ACHP's Patient Center Medical Home & Payment Reform

A Report from the Trenches

National Pay for Performance Summit
March 9 – San Francisco, CA

MAKING HEALTH CARE BETTER

ACHP
ALLIANCE OF COMMUNITY HEALTH PLANS

Outcomes

- Provide an overview of non-profit community health plans' approach to redesigning payment to reward achievement of Triple Aim outcomes

- Offer specific "real world" experiences of how changes to payment actually get implemented

ACHP Mission

ACHP and its members

improve the health of the communities we serve

and

actively lead the transformation of health care

so that it is

safe, effective, patient-centered, timely,

efficient and equitable.

ACHP Member Organization Attributes

Quadruple Aim: Focused on health of populations, optimal patient experience (outcomes, quality, satisfaction), affordability, and community benefit.

Community-based: Building communities to better health. Loyal to communities and inspiring loyalty in return.

Provider Partnerships: Partnered closely with dedicated provider groups and network physicians to improve health and health care delivery. Accept risk and share it with providers through payment strategies. Align incentives for delivery system reforms.

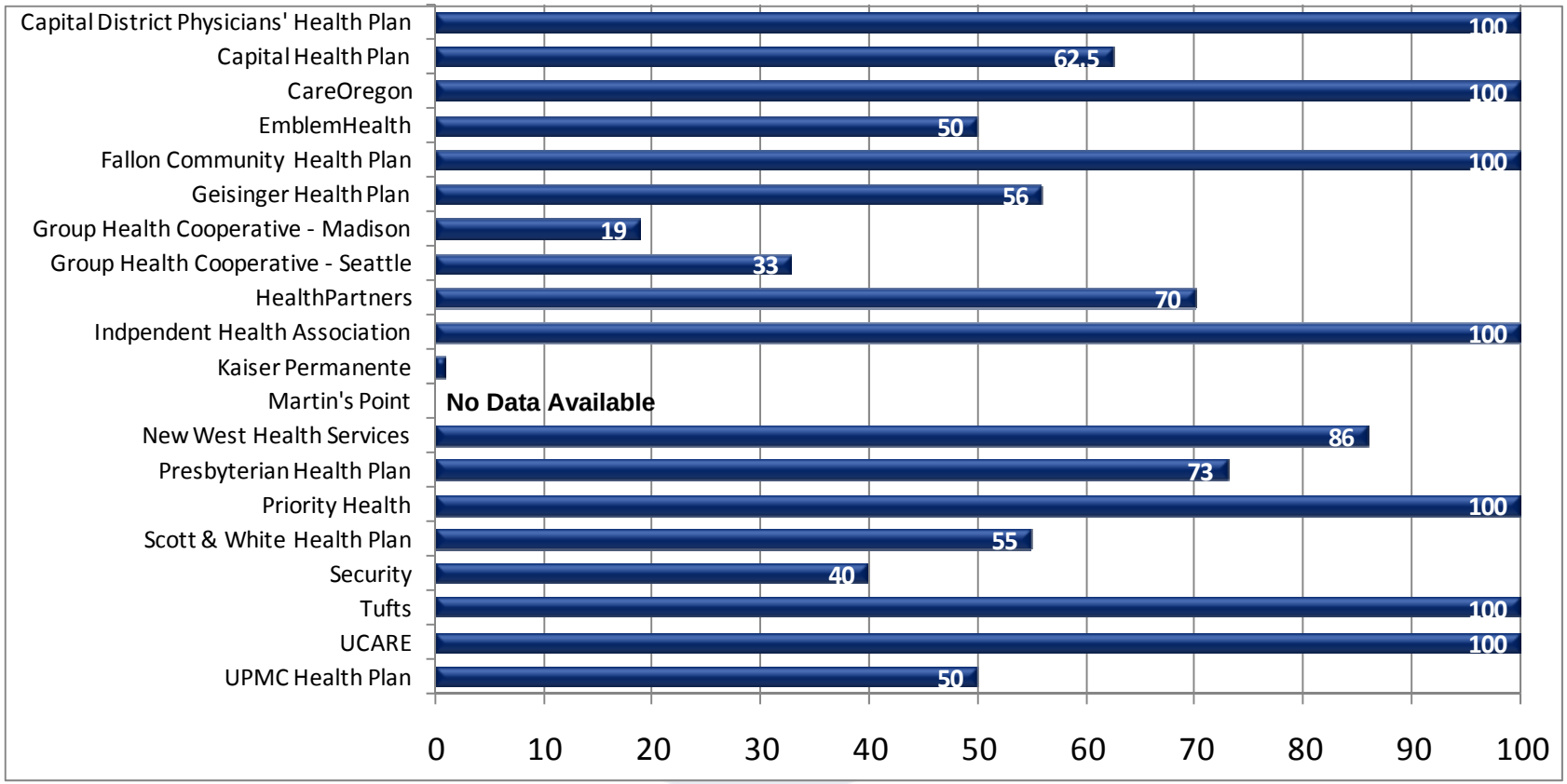
Non-Profit Orientation: Making decisions that keep consumers healthy for the long-term. Providing community benefit. The community is the chief stakeholder in our plans' success.

ACHP Members

Capital District Physicians' Health Plan	(Albany, NY)
Capital Health Plan	(Tallahassee, FL)
CareOregon	(Portland, OR)
Emblem Health	(New York, NY)
Fallon Community Health Plan	(Worcester, MA)
Geisinger Health Plan	(Danville, PA)
Group Health	(Seattle, WA)
Group Health Cooperative of South Central Wisconsin	(Madison, WI)
HealthPartners	(Minneapolis, MN)
Independent Health	(Buffalo, NY)
Kaiser Foundation Health Plans and the Permanente Federation	(Oakland, CA)
Martin's Point Health Care	(Portland, ME)
New West Health Services	(Helena, MT)
Presbyterian Health Plan	(Albuquerque, NM)
Priority Health	(Grand Rapids, MI)
Scott & White Health Plan	(Temple, TX)
Security Health Plan	(Marshfield, WI)
Tufts Health Plan	(Waltham, MA)
UCare Minnesota	(Minneapolis, MN)
UPMC Health Plan	(Pittsburgh, PA)

ACHP's Mixed Delivery Models

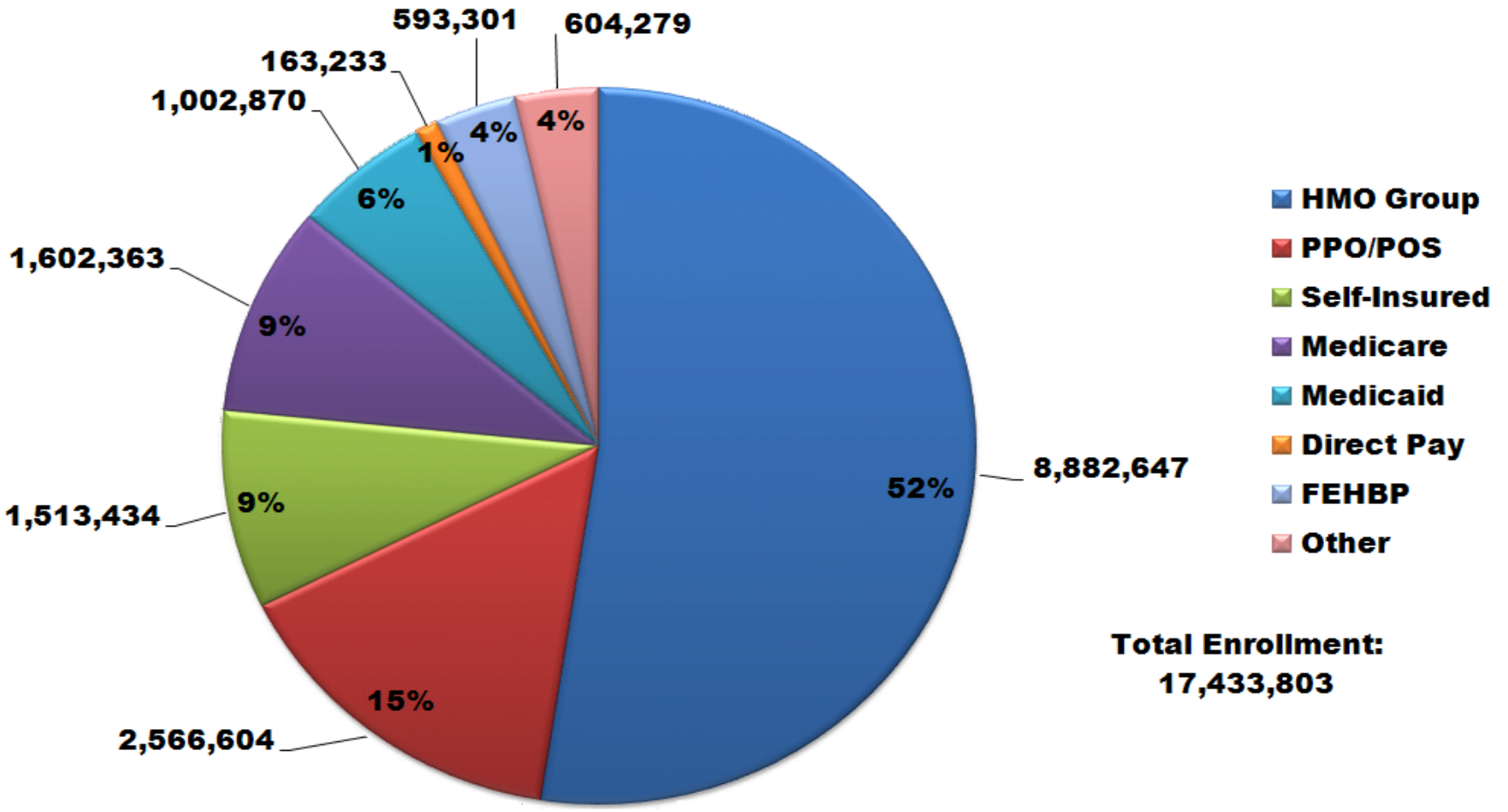
Percent of Members Aligned with Network PCPs (versus plan-owned/associated)



Source: a combination of self-reported data, direct member reports, and 2009 Interstudy data reflecting 2008 reporting

Plan-owned/associated PCPs include those employed by the same corporate parent organization, or those provider groups engaged in an exclusive delivery relationship with the health plan

ACHP Total Membership Distribution



Source: a combination of self-reported data, direct member reports, and 2009 Interstudy data reflecting 2008 reporting.

Rationale for Primary Care Innovation:

Patient Centered Medical Home as One Vehicle

- Demand on Primary Care Increasing
  - aging population
  - disease burden
  - complexity of treatment options

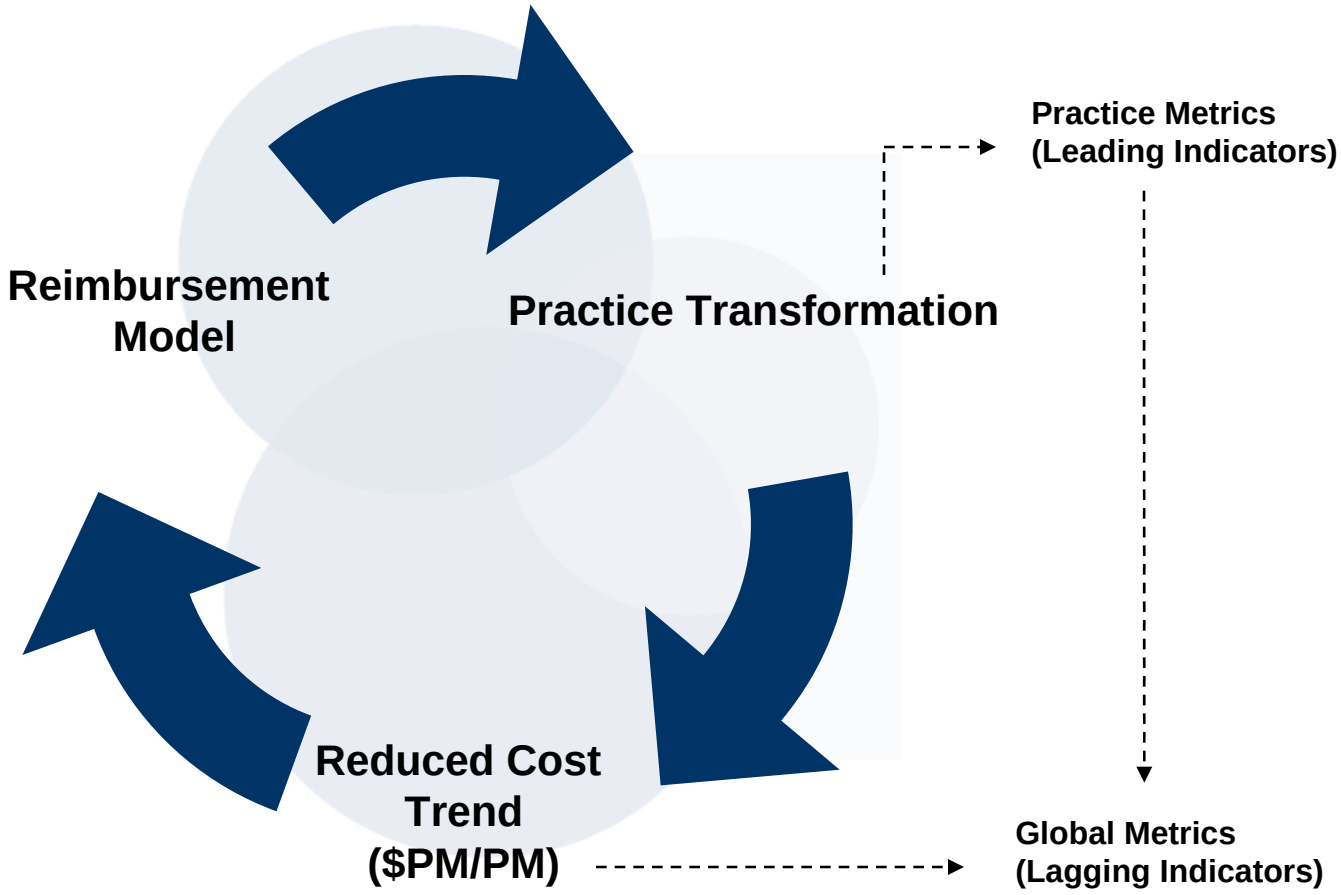
- Workforce Weakened
  - supply of primary care physicians
  - dysfunctional reimbursement systems
  - insufficient resources (staff, electronic tools)

ACHP Patient Centered Medical Home Collaborative

- The ACHP PCMH Collaborative is committed to achieving and demonstrating Triple Aim outcomes through reinventing the way primary care is ***incented*** and ***delivered***.

- Established ACHP member collaborative in 2008
  - Created “integrator” standards for health plans
  - Developed comprehensive measure set aligned with IHI’s Triple Aim
  - Piloting multiple models for reimbursement
  - Established forums for reporting progress and learning

Model of Key Elements for Achieving Sustainable Outcomes



ACHP Payment Transformation: Guiding Principles

- Over a period of years, enhance the ability of primary care physicians to achieve Triple Aim goals (reduced cost trend, enhanced patient experience, improved population health)
  - Understand that, during a period of transition, investment in primary care may be required in order to provide the infrastructure that will be needed to accommodate transformation
  - Require a positive return on investment (lower costs and improved efficiency) as a means of justifying continuation of enhanced primary care reimbursement.
  - Assure that incentives align with and support desired behaviors
  - Focus on clarifying the value of excellent primary care medicine to medical students and practicing physicians
- Collaborate with specialists and hospitals to ensure comprehensive alignment of care redesign and reimbursement
- Develop models that can be adopted across a broad spectrum of primary care practices—e.g., private, employed, FQHC.
- Recognize that ACHP plans, in collaboration with ACHP staff, have the focus and flexibility to provide national leadership around payment reform

Priority Health: Can We Get Off the Fee-For-Service Treadmill?

Jim Byrne, MD
Chief Medical Officer
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Accountability and Payment Reform:

We Need to Connect the Dots

The provision of primary care services, including prevention, acute care, and chronic disease management, is at the very heart of the efforts to address health reform.

Health reform cannot succeed without payment reform, and vice versa

Payment Reform: Getting off the Fee-for-Service Treadmill

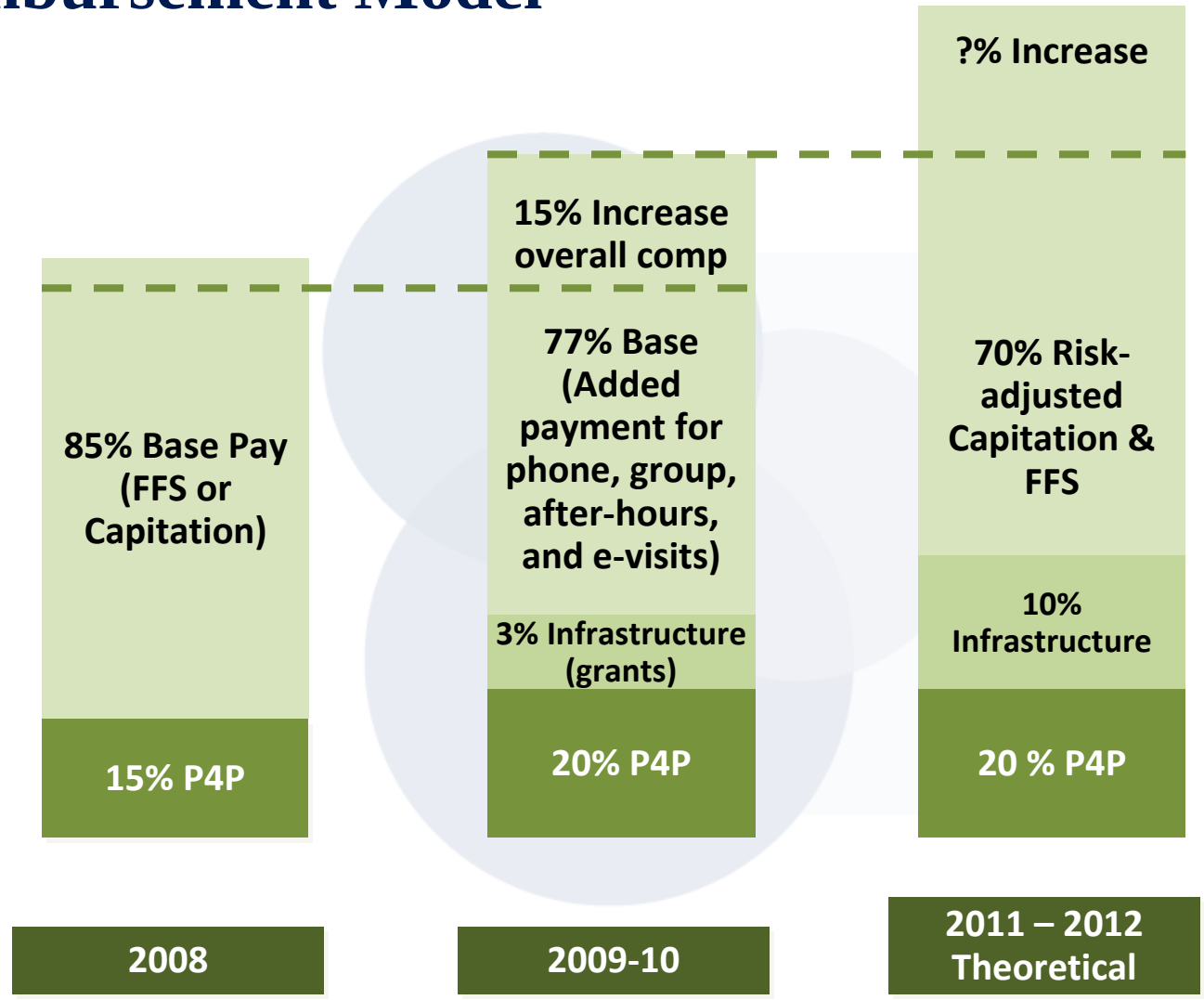
Current Payment Strategies

Commercial 2010

PCP revenue to increase by 9% *on average*

- Base pay
- Performance-based pay—available for all products—can add 15-25% revenue
- Infrastructure support
  - Pilots—11 sites, $1.25M (allocated based on merit of grant application)
  - Reward for NCQA recognition for PCMH--$1-$3 pmpm X 12 months

Reimbursement Model



2010 Partners in Performance Preventive Health

Measures	Award	HMO / POS	SF/ PPO	Medicare	Target	Medicaid	Target
Mammography	$10	✓		✓	79%	✓	63%
Cervical Cancer Screenings	$10	✓			88%		
Childhood Immunizations	$175	✓			86%		
Well Child Visits 3-6 Years	$60	✓			85%		
Recorded BMI Level	$0.15 pmpm	✓			90%	✓	90%
Chlamydia Screenings	$15	✓	✓		54%	✓	69%

2010 Partners in Performance Disease Management

Measures	Award	HMO / POS	SF/ PPO	Medicare	Target	Medicaid	Target
Diabetes Care: Controlled HbA1c <7%	$50	✓	✓	✓	TBD	✓	TBD
Diabetes Care: Controlled HbA1c <8%	$50	✓	✓	✓	TBD	✓	TBD
Diabetes Care: Controlled LDL-C	$80	✓	✓	✓	54%	✓	45%
Diabetes Care: Annual Retinal Exam	$25	✓	✓	✓	74%	✓	71%
Diabetes Care: Monitoring for Nephropathy	$25	✓	✓	✓	89%	✓	85%
Diabetes Care: Controlled Blood Pressure	$100	✓	✓	✓	42%	✓	42%
Optimal Diabetes Care	$200 $125 $75	✓	✓	✓	30% 25% 20%	✓	30% 25% 20%
Hypertension: Controlled Blood Pressure	$75	✓		✓	72%	✓	67%
Asthma Medication Management	$100	✓	✓		TBD	✓	TBD
Avoidance of Antibiotic Treatment in Adults with Bronchitis	$50	✓			31%		

2010 Partners in Performance

Measures	Award	HMO / POS	SF/ PPO	Medicare	Target	Medicaid	Target
Annual Lab Monitoring of Patients on Persistent Medication	$25	✓			84%		
e-Prescribing	$0.25 pmpm	✓		✓	50%	✓	50%
Patient Registry Utilization	$0.25 pmpm	✓		✓	Standards Met	✓	Standards Met
Generic Prescriptions Filled: Pediatric Patient Population	Shared Savings	✓		✓	71%	✓	71%
Generic Prescriptions Filled: Selected Therapeutic Classes – Adult Population	Shared Savings	✓		✓	78%	✓	78%
ED Visits per 1,000	Shared Savings	✓			125		

Bundled Payments Drive Care Coordination

- Prometheus/Bridges to Excellence project, supported by RWJ grant—one of four sites nationally
- Prometheus/BTE technology provides:
  - Evidence-informed case rates for chronic diseases and acute medical and surgical diagnoses
  - Measurement of potentially avoidable costs
- Providers receive shared savings if quality goals met and costs reduced
- Incentives drive delivery system integration, comprehensive care

Summary

- Health plans need to use economic engines to help drive triple aim change in collaboration with providers
- Change will not happen without leadership
- System change requires systems (e.g., ACOs)
- Payment must be linked to outcomes, not volumes
- Innovation will occur within communities (Gawande)

Independent Health:
Collaboration, Innovation are Keys to Delivery System Reform

Dr. Thomas Foels
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The Design

2009 Pilot Program Participants

- Summer 2008 Primary Care – Member Joint Advisory
- Launch January 2009
- Two-Year Pilot Program
- 23 Practice Sites (small group, EMR-enabled, diverse)
- 140 Physicians
- 50,000 members

Criteria

1. Access
2. Patient Monitoring
3. Case Management
4. Patient Self Monitoring
5. E-prescribing
6. Test Tracking
7. Referral Preferences
8. Performance Reporting
9. Electronic Communication

The Outcomes

"The End in Mind"

Sustainability of PCMH

Design

Criteria
(NCQA)

Reimbursement

Implement

Training
Change Mgt

Systems
Change

Outcomes

“Triple Aim”

Quality
Cost
Experience

Sustainability of PCMH

Design

Criteria
(NCQA)

Reimbursement

Implement

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Systems
Change

Outcomes

“Triple Aim”

Quality
Cost
Experience

Measurement

Measurement: Triple Aim

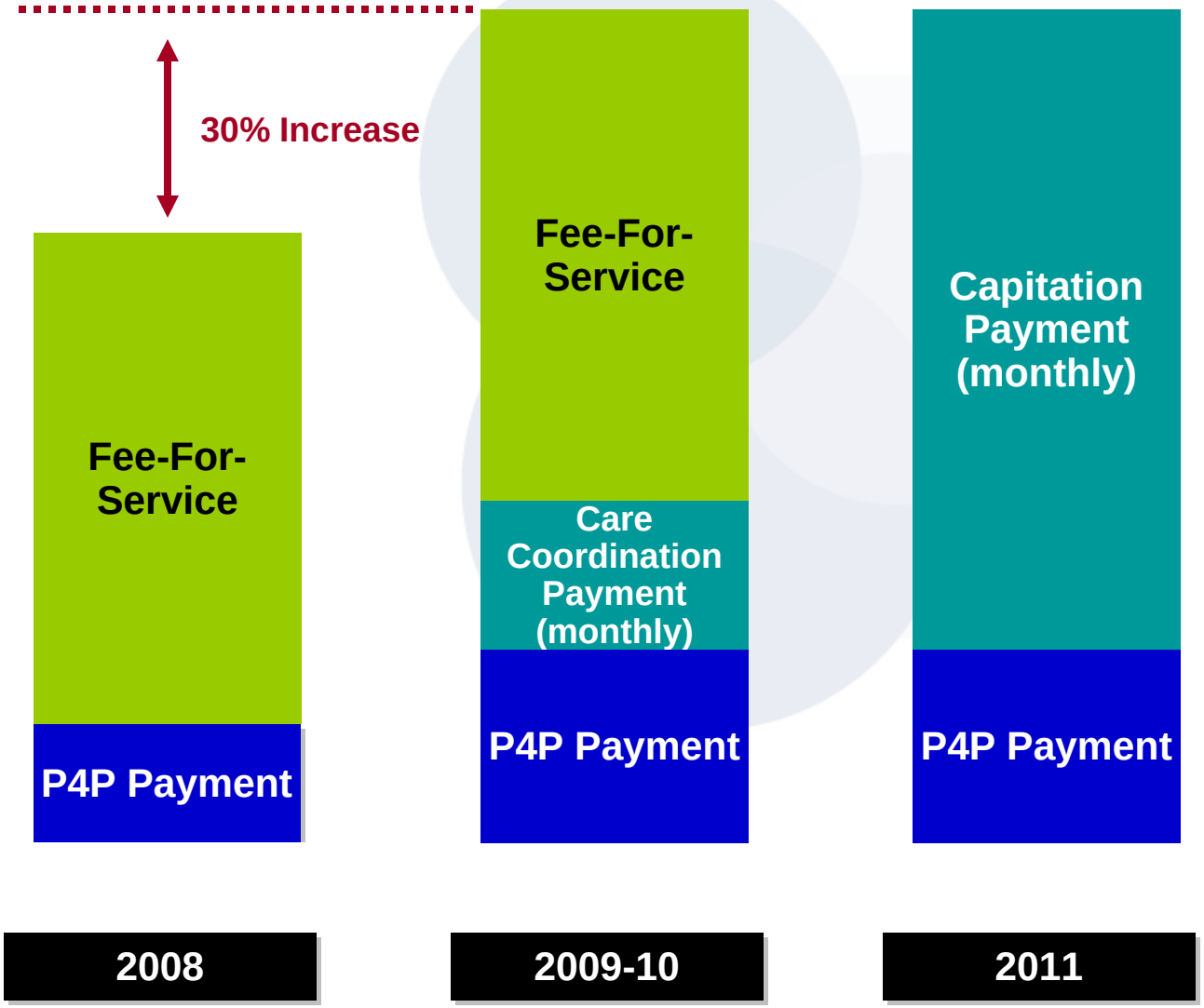
<table>
<tr><td>Quality</td><td colspan="2">• % of members who had a preventive care visit
• Patients 42-69 yrs who had a screening mammography in last 12 months
• Patients 50-80 years that had appropriate screening for colorectal cancer
• Patients that had cervical screening test in the last 36 reported months
• Patients 16-25 years that had a Chlamydia screening in the last 12 months</td></tr>
<tr><td rowspan="2">Utilization</td><td colspan="2">Done by service category, risk-adjusted for age, gender, condition, line of business compared to peers.</td></tr>
<tr><td>ER
Hospital Svcs
Lab
Pharmacy</td><td>Radiology
Primary Care
Specialty Care</td></tr>
</table>

Measurement: Triple Aim cont.

Satisfaction	Patients	Staff
	• # of surveys submitted • Overall experience of care: % of patients who would recommend doctor to family or friends • % of patients who feel MD is fully informed of the care they receive from other MD's • % of patients who feel doctor customizes their treatment according to their individual needs • % of patients who feel doctor is effective at getting them to be responsible for their health	• # of surveys submitted (same question) • Overall rating of team • Team Loyalty: % of staff who would recommend practice as great place to work • Empowerment: % of staff who feel they have opportunities to use initiative and improve their work • Team Morale: % of staff who feel the people they work with cooperate, communicate and help each other • Team Stress: % of staff who feel it is very stressful to work in the office • % of staff who would recommend practice to family and friends

Reimbursement Redesign

Redesigned Reimbursement Model



“The Special Sauce”

Creating the PCMH

Creating the PCMH

VS

Creating the PCMH

Technical Change	*Adaptive Change*
"Recipe"	**"Just the Ingredients"**
	
Solution exists, just apply it	Implementation process unclear
Problem well defined	Front line workers contribute
Leaders tell people what to do	Leaders empower others

Creating the PCMH

Technical Change	*Adaptive Change*
"Recipe"	**"Just the Ingredients"**
Solution exists, just apply it	Implementation process unclear
Problem well defined	Front line workers contribute
Leaders tell people what to do	Leaders empower others

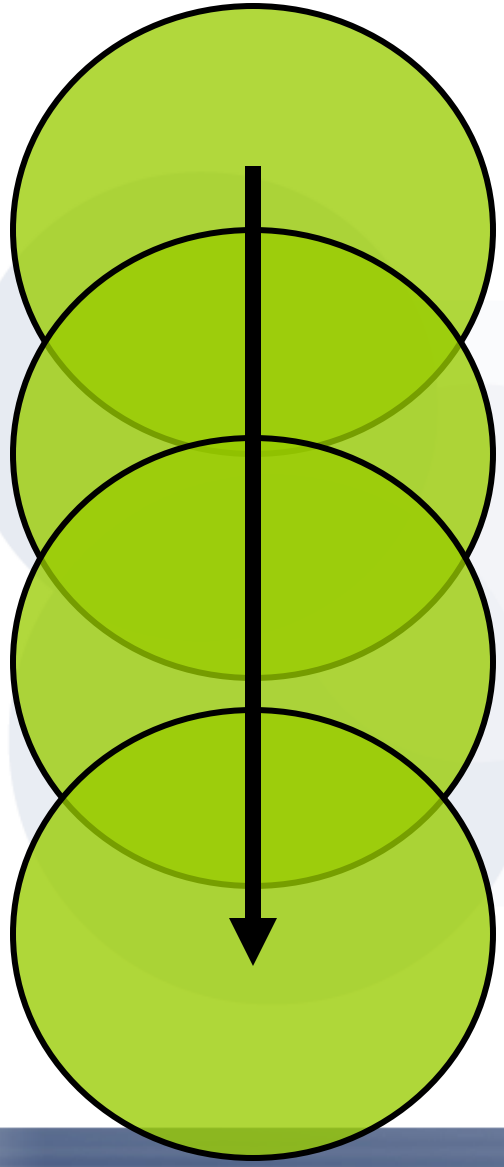
PCMH: Key Success Strategies

- Physician and Member at the design table
- Organization buy-in
- Dedicated Resources
  - Project management, IT/IM, Finance/Provider Reimbursement
  - Practice Management Resources *("the how-to of improvement")*
- Network with other PCMH programs
  - PCC-PCMH
- Continuous re-evaluation of the program (Plan-Do-Study-Act)
- ***Patience, Tenacity, Diplomacy, Humility***

The Next Phase of PCMH: Specialty Care

Health Plan leverages relationship

Hospital leverages relationship



PCMH

Cardiologist

Cardiologist Interventionalist

Hospital

Lessons Learned

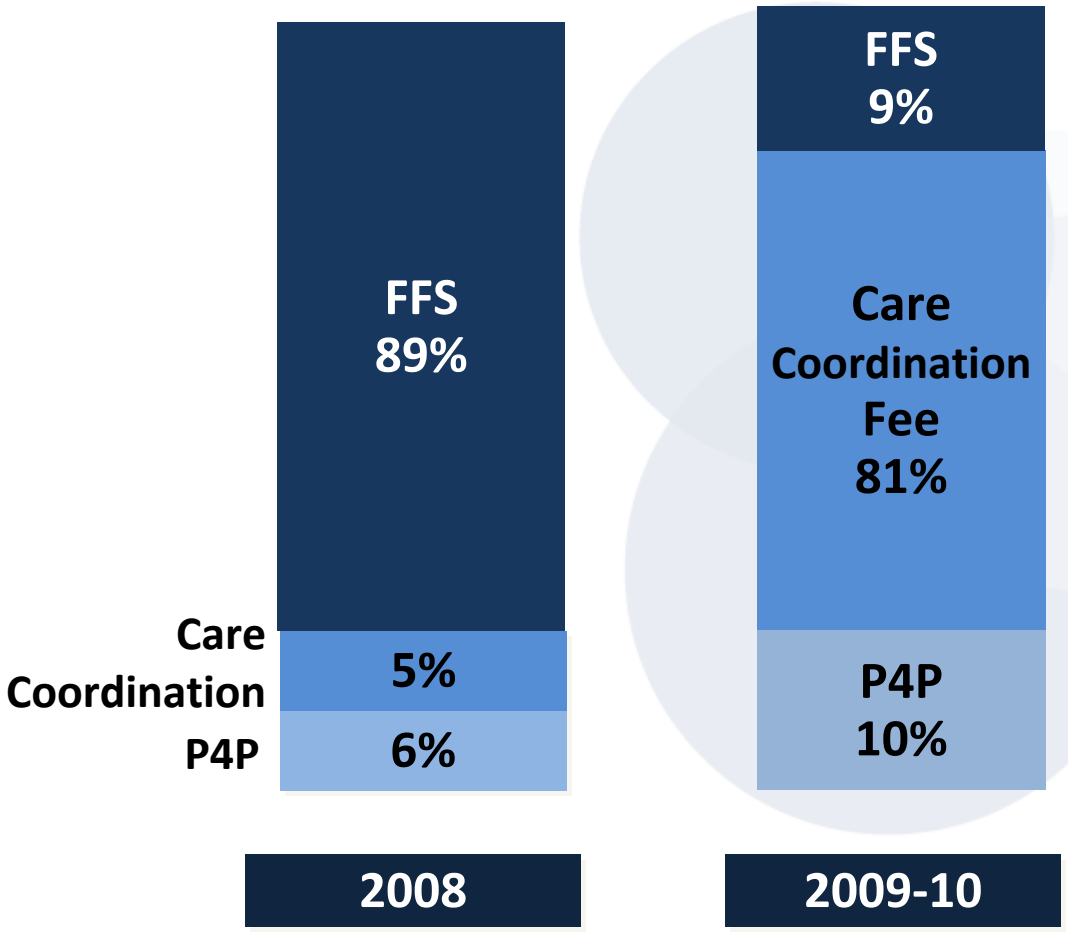
Lessons Learned at Independent Health

- Transforming health care culture is hard!
- Team building - physician leadership, inadequate communication, historical lack of staff and patient focus
- Limited HIT – limited resources, limited time
- Competing Demands – understaffed offices (lack of RNs), no formal training in disease management
- Bringing the model to scale – creating the PCMH as the community standard

Piloting Models to Affect Delivery System Reform

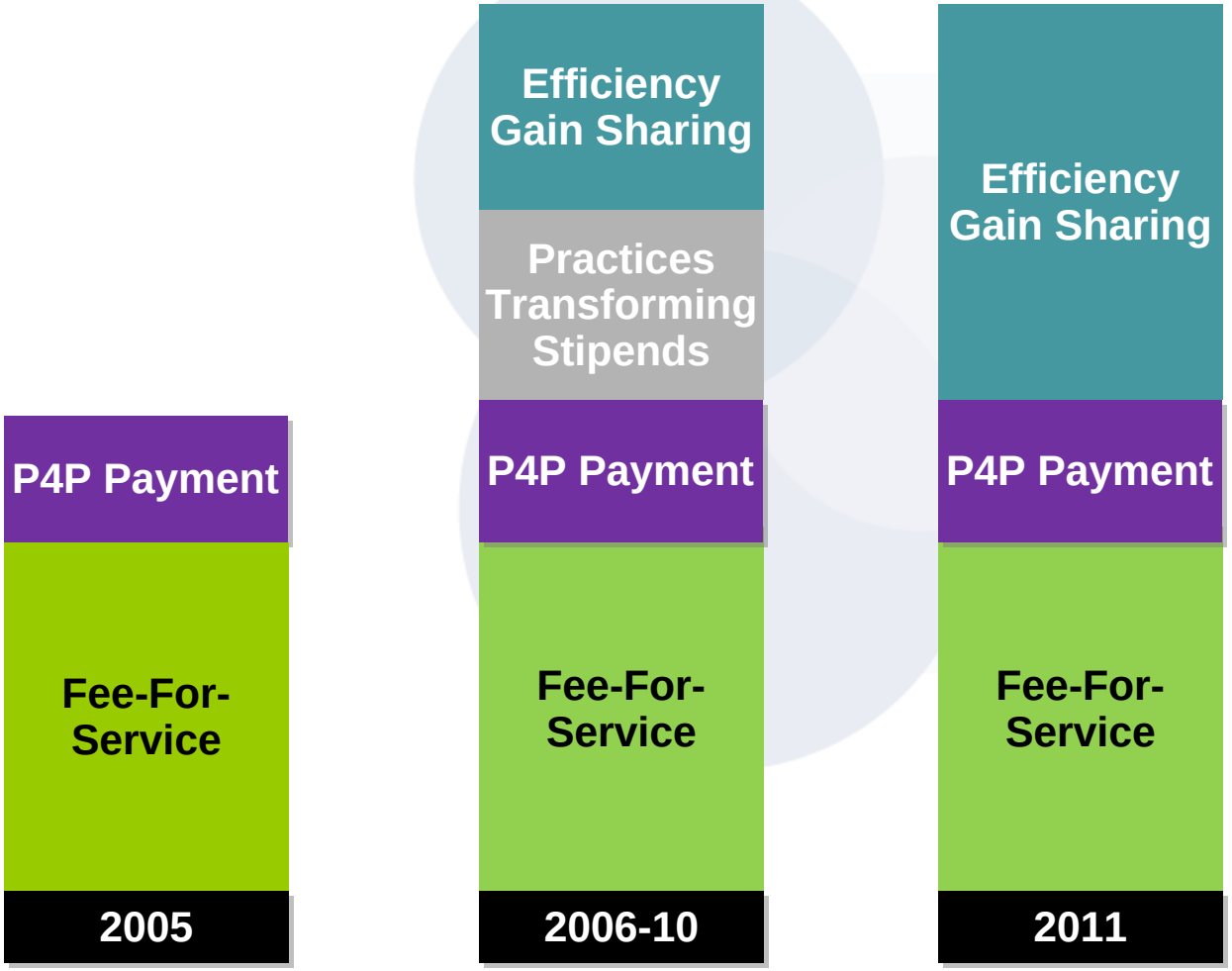
- Today we showcased two ACHP member organizations who are redesigning payment models to align with achieving triple aim outcomes
- Other ACHP organizations are also piloting payment reform in their communities
  - Capital District Physician's Health Plan – slide 45
- This is a journey without easy answers, or one right way.
- We believe through continued collaboration -- with providers, our communities, and each other we will enhance the patient experience, lower costs, and improve population health

Capital District Physician's Health Plan Reimbursement Model



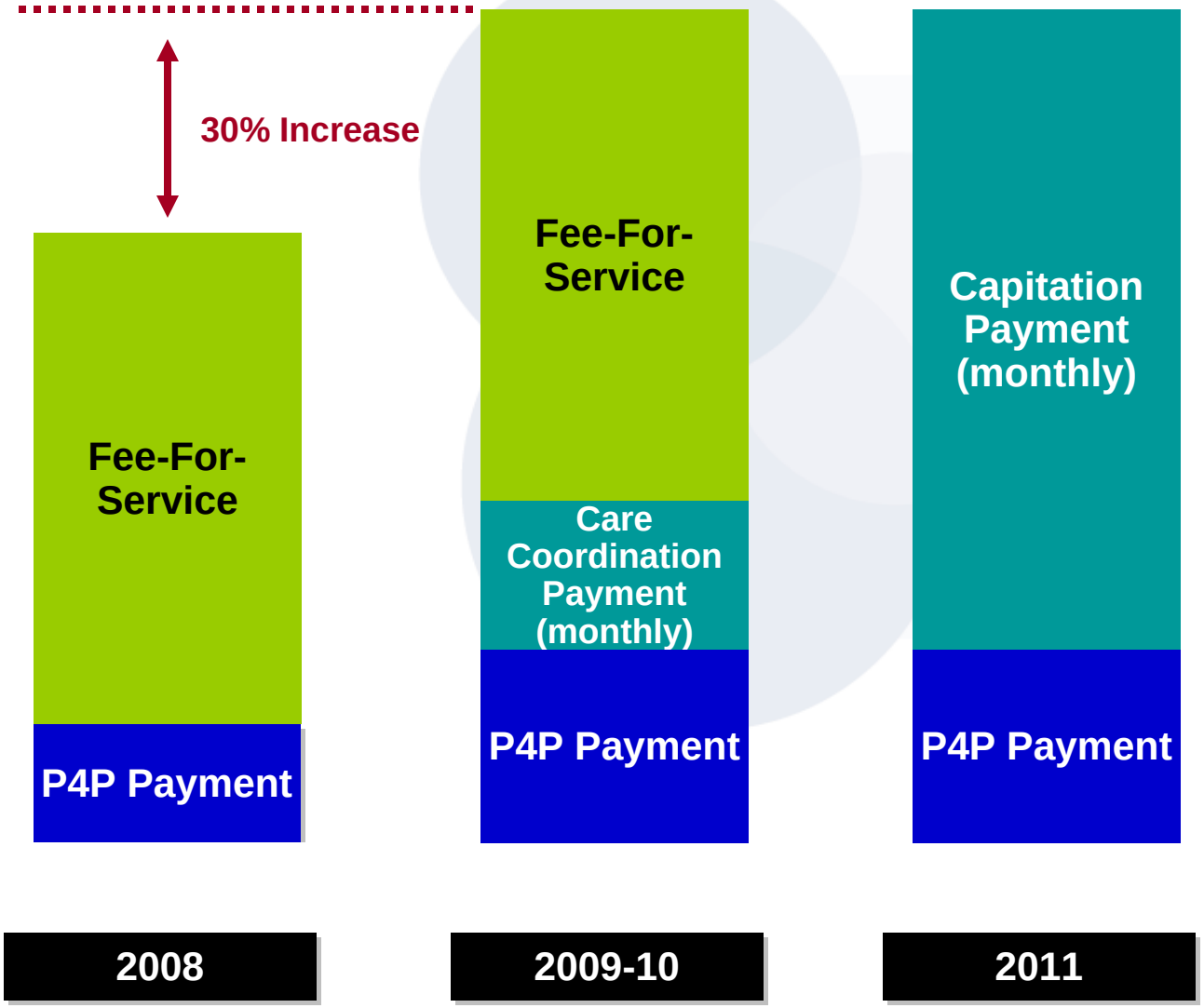
New model results in potential 57% increase in total income for physicians.

Geisinger Redesigned Reimbursement Model

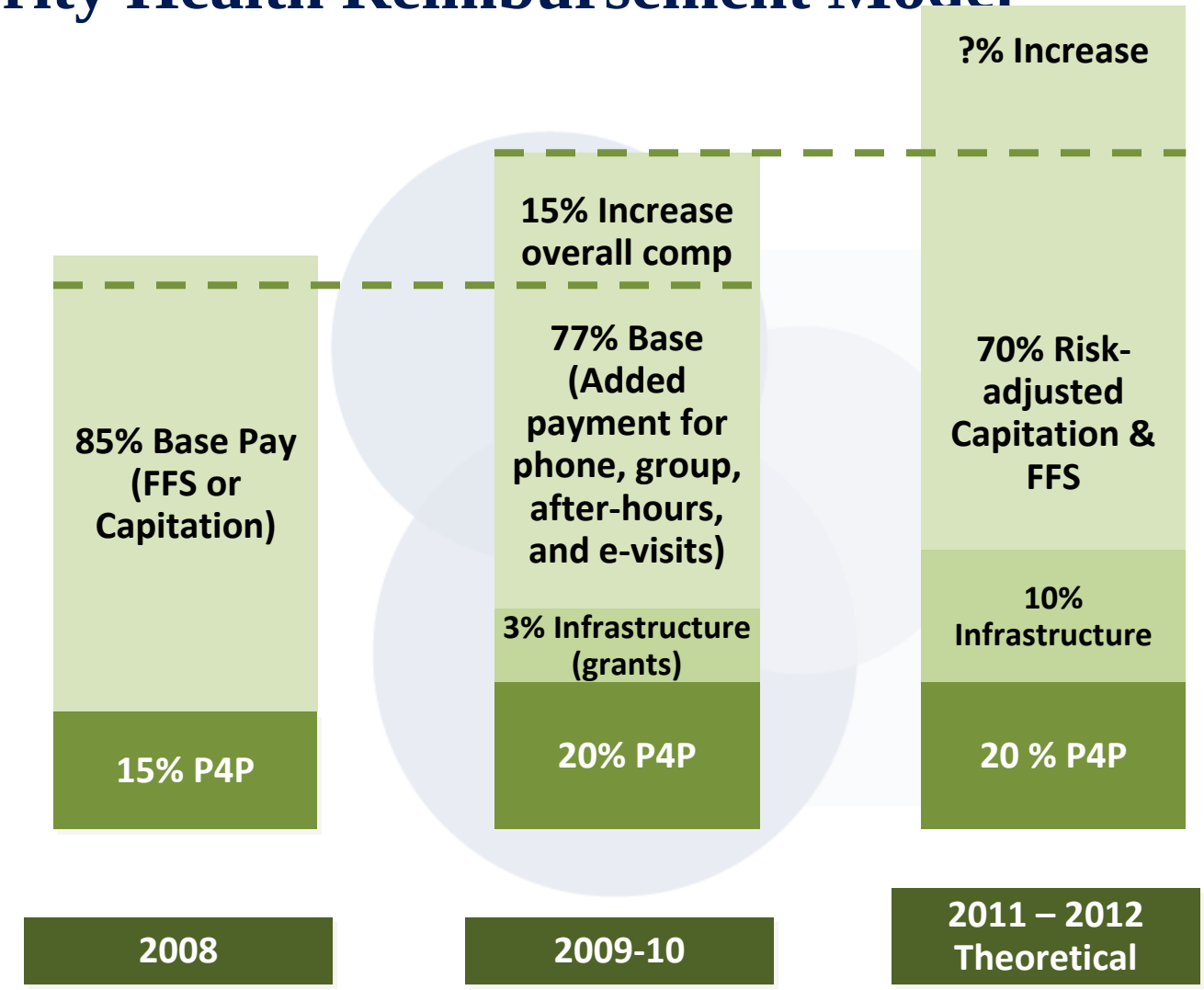


1 – must meet quality metrics to share
2 – new sites receive for 18 months

Independent Health Reimbursement Model



Priority Health Reimbursement Model



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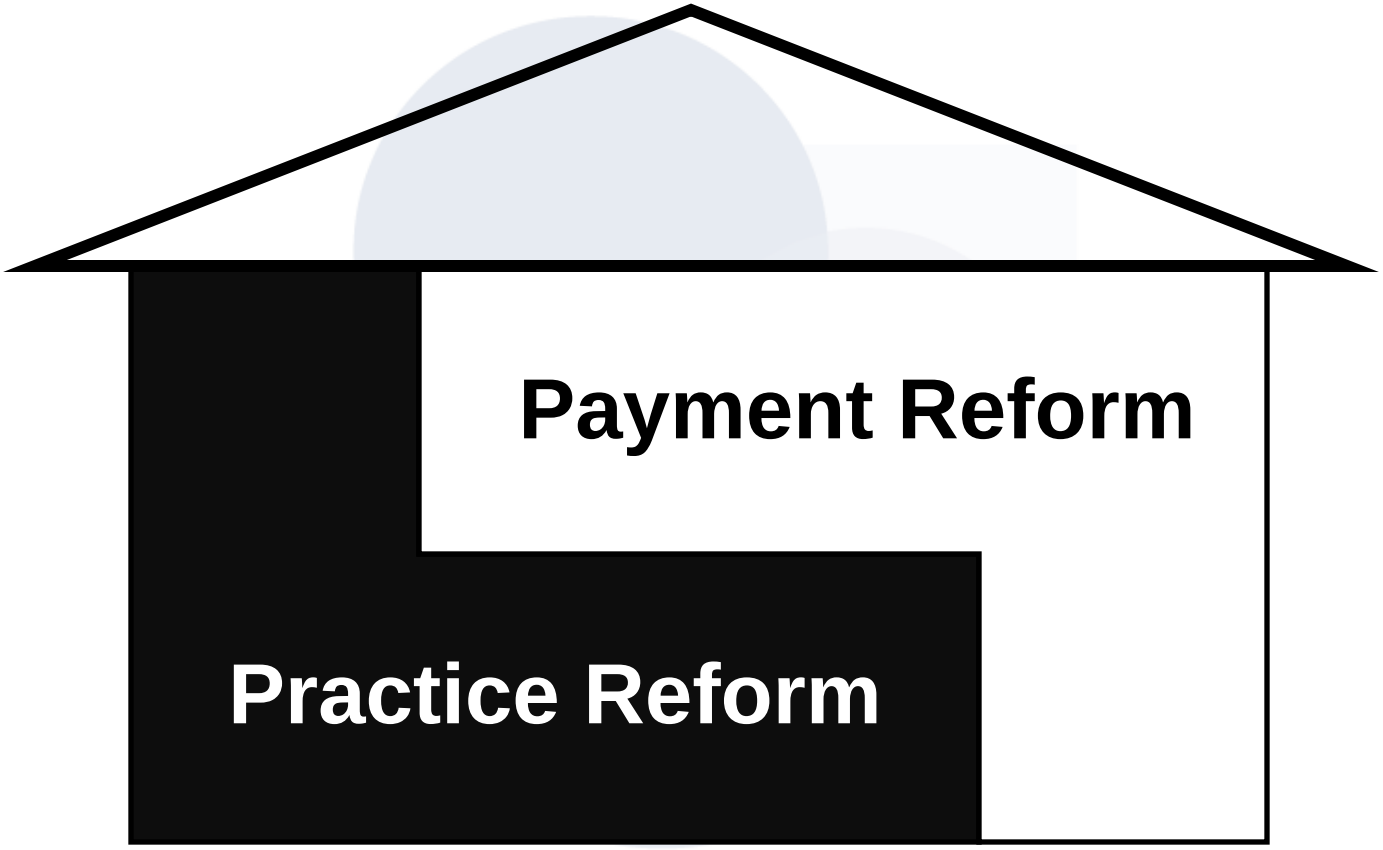
Appendix

- Capital District Physician's Health Plan PCMH and Payment Overview
- Independent Health Performance Dashboards
- ACHP Medical Home Standards for Health Plans

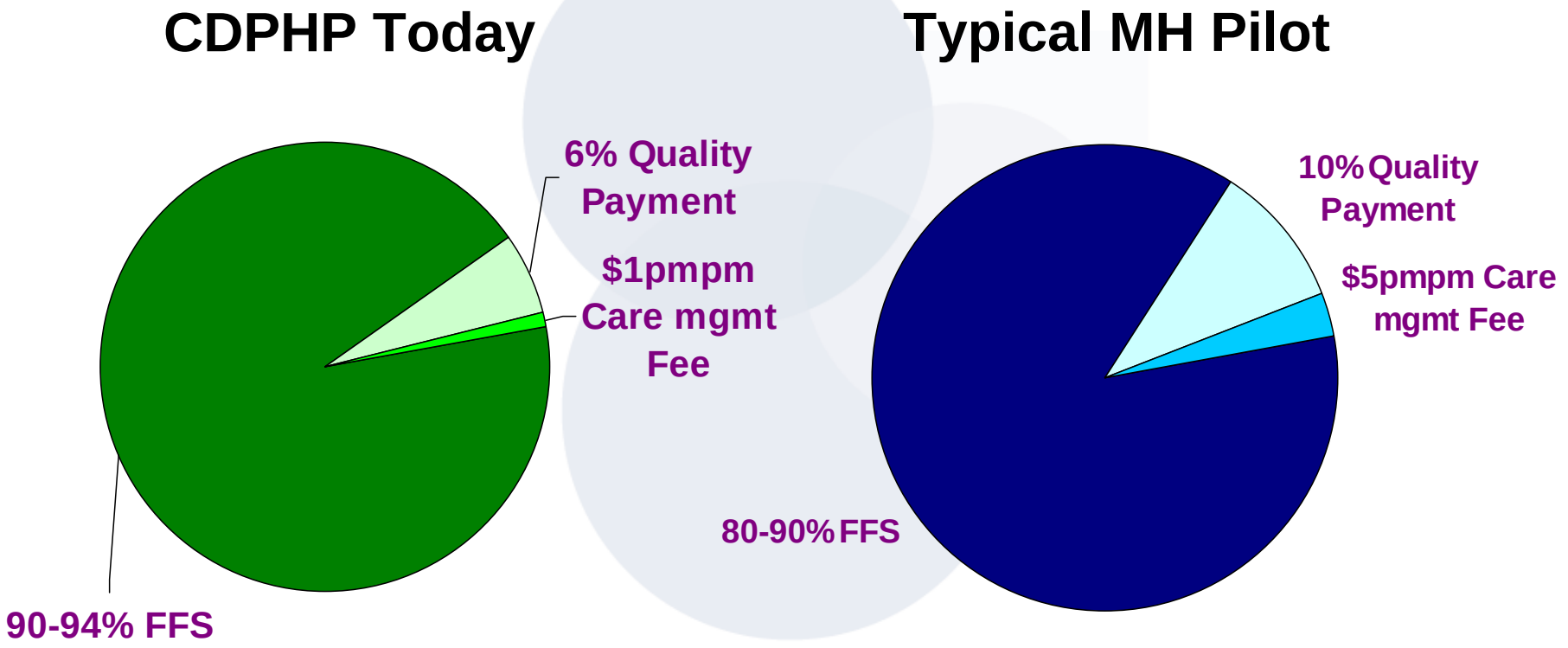
Capital District Physician Health Plan's Pilot Approach



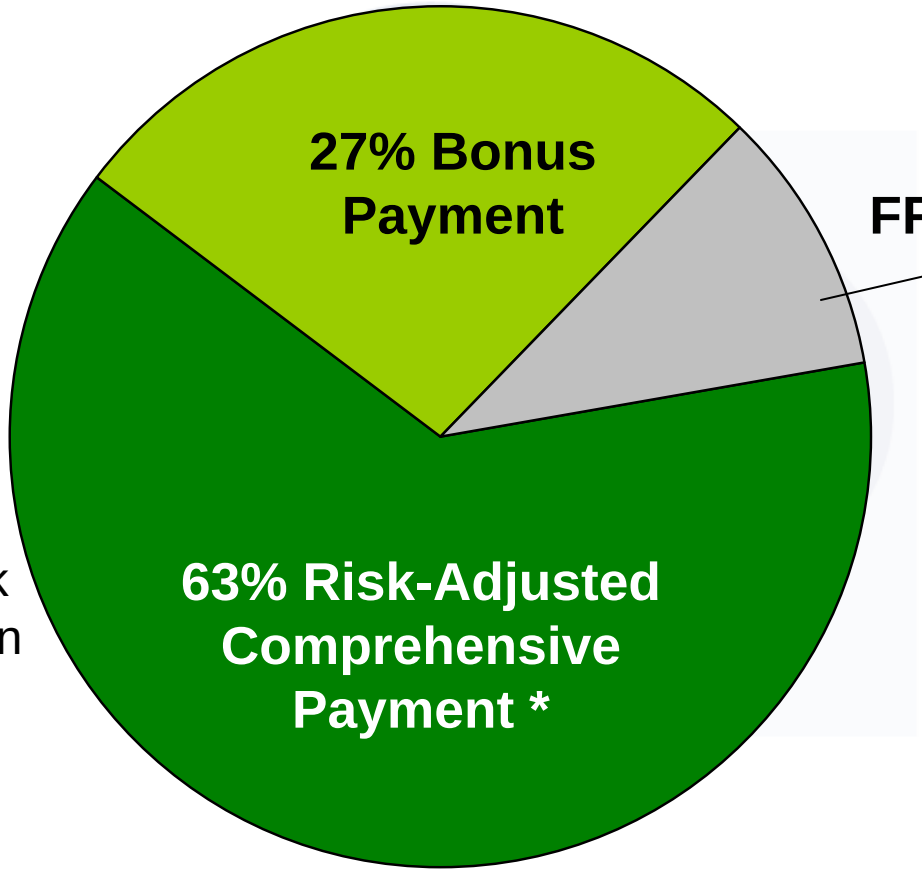
Goals for Practice Reform

- NCQA Recognition
- Practice Transformation—Sustainability
- Care Management process—Quality
- Care Coordination process—Efficiency

Payment Reform – Compensation Today



Payment Reform – CDPHP Pilot



Note: Belief in risk adjusted capitation is stronger than ever, despite the challenges of attribution.

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

Summary of CDPHP Model

Risk Adjusted Base Payment

2 components:

PCAL & CF: PMPM =PCAL*CF

	Base	PCAL Increment
Commercial HMO	$128.80	$60.69
Commercial non-HMO	$105.16	$49.65
Medicaid	$90.74	$42.74
Medicare	$101.83	$48.08

Bonus Payment Model

Based on Triple Aim (experience, effectiveness, efficiency)

- $50k potential/MD with avg. patient panel
- Effectiveness will determine available bonus and is based upon 18 selected HEDIS measures
- Risk adjusted efficiency measurement will determine distribution

Ingenix Efficiency Score Ranking

Pilot Year 1 Scoring:

<60% $25,000 opportunity

$1000 per point of improvement from prior year

>60% $25,000 opportunity plus

$625 per point between 60 – 90

>90% $50,000 opportunity per MD

Note: $50K max per 1.0 FTE MD still applies

Base Payment Reconciliation Process for the Pilot

Step 1: Calculate amount model predicts

Step 2: Subtract actual amount paid

Step 3:

- Scenario 1:

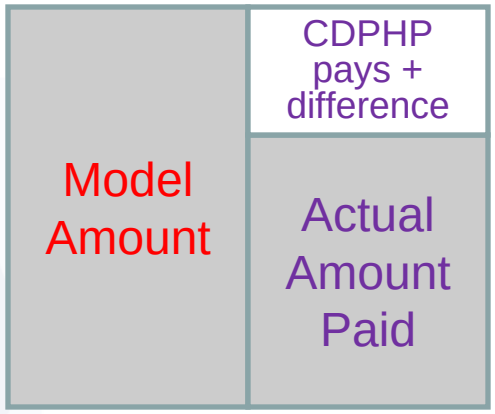
  Positive Result = CDPHP pays difference

- Scenario 2:

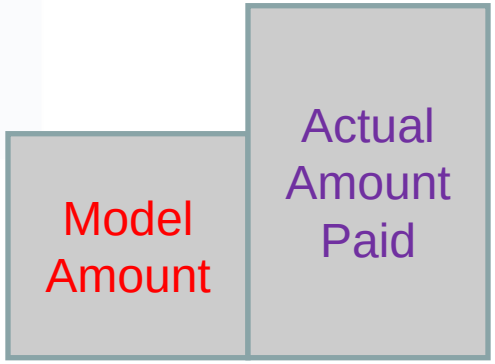
  Negative Result = No payment

Practices have been paid $210,957 for Q1, Q2 reconciliations

Scenario 1:



Scenario 2:



CDPHP: Summary of Efficiency Metrics

(Distributing the Bonus Opportunity)

A. Population Based

- Specialty Care and Other Outpatient Hospital
- Pharmacy
- Radiology

B. Episode Based

- Specialty Care and Other Outpatient Hospital
- Pharmacy
- Radiology

C. Utilization

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

CDPHP Preliminary Findings

Effectiveness (Quality) is improving across all practices and Efficiency (Cost) is variable.

- Effectiveness (Quality)
  - HEDIS 2009 (reflective of 2008 performance just available)
- Efficiency (Cost)
  - Q1 2009 most recent data secondary to claims lag and Ingenix processing

Quality Metrics: Independent Health

Quality Dashboard

Example Family Practice
(Full Year 2008)

Preventive Care - Adults	Doc A			Doc B			Doc C			Doc D			Group Total			Peer Rate
	%	# Num	# Den	%	# Num	# Den	%	# Num	# Den	%	# Num	# Den	%	# Num	# Den	%
% of members who had a preventive care visit	86%	160	186	89%	124	140	88%	131	149	90%	226	251	88%	641	726	89%
Patients 42-69 years of age who had a screening mammogram in the last 12 months	83%	44	53	85%	28	33	73%	16	22	84%	31	37	82%	119	145	70%
Patients 50-80 years that had appropriate screening for colorectal cancer	25%	15	60	28%	11	40	39%	12	31	28%	12	43	29%	50	174	25%
Patients that had a cervical cancer screening test in the last 36 reported months (new measure)																
Patients 16-25 years of age that had a Chlamydia screening in the last 12 months	20%	2	10	40%	2	5	55%	6	11	36%	4	11	38%	14	37	52%
Composite Preventive Quality Score	**72%**	**221**	**309**	**76%**	**165**	**218**	**77%**	**165**	**213**	**80%**	**273**	**342**	**76%**	**824**	**1082**	Target

Utilization Metrics: Independent Health

Utilization Dashboard
Example Family Practice

Utilization Index by Service Category* ~ Full Year 2008 (Commercial)

Physician	Members	ER	Hospital Svcs	Laboratory	Pharmacy	Primary Care	Radiology	Specialty Care	Physician Total	Target
Doc A	247	0.66	1.01	0.96	0.88	0.89	1.09	1.16	1.00	
Doc B	174	1.33	2.18	0.76	1.18	0.89	0.93	1.28	1.34	
Doc C	135	0.83	1.16	0.75	0.83	0.90	1.82	1.16	1.06	
Doc D	239	1.22	0.90	0.77	0.99	0.88	0.47	0.76	0.84	
Doc E	187	1.89	1.29	0.84	1.11	0.99	0.91	1.01	1.11	
Doc F	99	1.02	0.69	0.6	1.27	0.91	0.84	0.82	0.92	
Group Total	**1081**	**1.16**	**1.21**	**0.81**	**1.02**	**0.91**	**0.96**	**1.03**	**1.04**	

*Utilization Index is the risk-adjusted utilization compared to peers. Risk adjustment is based on age, gender, condition and line of business.
An index less than 1 indicates utilization less than expected. An index greater than 1 indicates utilization greater than expected.

Satisfaction Metrics: Independent Health

Satisfaction Dashboard					
Example Family Practice~ April 2009					
Patient Satisfaction	**Group Total**	**Doc A**	**Doc B**	**Doc C**	**Doc D**
Number of patient surveys submitted	392	98	98	98	98
Overall Experience of Care: % of patients who would recommend doctor to family or friends?	71%	37%	63%	72%	70%
% of patients who feel doctor is fully informed of the care they receive from other doctors.	50%	45%	42%	45%	58%
% patients who feel doctor customizes their treatment according to their individual needs.	56%	40%	52%	61%	56%
% patients who feel doctor is effective at getting them to be responsible for their health.	51%	39%	42%	53%	55%

Staff Satisfaction	**Group Total**	**Overall PCMH Comparison**
Number of staff surveys submitted	37	NA
Overall Rating of Team (0=worst; 10=best)	8.05	7.82
Team Loyalty: % of staff who would recommend the practice as a great place to work.	70%	41%
Empowerment: % of staff who feel they opportunities to use initiative and improve their work.	56%	38%
Tream Morale: % of staff who feel that the people they work with cooperate, communicate and help each other.	84%	65%
Team Stress: % of staff who feel it is very stressful to work in the office.	3%	6%
% of staff who would recommend practice to family and friends.	84%	64%

ACHP PCMH Standards: Building on NCQA

ACHP plans function as a critical integrator to ensure that effective care coordination takes place.*

Standard	Example
Supporting Integration: Plan provides additional support to providers (e.g. feedback on performance, in-office case management, etc.) to support medical home activities.	• Providing case management support to practices (often embedded within the practice) • Providing tools for disease management, such as registries or population stratification • Regular meetings with PCMH practices to discuss progress, challenges, lessons learned.
Outcomes Measurement – Plan works with practices to collect data on jointly developed indicators that measure triple aim outcomes. Practices also develop and track progress on leading indicators on a regular basis (daily, weekly, monthly).	Some of the metrics being used by ACHP plans include: • Total cost of care • Hospital readmissions and ED utilization • Consumer satisfaction
Patient Centered Care & Coordination (360º degree care) - Practice acts as a primary coordinator of all care (including care received at inpatient and outpatient sites). Plan provides support and information to facilitate 360º care.	• The practice actively reviews cases of patients who are receiving care at other sites and coordinates transitions in care. • The integrator works to ensure patients are seen within the practice within 14 days or less of being discharged from the hospital
Value-Based Practice Reimbursement – Outside of FFS, payer provides infrastructure support for the medical home, with an ultimate goal of getting to outcomes-based payment.	• Infrastructure grants for developing electronic medical records • Incentive payments based on quality and efficiency performance • Capitated payments to support activities like care coordination not reimbursed in FFS

*could be a health plan, an ACO, large multi-specialty group practice/integrated delivery system, regional collaborative