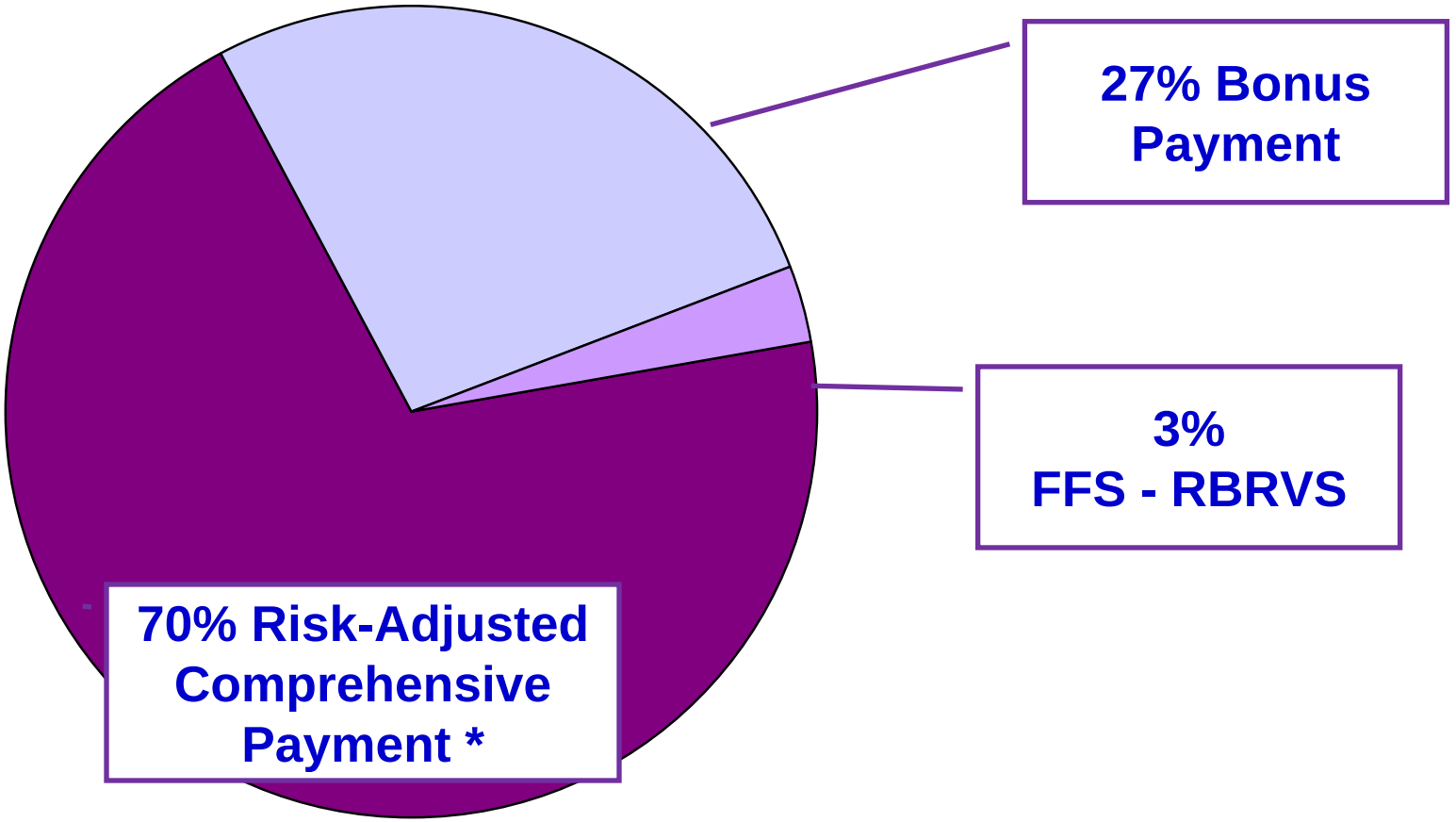
Payment Reform

Payment Reform

- Comprehensive payment for comprehensive care
- Align financial incentives
- Create an opportunity to significantly increase primary care physician income (35 – 50%)

Goroll AH, Berenson RA, Schoenbaum SC, Gardner LB. Fundamental reform of payment for adult primary care: comprehensive payment for comprehensive care. J Gen Intern Med 2007; 22:410-5.

Payment Reform – CDPHP Pilot



Targeted at improving base reimbursement approximately $35,000 to reflect increased costs of implementing and operating a medical home.

Pilot Practice Opportunity

- Per physician with average panel size/risk
  - $35K – base payment increase to cover Medical Home expenses
  - $50K – bonus potential
- Performance will be reported at the individual physician level and the practice
- All payments will be made at the practice level

Risk Adjusted Comprehensive Base Payment

Primary Care Activity Level Model

- DxCG/Verisk developed a risk-adjustment model (PCAL) for the CDPHP Medical Home project.

- A risk-adjusted base capitation payment linked to the expected level of activity needed to provide optimal primary care for a physician's patient panel.

Risk Adjusted Comprehensive Base Payment

- Two components of the formula
  - PCAL = Primary Care Activity Level
  - CF = Conversion Factor

- PMPM = PCAL x CF

CDPHP Panel Attribution

- We will be using the Ingenix “imputation” logic for CDPHP patient attribution.
- Patients who have not been seen within the past 24 months will not be included.
- We will <u>not</u> be using HMO assignment.

Bonus Payment Model

Bonus Model Components

- Satisfaction / Access
- Effectiveness (Quality)
- Efficiency (Cost)

Challenge of Bonus Measure Design

To identify those metrics upon which to base a bonus payment which are strongly correlated to lesser costs and the maintenance or improvement of quality

Bonus Program

- $50K potential per physician with average patient panel.
- A minimum performance of satisfaction/access is a threshold requirement for any bonus eligibility.
- Effectiveness (BTE) will determine available bonus.
- Risk adjusted efficiency measurement (Ingenix) will determine distribution.
- Measurement and payment will be at the practice level, however, data for individual physician performance will also be reported.

Effectiveness

- To ensure that the quality of health care delivery is at least maintained or preferably enhanced under this payment model.
- Measures of:
  - Population Health
  - Acute Disease Management
  - Chronic Disease Management
- Bridges to Excellence tool set

Clinical areas of measurement

- Population health
- Hypertension
- Diabetes
- CHF
- CAD
- Asthma
- COPD
- Back Pain
- IVD/Stroke

Some measures are cross-cutting:

- **BP**
- **LDL**
- **Use of diuretics**
- **Smoking cessation**

Example

Doctor Jones	Possible Points Care Link	Actual Points Care Link	% of Patients	Weighted Score	Total
Population Health	100	91.05	40.0%	36.42	70.91
Hypertension Care Link	100	68.65	15.0%	10.30	
Cardiac Care Link	100	74.91	7.5%	5.62	
Diabetes Care Link	100	68.80	15.0%	10.32	
Heart Failure Care Link	100	59.71	2.5%	1.49	
Asthma Care Link	100	33.79	20.0%	6.76	

Doctor Jones	Possible Points Care Link	Measure	Num/Den Result	Measure	Actual Points Care Link
Diabetes Care Link	100				68.80
Clinical Measures					
Poor control measures					
HgBA1c Control		15	10.74%	13.39	
Blood Pressure Control		15	20.13%	11.98	
LDL Control		10	33.33%	6.67	
Superior control measures					
HgBA1c Superior Control		10	23.08%	2.31	
Blood Pressure Superior Control		10	41.03%	4.10	
LDL Superior Control		10	61.54%	6.15	
Process measures					
Ophthomalogic Exam		10	60.26%	6.03	
Nephropathy Assessment		5	95.92%	4.80	
Podiatry Exam		5	76.83%	3.84	
Smoking Status and Cessation Advice and Treatment		10	95.35%	9.53	

Available Bonus

- On an Effectiveness scale of 100, a physician needs to score a minimum of 50 in order to qualify for a bonus.
- Assuming average size physician panel, every point over 50 will qualify for a bonus of $1,250 per point. Physician with a score >=90 will receive the maximum bonus amount.

Example: For a physician with effectiveness score of 71:

(Effectiveness score – 50) x $1,250 = Available Bonus Amount

(71-50) x $1,250 = $26,250

Efficiency

- To ensure that bonus payments are associated with aggregate cost savings to allow for a sustainable payment model
- Claims based measurement
- Ingenix tools

Efficiency will be measured along three dimensions

A. Utilization Based

B. Population Based

C. Episode Based

A. Utilization-Based

1. Hospitalization rates (inpatient admissions per 1000 patients)
    - Hospitalization rates will be calculated only for Ambulatory Care Sensitive Conditions.

Ambulatory Care Sensitive Conditions

Epileptic convulsions

Severe ear, nose, and throat infections

Chronic obstructive pulmonary disease

Bacterial pneumonia

Asthma

Congestive heart failure

Hypertension

Angina

Cellulitis

Diabetes "A"

Hypoglycemia

Gastroenteritis

Kidney/urinary infection

Dehydration - volume depletion

Iron deficiency anemia

Pelvic inflammatory disease

A. Utilization-Based (continued)

2. Emergency Room Rates (ER visit rate per 1000 members)

Exclusions:

- ER visits with an eventual admission
- Trauma
- Random events
  - Acute
  - High intensity/severe (cancer, etc.)

B. Population-Based

Population-based efficiency will be measured in three categories ($PMPM costs by type of service.)

1. Specialty care and outpatient
   - Includes all specialties
   - Includes all non - radiology, non - lab outpatient costs
   - Excludes inpatient, surgical centers, and ER costs
2. Radiology
   - All professional and facility radiology costs
   - Excludes inpatient radiology costs
3. Pharmacy
   - Pharmacy costs associated with pharmacy benefit

C. Episode-Based

All medical costs associated with a given medical condition, adjusted for differences in case-mix

Selection criteria:

- Clinical significance
  - High prevalence
  - High incidence
- Economic significance
- Sensitive/amenable to primary care, i.e., actionable
- Demonstrated variations in cost/utilization of care

C. Episode-Based (continued)

Episodes for selected medical conditions (cost per episode)

- Diabetes, asthma, CAD, CHF, sinusitis, GERD, hypertension, and low back pain

The same three types of services as population-based measures:

1. Specialty care and outpatient
2. Pharmacy
3. Radiology

Summary of Efficiency Metrics

A. Utilization-based

- Inpatient hospital admissions (selected)
- Emergency room encounters (selected)

B. Population-based

- Specialty care and outpatient
- Pharmacy
- Radiology

C. Episode-based

- Specialty care and outpatient
- Pharmacy
- Radiology

Efficiency Example
Ingenix Index

	Index
A. Utilization	
• Inpatient hospital admissions (selected)	1.50
• Emergency room encounters (selected)	0.90
B. Population-Based	
• Specialty care and other outpatient hospital	1.20
• Pharmacy	0.90
• Radiology	1.35
C. Episode-Based	
• Specialty care and other outpatient hospital	1.35
• Pharmacy	0.85
• Radiology	0.95

Efficiency Example Weightings

	Weight	Index
A. Utilization		
• Inpatient hospital admissions (selected)	5%	1.50
• Emergency room encounters (selected)	5%	0.90
B. Population-Based		
• Specialty care and other outpatient hospital	35%	1.20
• Pharmacy	15%	0.90
• Radiology	10%	1.35
C. Episode-Based		
• Specialty care and other outpatient hospital	15%	1.35
• Pharmacy	10%	0.85
• Radiology	5%	0.95

Efficiency Example Composite

	Weight	Index	Composite
• Population-Based			
• Specialty care and other outpatient hospital	35%	1.20	0.420
• Pharmacy	15%	0.90	0.135
• Radiology	10%	1.35	0.135
• Episode-Based			
• Specialty care and other outpatient hospital	15%	1.35	0.202
• Pharmacy	10%	0.85	0.085
• Radiology	5%	0.95	0.048
• Utilization			
• Inpatient hospital admissions (selected)	5%	1.50	0.075
• Emergency room encounters (selected)	5%	0.90	0.045
Composite Total			**1.145**

Ranking

- Each physician's Composite Efficiency Score will be ranked relative to the peer group
- Ranking determines the payout of the available bonus

Bonus Distribution – Efficiency

- Each practice's Composite Efficiency Score will be ranked relative to their peer group of primary care physicians in the Capital District
  - If a practice is below the 60th percentile (Efficiency Threshold), the practice will not be eligible for any bonus.
  - If a practice ranked between 60th and 90th percentile, each additional percentile point is worth 2.5% of the available bonus.
  - If a practice is above 90th, the practice will receive 100% of the available bonus.

Bonus Distribution Summary

(for average panel size)

- **Create the Bonus Opportunity**
  - Effectiveness Score
    - 0 – 50 = No opportunity
    - 51 – 90 = $1,250 per point above 50
    - > 90 = $50,000 opportunity
- **Distribute the Bonus Opportunity**
  - Efficiency Ranking
    - 0 – 60th = No distribution
    - 61st to 90th = 2.5% per percentile above 60th
    - > 90th = $50,000

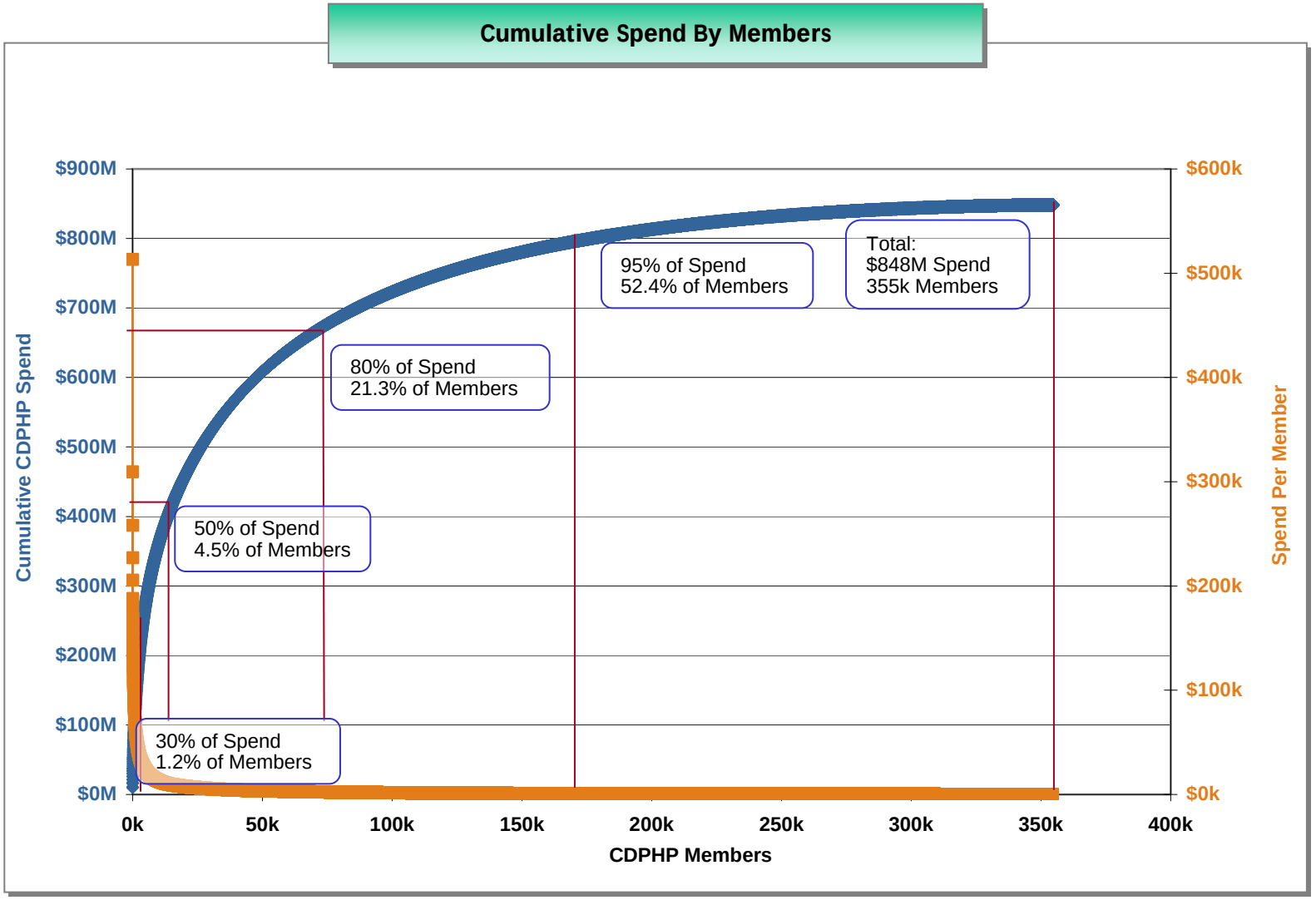
Illustration of Bonus Program Scenarios

Practice	Average Effectiveness Score	Available Bonus amount per MD	Average Efficiency ranking	Bonus Per physician	Total Practice Bonus
A (10 MDs)	92	$50,000	45th	$0	$0
B (5 MDs)	45	$0	92nd	$0	$0
C (4 MDs)	94	$50,000	85th	(85-60) x 2.5% = 62.5% of $50,000 or $31,250	$125,000

Pilot Hypothesis

Is the aggregate savings associated with better health outcomes and lower utilization sufficient to fund the enhanced compensation to a primary care physician as well as provide a surplus to the plan?

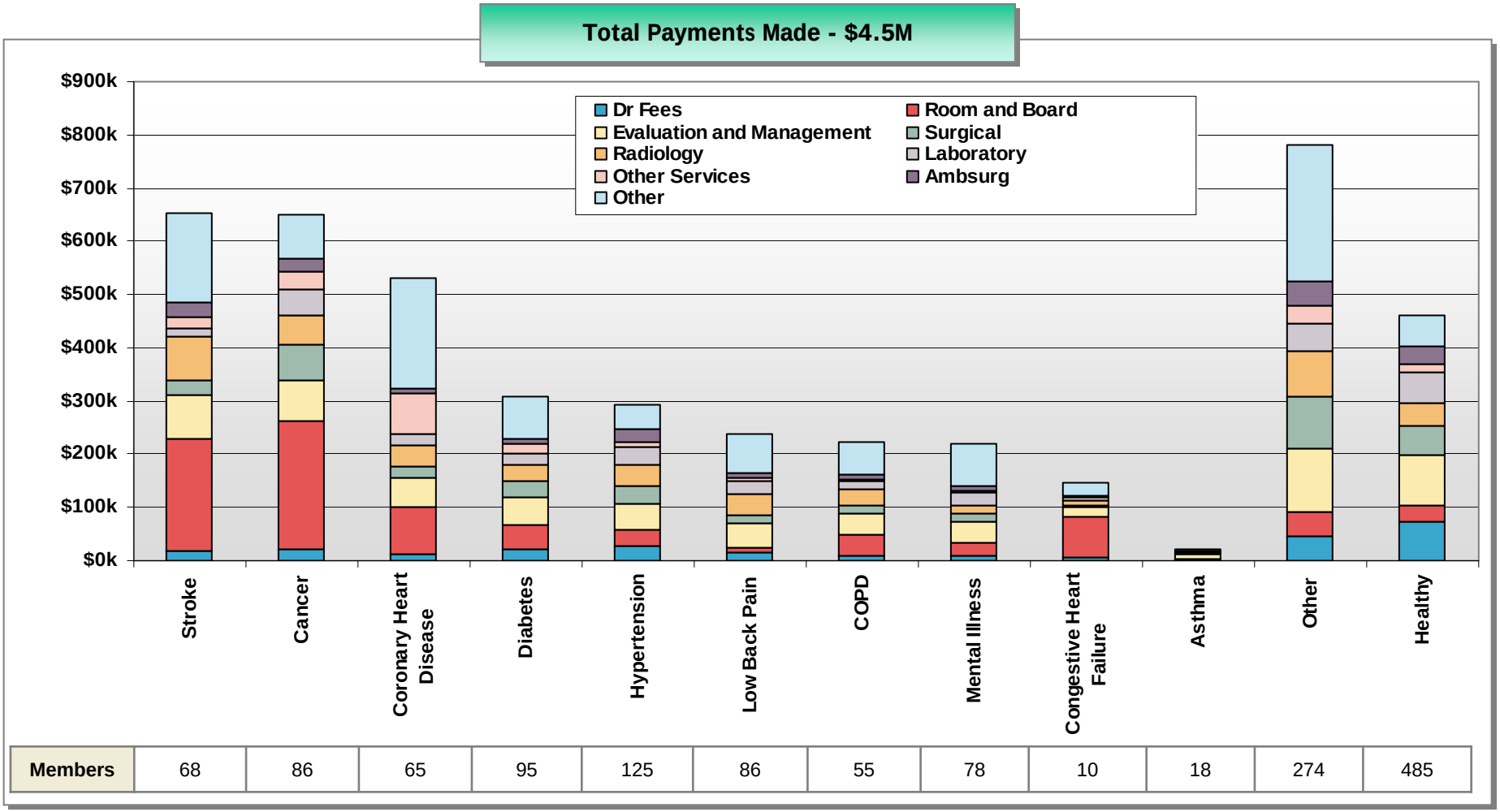
Cumulative Member Spend



Note: Data does not include LabCorp or pharma spend

Sources: 2006 CDPHP Medical Claims, ChapterHouse Analysis

While Only Accounting for 6% of Total Spend, $4.5M Was Spent on Doctor X's Patients



Members	68	86	65	95	125	86	55	78	10	18	274	485

Notes:
1. Does not include LabCorp or pharma spend
2. Shows total spend for any member who visited doctor during 2006

Sources: 2006 CDPHP claims data; ChapterHouse Analysis

Pilot Economics

In our payment model, < 2% of total health care expense for a primary care physician's practice would need to be saved to support an increased payment opportunity of $85,000 per physician.

Times Unio

Friday, December 31, 2010

Primary Care Saved

Three local physician practices, Capital Care Clifton Park, Community Care Schodack and Latham Med, along with insurer CDPHP have successfully created an innovative and sustainable model for the reimbursement of primary care physicians. This has led to an immediate resurgence in the interest in primary care medicine as a career for medical students.

Amazingly, this was accomplished while demonstrating better health outcomes and market leading satisfaction scores for patients, employers and physicians.

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