ACHP’s Patient Center Medical Home & Payment Reform
A Report from the Trenches

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

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Percentage Aligned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital District Physicians' Health Plan</td>
<td>100</td>
</tr>
<tr>
<td>Capital Health Plan</td>
<td>100</td>
</tr>
<tr>
<td>CareOregon</td>
<td>67.5</td>
</tr>
<tr>
<td>EmblemHealth</td>
<td>100</td>
</tr>
<tr>
<td>Fallon Community Health Plan</td>
<td>100</td>
</tr>
<tr>
<td>Geisinger Health Plan</td>
<td>100</td>
</tr>
<tr>
<td>Group Health Cooperative - Madison</td>
<td>19</td>
</tr>
<tr>
<td>Group Health Cooperative - Seattle</td>
<td>33</td>
</tr>
<tr>
<td>HealthPartners</td>
<td>70</td>
</tr>
<tr>
<td>Independent Health Association</td>
<td>100</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>100</td>
</tr>
<tr>
<td>Martin’s Point</td>
<td>100</td>
</tr>
<tr>
<td>New West Health Services</td>
<td>86</td>
</tr>
<tr>
<td>PresbyterianHealth Plan</td>
<td>100</td>
</tr>
<tr>
<td>Priority Health</td>
<td>100</td>
</tr>
<tr>
<td>Scott &amp; White Health Plan</td>
<td>50</td>
</tr>
<tr>
<td>Security</td>
<td>55</td>
</tr>
<tr>
<td>Tufts</td>
<td>100</td>
</tr>
<tr>
<td>UCARE</td>
<td>100</td>
</tr>
<tr>
<td>UPMC Health Plan</td>
<td>50</td>
</tr>
</tbody>
</table>

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

- Reimbursement Model
- Practice Transformation
- Reduced Cost Trend ($PM/PM)

Practice Metrics (Leading Indicators)
Global Metrics (Lagging Indicators)
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
Jim.Byrne@priorityhealth.com
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

- 85% Base Pay (FFS or Capitation)
  - 15% P4P

- 15% Increase overall comp
  - 77% Base (Added payment for phone, group, after-hours, and e-visits)
  - 3% Infrastructure (grants)
  - 20% P4P

- ?% Increase
  - 70% Risk-adjusted Capitation & FFS
  - 10% Infrastructure
  - 20 % P4P

- 2008
- 2009-10
- 2011 – 2012 Theoretical
## 2010 Partners in Performance Preventive Health

<table>
<thead>
<tr>
<th>Measures</th>
<th>Award</th>
<th>HMO/POS</th>
<th>SF/PPO</th>
<th>Medicare</th>
<th>Target</th>
<th>Medicaid</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammography</td>
<td>$10</td>
<td>✓</td>
<td>✓</td>
<td>79%</td>
<td>✓</td>
<td>✓</td>
<td>63%</td>
</tr>
<tr>
<td>Cervical Cancer Screenings</td>
<td>$10</td>
<td>✓</td>
<td></td>
<td>88%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood Immunizations</td>
<td>$175</td>
<td>✓</td>
<td></td>
<td>86%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well Child Visits 3-6 Years</td>
<td>$60</td>
<td>✓</td>
<td></td>
<td>85%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recorded BMI Level</td>
<td>$0.15 pmpm</td>
<td>✓</td>
<td></td>
<td>90%</td>
<td>✓</td>
<td>✓</td>
<td>90%</td>
</tr>
<tr>
<td>Chlamydia Screenings</td>
<td>$15</td>
<td>✓</td>
<td>✓</td>
<td>54%</td>
<td>✓</td>
<td>✓</td>
<td>69%</td>
</tr>
</tbody>
</table>
## 2010 Partners in Performance Disease Management

<table>
<thead>
<tr>
<th>Measures</th>
<th>Award</th>
<th>HMO/POS</th>
<th>SF/PPO</th>
<th>Medicare</th>
<th>Target</th>
<th>Medicaid</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Care: Controlled HbA1c &lt;7%</td>
<td>$50</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>TBD</td>
<td>✓</td>
<td>TBD</td>
</tr>
<tr>
<td>Diabetes Care: Controlled HbA1c &lt;8%</td>
<td>$50</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>TBD</td>
<td>✓</td>
<td>TBD</td>
</tr>
<tr>
<td>Diabetes Care: Controlled LDL-C</td>
<td>$80</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>54%</td>
<td>✓</td>
<td>45%</td>
</tr>
<tr>
<td>Diabetes Care: Annual Retinal Exam</td>
<td>$25</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>74%</td>
<td>✓</td>
<td>71%</td>
</tr>
<tr>
<td>Diabetes Care: Monitoring for Nephropathy</td>
<td>$25</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>89%</td>
<td>✓</td>
<td>85%</td>
</tr>
<tr>
<td>Diabetes Care: Controlled Blood Pressure</td>
<td>$100</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>42%</td>
<td>✓</td>
<td>42%</td>
</tr>
<tr>
<td>Optimal Diabetes Care</td>
<td>$200</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>30%</td>
<td>✓</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>$125</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>25%</td>
<td>✓</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>$75</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>✓</td>
<td>20%</td>
</tr>
<tr>
<td>Hypertension: Controlled Blood Pressure</td>
<td>$75</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>72%</td>
<td>✓</td>
<td>67%</td>
</tr>
<tr>
<td>Asthma Medication Management</td>
<td>$100</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>TBD</td>
<td>✓</td>
<td>TBD</td>
</tr>
<tr>
<td>Avoidance of Antibiotic Treatment in Adults with Bronchitis</td>
<td>$50</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>31%</td>
<td>✓</td>
<td>TBD</td>
</tr>
</tbody>
</table>
## 2010 Partners in Performance

<table>
<thead>
<tr>
<th>Measures</th>
<th>Award</th>
<th>HMO / POS</th>
<th>SF/ PPO</th>
<th>Medicare</th>
<th>Target</th>
<th>Medicaid</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Lab Monitoring of Patients on Persistent Medication</td>
<td>$25</td>
<td>✓</td>
<td></td>
<td></td>
<td>84%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e-Prescribing</td>
<td>$0.25 pmpm</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>50%</td>
<td>✓</td>
<td>50%</td>
</tr>
<tr>
<td>Patient Registry Utilization</td>
<td>$0.25 pmpm</td>
<td>✓</td>
<td>✓</td>
<td>Standards Met</td>
<td>✓</td>
<td>Standards Met</td>
<td></td>
</tr>
<tr>
<td>Generic Prescriptions Filled: Pediatric Patient Population</td>
<td>Shared Savings</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>71%</td>
<td>✓</td>
<td>71%</td>
</tr>
<tr>
<td>Generic Prescriptions Filled: Selected Therapeutic Classes – Adult Population</td>
<td>Shared Savings</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>78%</td>
<td>✓</td>
<td>78%</td>
</tr>
<tr>
<td>ED Visits per 1,000</td>
<td>Shared Savings</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>125</td>
</tr>
</tbody>
</table>
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
Chief Medical Officer
drfoels@independenthealth.com
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**
- Training
- Change Mgt
- Systems Change

**Outcomes**
- “Triple Aim”
- Quality
- Cost
- Experience
Measurement
### Measurement: Triple Aim

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

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

- 30% Increase
- Fee-For-Service
  - P4P Payment
- Fee-For-Service (monthly)
  - P4P Payment
- Capitation Payment (monthly)
- 2008
- 2009-10
- 2011
“The Special Sauce”
Creating the PCMH
Creating the PCMH
## Creating the PCMH

<table>
<thead>
<tr>
<th>Technical Change</th>
<th>Adaptive Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>“Recipe”</strong></td>
<td><strong>“Just the Ingredients”</strong></td>
</tr>
<tr>
<td>Solution exists, just apply it</td>
<td>Implementation process unclear</td>
</tr>
<tr>
<td>Problem well defined</td>
<td>Front line workers contribute</td>
</tr>
<tr>
<td>Leaders tell people what to do</td>
<td>Leaders empower others</td>
</tr>
</tbody>
</table>
Creating the PCMH

**Technical Change**

"Recipe"

- Solution exists, just apply it
- Problem well defined
- Leaders tell people what to do

**Adaptive Change**

"Just the Ingredients"

- Implementation process unclear
- Front line workers contribute
- 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

- **30% Increase**

- **Fee-For-Service**
  - P4P Payment
  - 2008

- **Fee-For-Service**
  - Care Coordination Payment (monthly)
  - P4P Payment
  - 2009-10

- **Capitation Payment (monthly)**
  - P4P Payment
  - 2011
Priority Health Reimbursement Model

- **85% Base Pay** (FFS or Capitation)
  - **15% P4P**

- **15% Increase overall comp**
  - **77% Base** (Added payment for phone, group, after-hours, and e-visits)
  - **3% Infrastructure (grants)**
  - **20% P4P**

- **70% Risk-adjusted Capitation & FFS**
  - **10% Infrastructure**
  - **20 % P4P**

- **2008**
- **2009-10**
- **2011 – 2012 Theoretical**
# Contact Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Title</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jim Byrne, MD</td>
<td>Priority Health</td>
<td>Chief Medical Officer</td>
<td><a href="mailto:jim.byrne@priorityhealth.com">jim.byrne@priorityhealth.com</a></td>
</tr>
<tr>
<td>Lynne Cuppernull</td>
<td>ACHP</td>
<td>Director, Learning &amp; Innovation</td>
<td><a href="mailto:lcuppernull@achp.org">lcuppernull@achp.org</a></td>
</tr>
<tr>
<td>Duane Davis, MD</td>
<td>Geisinger</td>
<td>Chief Medical Officer &amp; VP</td>
<td><a href="mailto:dedavis@thehealthplan.com">dedavis@thehealthplan.com</a></td>
</tr>
<tr>
<td>Tom Foels, MD</td>
<td>Independent Health</td>
<td>Chief Medical Officer</td>
<td><a href="mailto:drfoels@independenthealth.com">drfoels@independenthealth.com</a></td>
</tr>
<tr>
<td>Bruce Nash, MD</td>
<td>Capital District Physician’s</td>
<td>Chief Medical Officer</td>
<td><a href="mailto:bnash@cdphp.com">bnash@cdphp.com</a></td>
</tr>
<tr>
<td></td>
<td>Health Plan</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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

Payment Reform

Practice Reform
Goals for Practice Reform

- NCQA Recognition
- Practice Transformation—Sustainability
- Care Management process—Quality
- Care Coordination process—Efficiency
Payment Reform – Compensation Today

CDPHP Today
- 90-94% FFS
- 6% Quality Payment
- $1pmpm Care mgmt Fee

Typical MH Pilot
- 10% Quality Payment
- $5pmpm Care mgmt Fee
- 80-90% FFS
Payment Reform – CDPHP Pilot

- **63% Risk-Adjusted Comprehensive Payment**: Targeted at improving base reimbursement approximately $35,000 to reflect increased costs of implementing and operating a medical home.

- **27% Bonus Payment**

- **10% FFS - RBRVS**

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

Risk Adjusted Base Payment

2 components:
PCAL & CF: PMPM = PCAL*CF

<table>
<thead>
<tr>
<th></th>
<th>Base</th>
<th>PCAL Increment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial HMO</td>
<td>$128.80</td>
<td>$60.69</td>
</tr>
<tr>
<td>Commercial non-HMO</td>
<td>$105.16</td>
<td>$49.65</td>
</tr>
<tr>
<td>Medicaid</td>
<td>$90.74</td>
<td>$42.74</td>
</tr>
<tr>
<td>Medicare</td>
<td>$101.83</td>
<td>$48.08</td>
</tr>
</tbody>
</table>

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
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)*

<table>
<thead>
<tr>
<th>Preventive Care - Adults</th>
<th>Doc A</th>
<th>Doc B</th>
<th>Doc C</th>
<th>Doc D</th>
<th>Group Total</th>
<th>Peer Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td># Num</td>
<td># Den</td>
<td>%</td>
<td># Num</td>
<td># Den</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of members who had a preventive care visit</td>
<td>86%</td>
<td>160</td>
<td>186</td>
<td>89%</td>
<td>124</td>
<td>140</td>
</tr>
<tr>
<td>Patients 42-69 years of age who had a screening mammogram in the last 12 months</td>
<td>83%</td>
<td>44</td>
<td>53</td>
<td>85%</td>
<td>28</td>
<td>33</td>
</tr>
<tr>
<td>Patients 50-80 years that had appropriate screening for colorectal cancer</td>
<td>25%</td>
<td>15</td>
<td>60</td>
<td>28%</td>
<td>11</td>
<td>40</td>
</tr>
<tr>
<td>Patients that had a cervical cancer screening test in the last 36 reported months <em>(new measure)</em></td>
<td>20%</td>
<td>2</td>
<td>10</td>
<td>40%</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Patients 16-25 years of age that had a Chlamydia screening in the last 12 months</td>
<td>72%</td>
<td>221</td>
<td>309</td>
<td>76%</td>
<td>165</td>
<td>218</td>
</tr>
<tr>
<td>Composite Preventive Quality Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Target
## Utilization Metrics: Independent Health

### Utilization Dashboard
**Example Family Practice**

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

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

*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

### Patient Satisfaction

<table>
<thead>
<tr>
<th>Metric Description</th>
<th>Group Total</th>
<th>Doc A</th>
<th>Doc B</th>
<th>Doc C</th>
<th>Doc D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patient surveys submitted</td>
<td>392</td>
<td>98</td>
<td>98</td>
<td>98</td>
<td>98</td>
</tr>
<tr>
<td>Overall Experience of Care: % of patients who would recommend doctor to family or friends?</td>
<td>71%</td>
<td>37%</td>
<td>63%</td>
<td>72%</td>
<td>70%</td>
</tr>
<tr>
<td>% of patients who feel doctor is fully informed of the care they receive from other doctors.</td>
<td>50%</td>
<td>45%</td>
<td>42%</td>
<td>45%</td>
<td>58%</td>
</tr>
<tr>
<td>% patients who feel doctor customizes their treatment according to their individual needs.</td>
<td>56%</td>
<td>40%</td>
<td>52%</td>
<td>61%</td>
<td>56%</td>
</tr>
<tr>
<td>% patients who feel doctor is effective at getting them to be responsible for their health.</td>
<td>51%</td>
<td>39%</td>
<td>42%</td>
<td>53%</td>
<td>55%</td>
</tr>
</tbody>
</table>

### Staff Satisfaction

<table>
<thead>
<tr>
<th>Metric Description</th>
<th>Group Total</th>
<th>Overall PCMH Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of staff surveys submitted</td>
<td>37</td>
<td>NA</td>
</tr>
<tr>
<td>Overall Rating of Team (0=worst; 10=best)</td>
<td>8.05</td>
<td>7.82</td>
</tr>
<tr>
<td>Team Loyalty: % of staff who would recommend the practice as a great place to work.</td>
<td>70%</td>
<td>41%</td>
</tr>
<tr>
<td>Empowerment: % of staff who feel they opportunities to use initiative and improve their work.</td>
<td>56%</td>
<td>38%</td>
</tr>
<tr>
<td>Team Morale: % of staff who feel that the people they work with cooperate, communicate and help each other.</td>
<td>84%</td>
<td>65%</td>
</tr>
<tr>
<td>Team Stress: % of staff who feel it is very stressful to work in the office.</td>
<td>3%</td>
<td>6%</td>
</tr>
<tr>
<td>% of staff who would recommend practice to family and friends.</td>
<td>84%</td>
<td>64%</td>
</tr>
</tbody>
</table>
ACHP PCMH Standards: Building on NCQA

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

<table>
<thead>
<tr>
<th>Standard</th>
<th>Example</th>
</tr>
</thead>
</table>
| **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