Post-conference Summit: Lessons Learned from Prometheus Pilot Sites

March 10, 2010

Agenda

- Review of the Prometheus Payment model and Implementation process
- Jim Byrne, MD, Priority Health
- Chris McTiernan, Independence Blue Cross
- Paul Brand, Employer's Coalition on Health
- Q&A

Overview of Prometheus Pilot Implementation Process

Doug Emery, MS

Program Implementation Manager

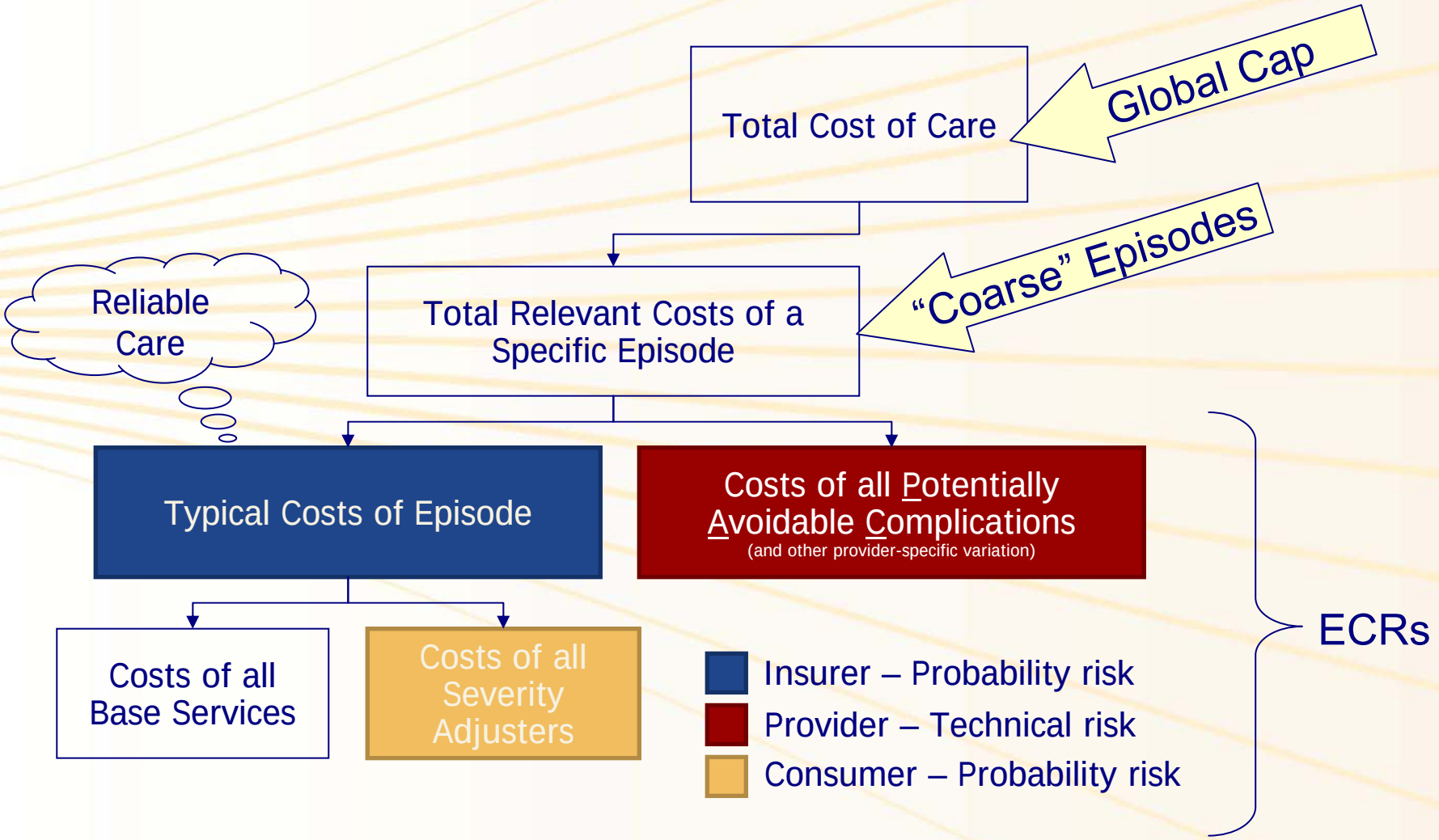
Agenda

- First Steps: Introduction to Methods
- Creating the Implementation Team
- Scoping the Project
- The Engine
- Two Channel Feedback System
- Observations

Methods

- Risk Bifurcation
- Evidence-informed Case Rates (ECR)
- Typical vs PAC
- Performance Measures
- Scorecard
- Glide Path

Risk Bifurcation



ECRs

Datasets

Code Sets & Rules

Statistical Models

ECR Working Group Definitions

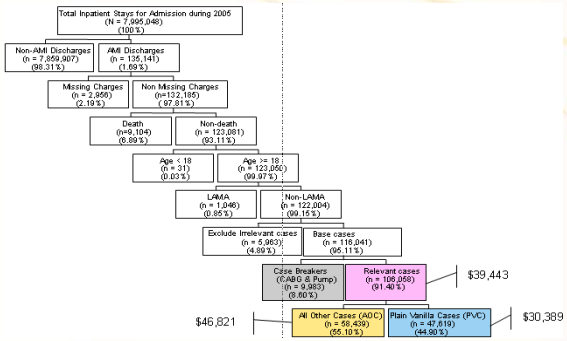
Underuse & Care Coordin

PAC Allowance

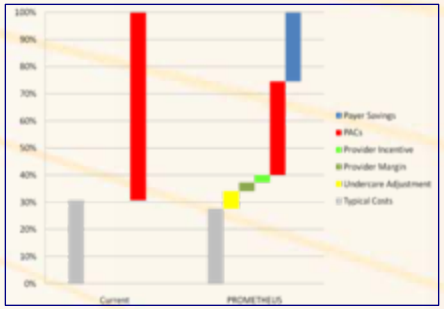
Step 1: Defining boundaries and slicing data

Step 2: Risk Adjustment for Typical Popul

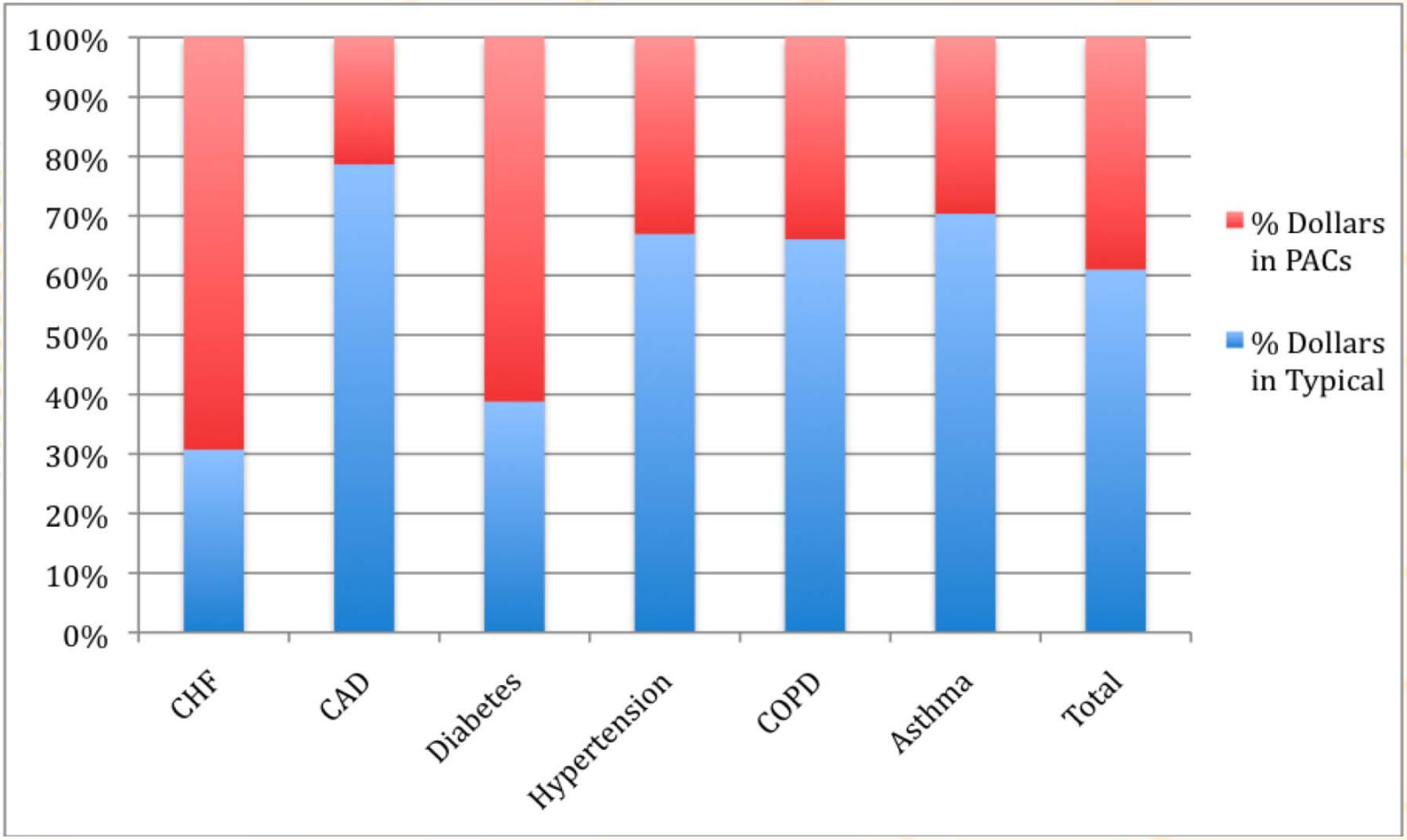
Step 3: PAC Allowance & Pricing the ECR



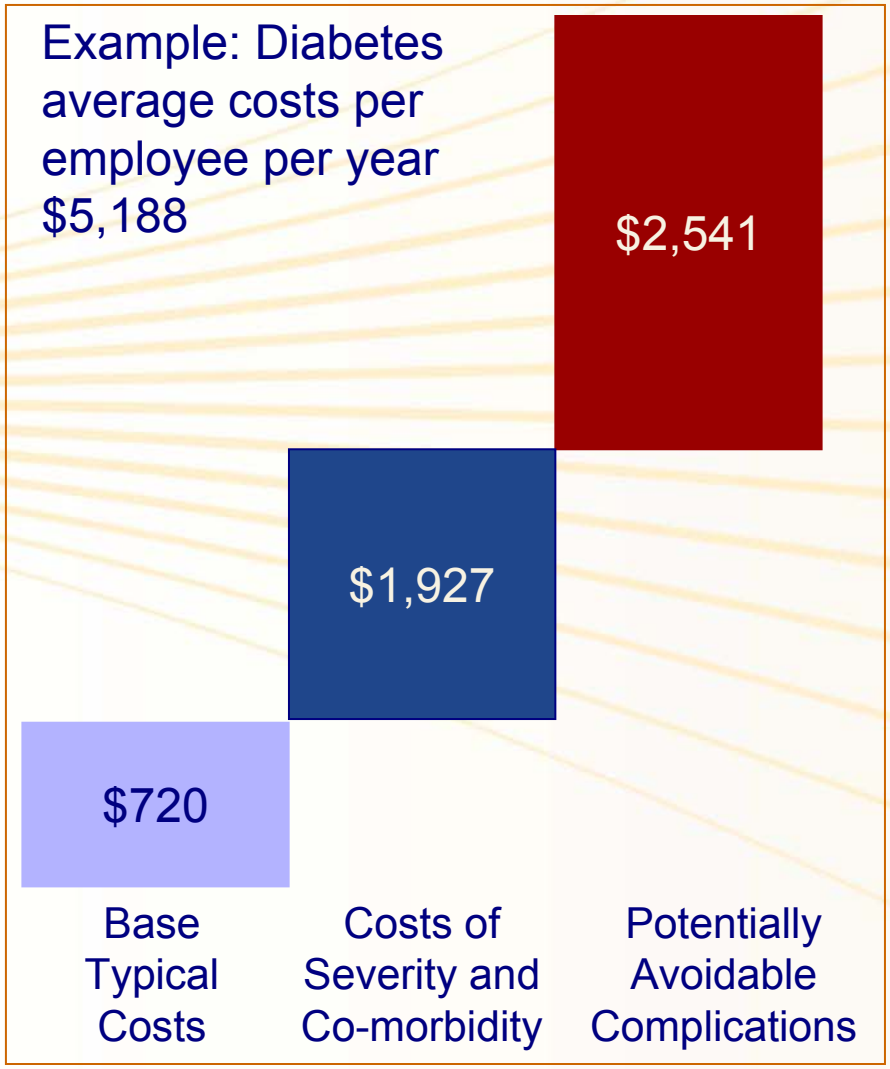
Variables	N	Ln Coefficient	Patient 1	Patient 2	Patient 3
Intercept	47,619	9.09215	1	1	1
PTCA, thrombolysis	29,200	0.75062	1	1	
Diagnostic cardiac catheterization, coronary arteriography	38,982	0.44984	1	1	1
Insertion of Balloon Pump	566	0.21249	1		
Blood transfusion	1,008	0.13689	1		
Diagnostic ultrasound of heart	2,696	0.04997			1
Congestive heart failure; nonhypertensive	11,542	0.09316	1		
Cardiac dysrhythmias	12,111	0.06205	1		
Coronary atherosclerosis and other heart disease	46,153	0.03266	1	1	1
Admission source: ER vs. Other/Another hosp	33,521	0.11723	1	1	
Bed size of hosp: Large vs. Medium/Small	36,394	0.07421	1	1	
Disp of patient (uniform): Other facility vs. routine/Short-term hosp	3,357	0.11833	1		
Race (Uniform). Black vs. White/NAm/Unk	2,768	0.06705			1
Admission day is a weekend	39,672	0.03334	1		1
Med House $ quartile for patient zip: $1 to <37k vs $37k to <61k	14,398	-0.00362			1
Evidence-informed Amount (No Technical Risk)			$71,180	$36,927	$16,870



Typical vs PAC



Measuring and managing financial risk with ECRs



- Transparency
- Provider re-engineering
- Payment/Compensation
- Benefit Design

- Benefit Design
- Disease Management
- Care Coordination

- Population Health

Plan-controlled activities

A tailored Scorecard for each Practice

- Physicians will be assessed using chronic condition modules that contain specific process measures
- A total Quality Scorecard will be developed based on a patient mix-weighted calculation

Illustrative

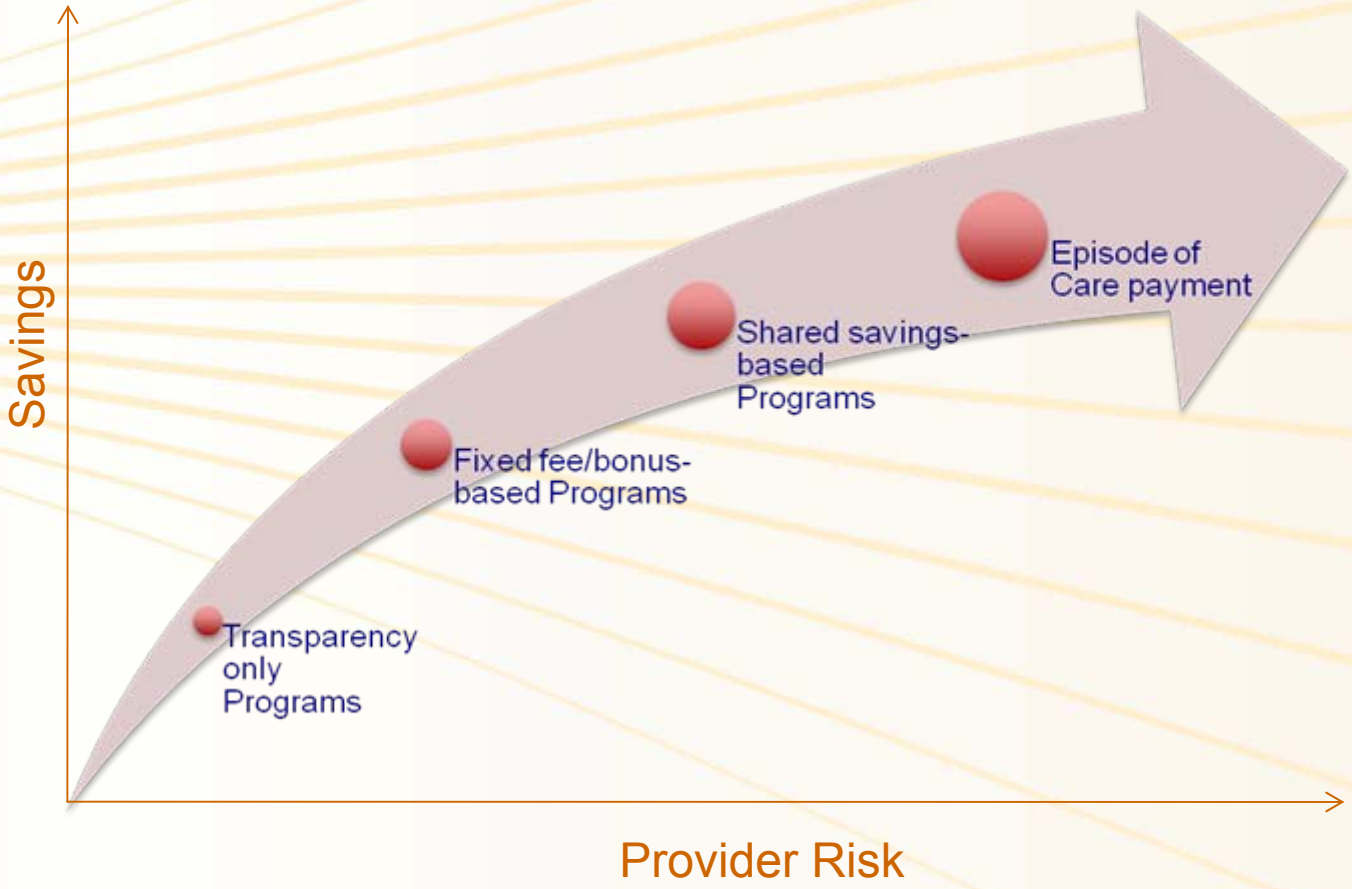
Chronic Obstructive Pulmonary Disease (COPD) Care

Clinical Measure	Points Per Measure	Num/Den Result	Points Awarded (Points per Measure x Num/Den Result)
Process Measures			
Lung Function/Spirometry Evaluation	10	89%	8.90
Inhaled Bronchodilator Therapy	10	97%	9.70
Smoking Status Cessation Advice & Treatment	20	87%	17.40
Assessment of COPD Exacerbations	10	95%	9.50
COPD Exacerbation Therapy	10	86%	8.60
Assessment of O2 Saturation	10	93%	9.30
Long-Term O2 Therapy	15	91%	13.65
Pneumococcal Vaccination	5	90%	4.50
Influenza Vaccination	10	95%	9.50
Total	100		91.05

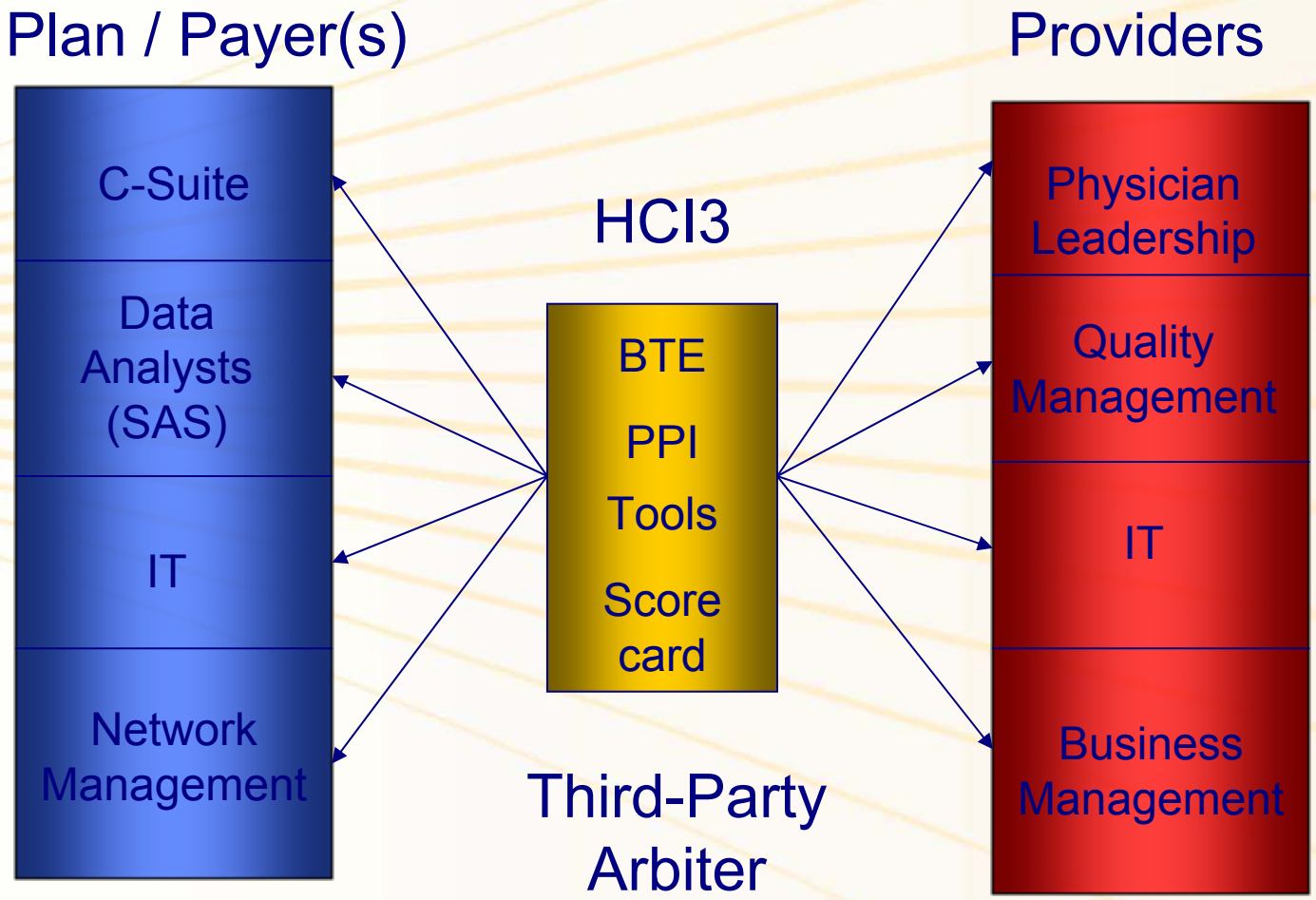
Illustrative

	Possible Points	Actual Points	% of Patients	Weighted Score (Actual points x % of patients)
COPD Care	100	91.05	40.0%	36.42
Hypertension Care	100	68.65	15.0%	10.30
Cardiac Care	100	74.90	7.5%	5.62
Diabetes Care	100	68.80	15.0%	10.32
Heart Failure Care	100	59.71	2.5%	1.49
Asthma Care	100	33.79	20.0%	6.76
Total	600	396.90	100%	70.91

Glide path for payment reform



The Implementation Team



Scoping the Pilot

- Schema – relationships of stakeholders
- Normalization – getting to baseline and understanding of opportunities
- Narrow*ize* – deciding where to start and how to make it work
- Project Plan Dashboard – tracking the implementation

The Engine

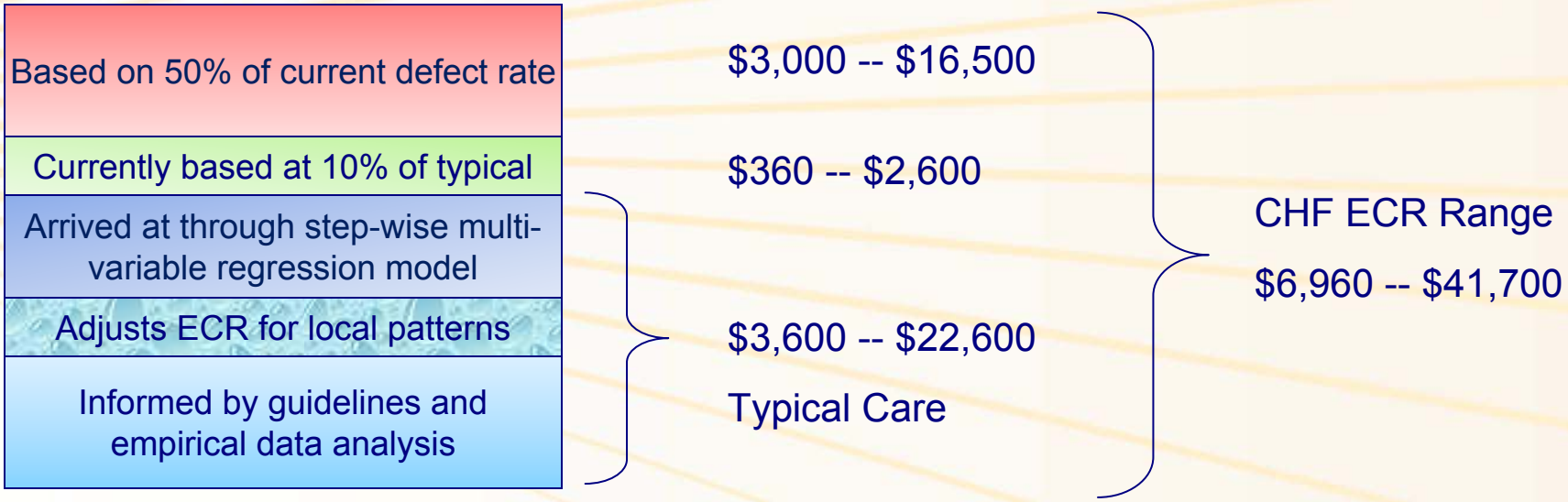
- A Medical Credit and Debit System
- Budget Calculations
- Engine Architecture
- Virtual Integration

Credits (Prospective Budget)
Debits (Retrospective Actual)

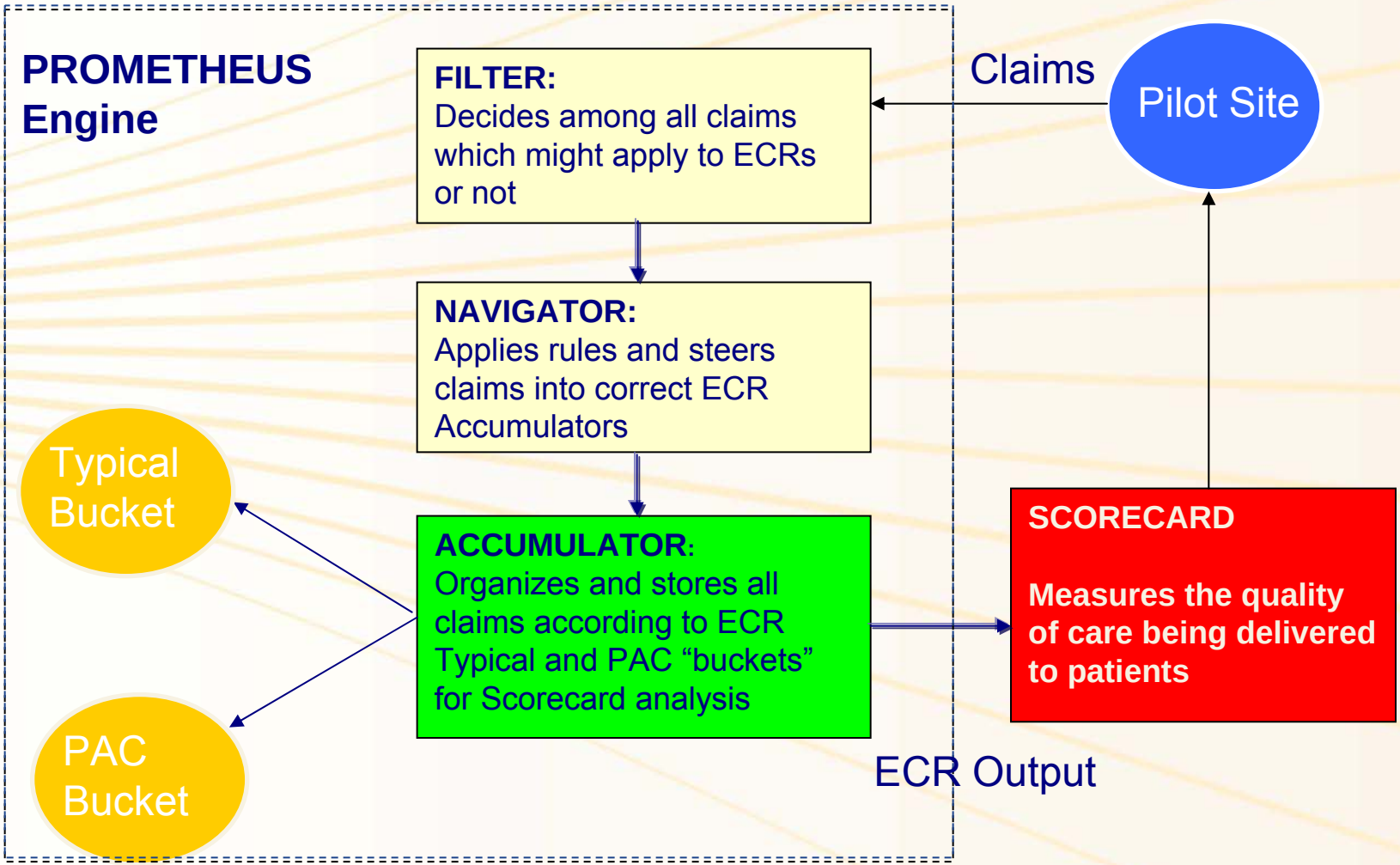
- The Engine is a combination of a claims tracking and financial accounting system, along with a scorecard that uses both claims and other data, including medical record data, to measure the quality of care that is being delivered to patients

Engine Calculates Budgets

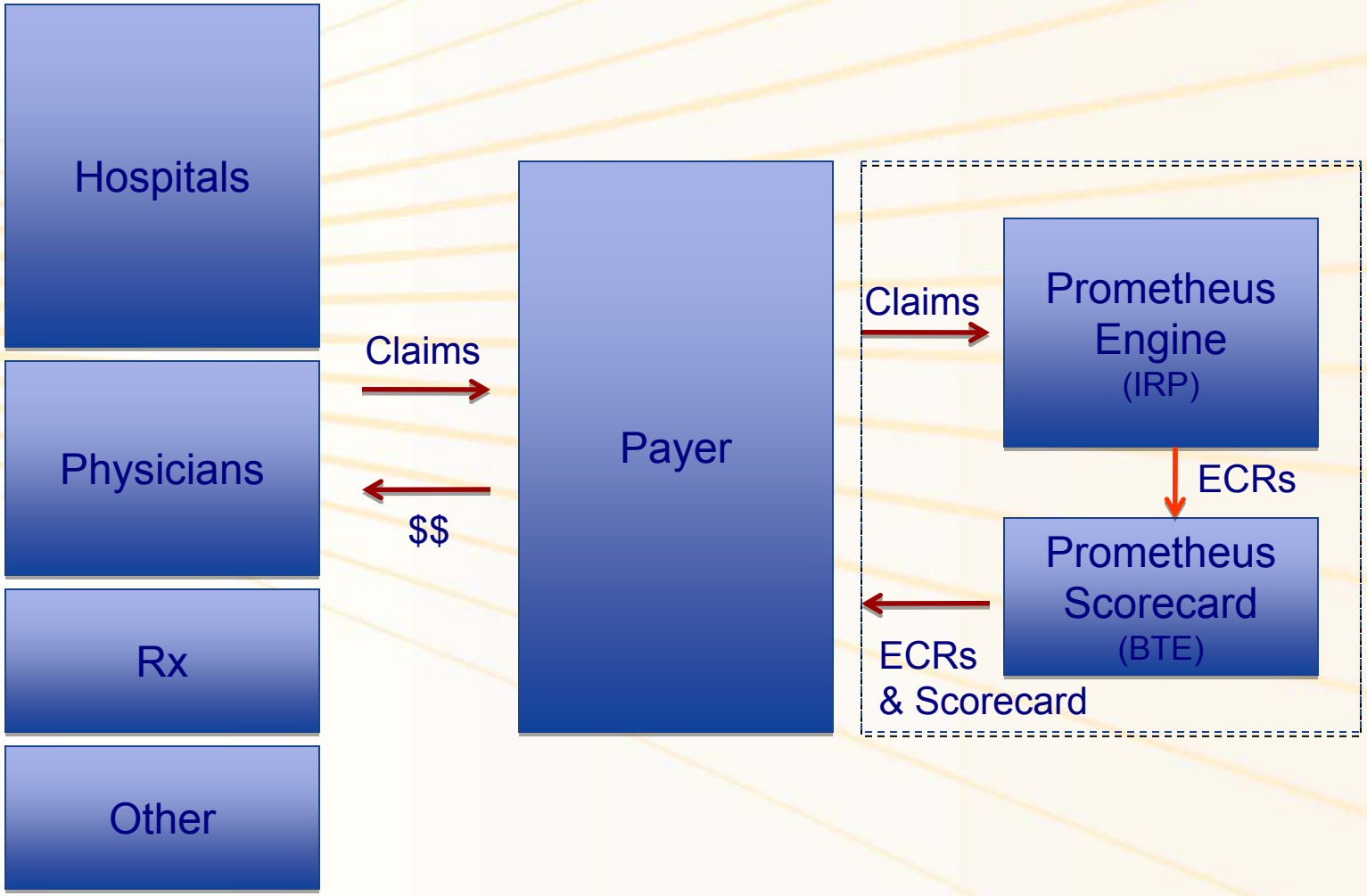
Total ECR price = Type of services * Frequency * Price per service



Engine Architecture



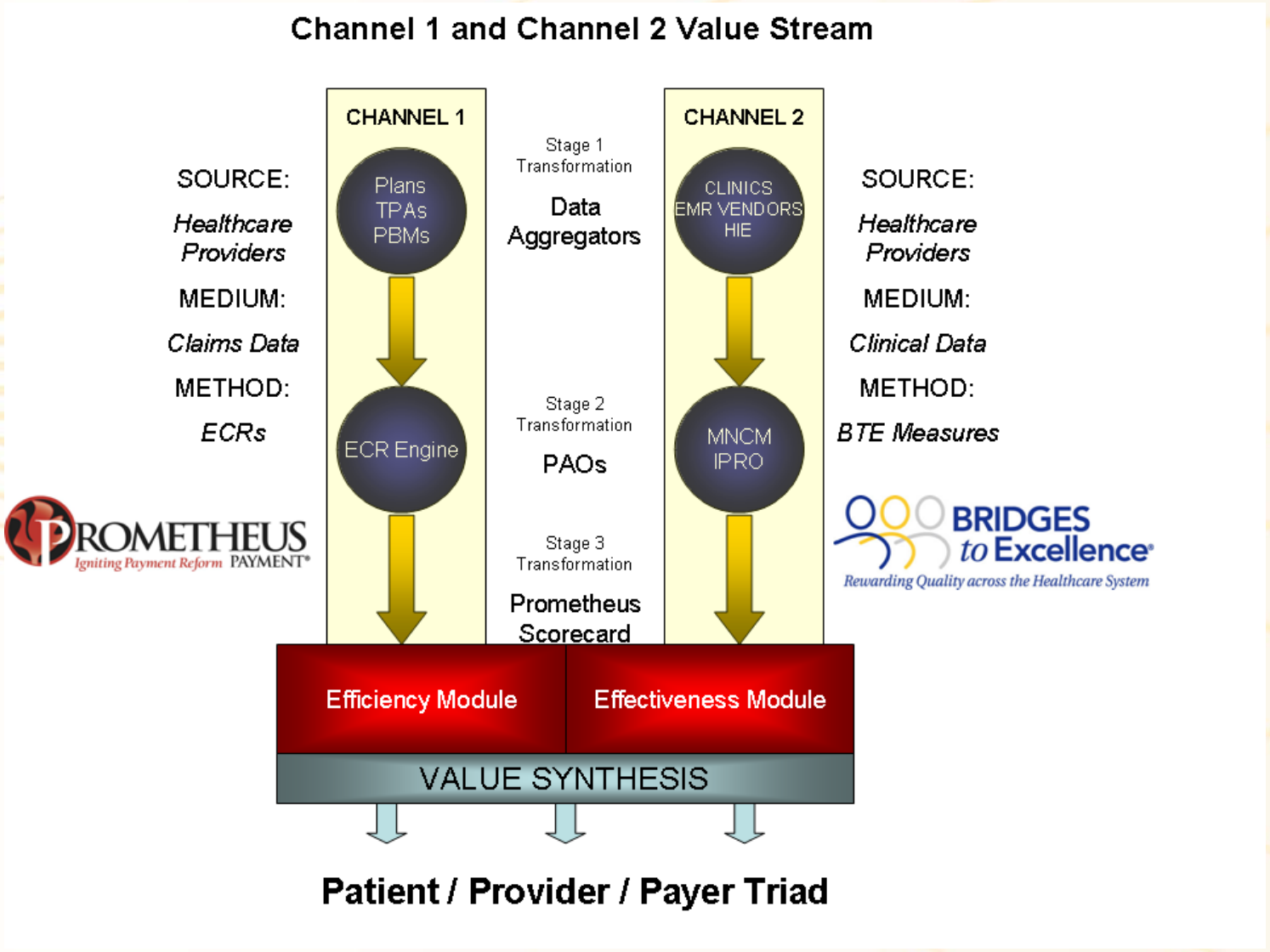
“Virtual” Integration



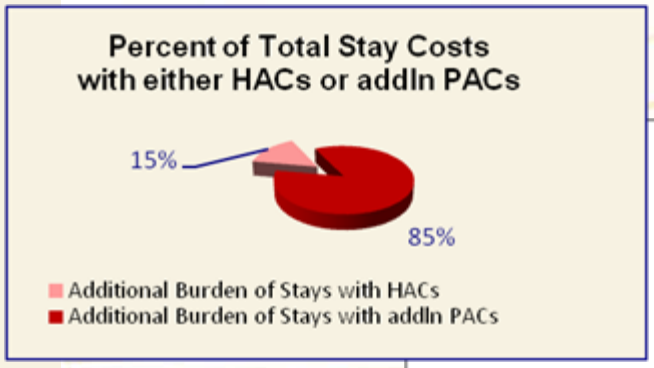
Two Channel Feedback System

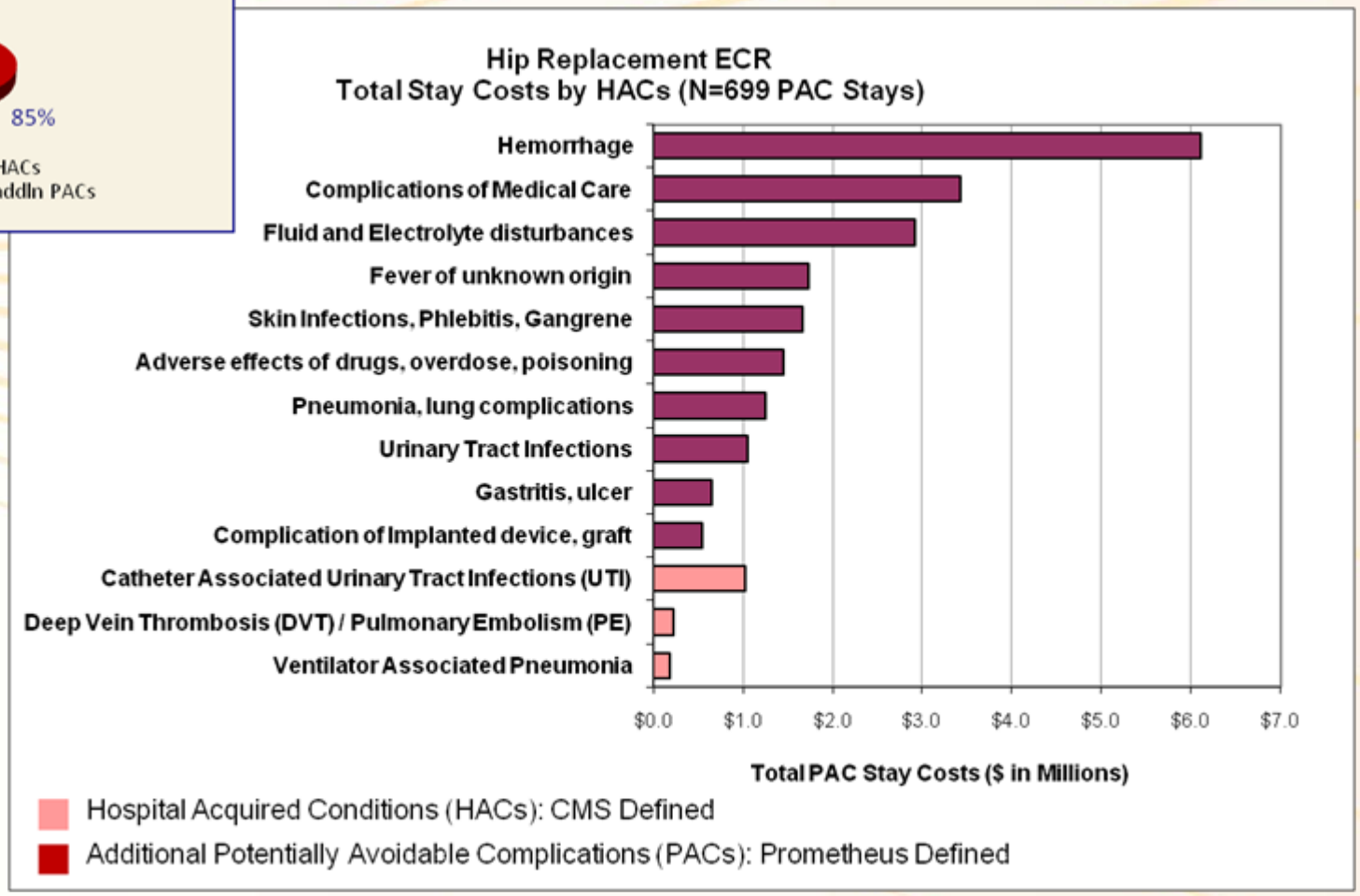
- How BTE and Prometheus Fit Together
- Feedback for Providers
- Feedback for Consumers

Prometheus / BTE Synthesis



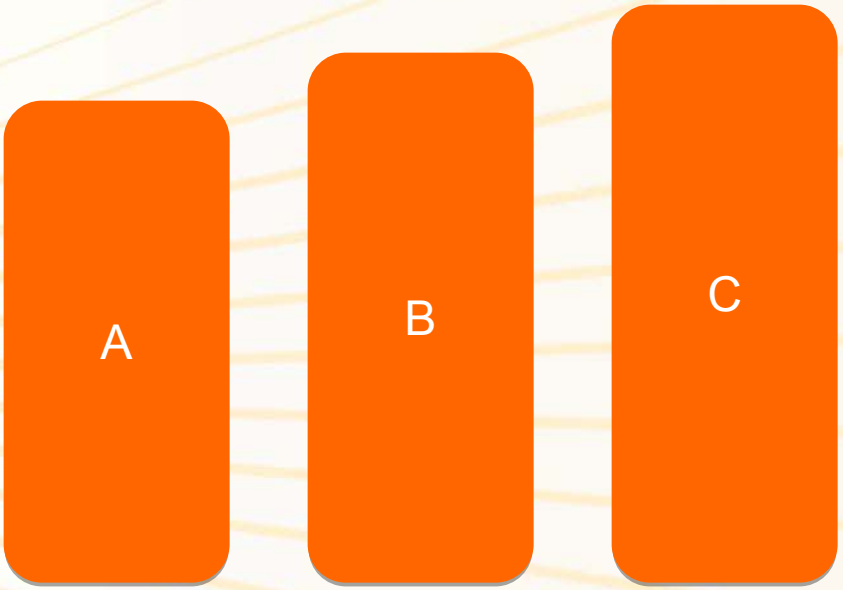
Provider Feedback





Consumer Engagement

Episode of CHF



Episode Cost	$25,500	$27,500	$30,000
Quality Score	82	90	92
Value Index	311	**305**	326
Co-pay	$560	$0	$1,700

Value Index = Episode Price / Quality Score
Co-pay A = (311-305) * 90
Co-pay C = (326-305) * 90

Each "team" can improve by (1) increasing their quality score, (2) decreasing their episode price – provided they meet the min Q score of 80

Observations

- Be flexible and adaptable – all sites are different!
- Initial data run is essential
- C-suite leadership and dedication to act BIG
- Dedicated internal staff
- Project planning, management and scope
- Know your PAC rates!

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For contact information:
www.HCI3.org
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www.prometheuspayment.org

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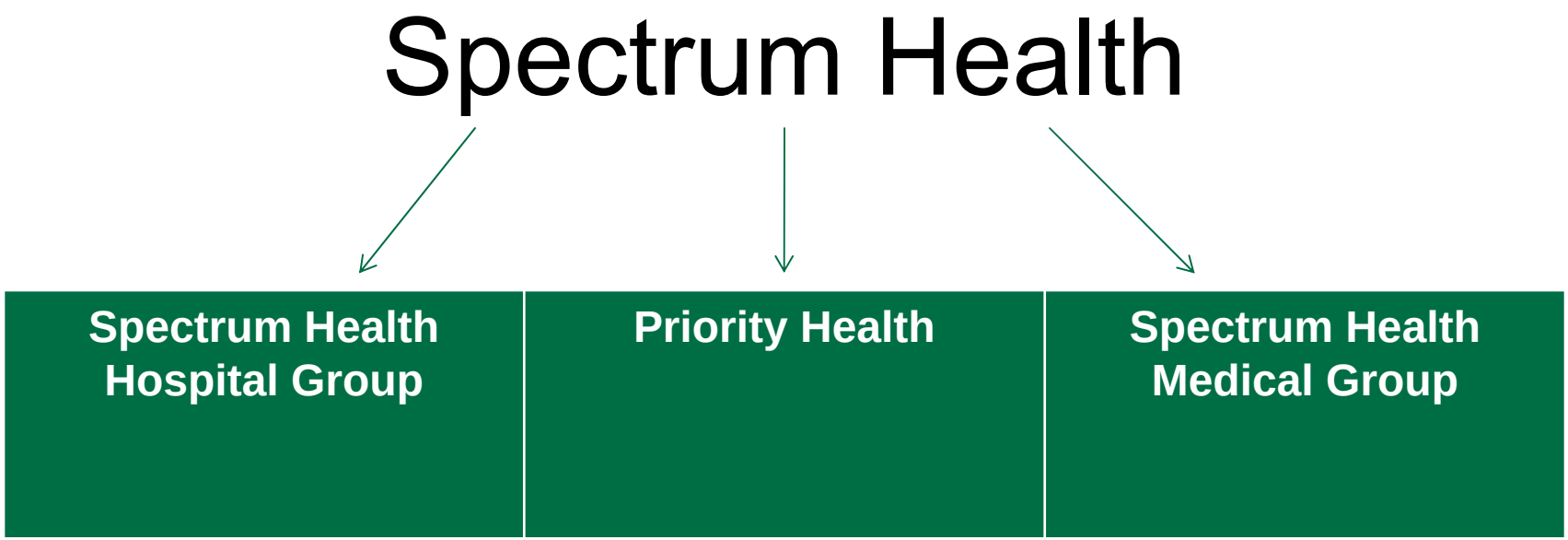
Bundled Payment as a Driver of Integration

National Pay for Performance Summit
March 10, 2010
San Francisco, CA

The Integrated System



Spectrum Health Hospital Group

- Two large urban hospital sites offering community hospital services + a broad range of tertiary services—Health Grades Top 5% three years in a row
  - Heart Center
  - Cancer Center
  - Children's Hospital
  - Three rural hospital sites
- Discussions with other systems
- Affiliations with MSU medical school and VanAndel Research Institute

Priority Health

- 580,000 member health plan
- State-wide presence, with a national network
- NCQA top 10% ranking for quality
- Broad variety of commercial products + Medicare and Medicaid
- Strong P4P since 1997

Spectrum Health Medical Group

- Multispecialty, >300 physicians
  - Primary care group
  - Children's Hospital sub-specialists
  - Recently added 200-physician multispecialty group
  - Recently added 30-physician cardiology group
- Relatively new, evolving and growing rapidly

Questions We've Been Asking Ourselves

How can we optimize these great resources to drive the Value Proposition?

Can we use economics to drive integration?

Do we wait for external forces to act or do we move proactively?

The Assessment of Prometheus: What We Like

- Focus on driving out waste (PACs, Channel 1) + quality (ECRs, Channel 2)
- Requirement for collaboration across the system
- Data-driven ECR selection
- BTE brings:
  - Objectivity of third party “referee”
  - Standardized IT engine, transparency
- Minimal financial risk from a system perspective
- Our strengths and weaknesses become apparent
- Scalability

The Assessment of Prometheus: What We Don't Like

- Must it be this complex? Yes, but…
- Are we ready for this? Probably not, but we have lots of reasons to make it work.
- Can we maintain momentum over a three year project timeline? Maybe.

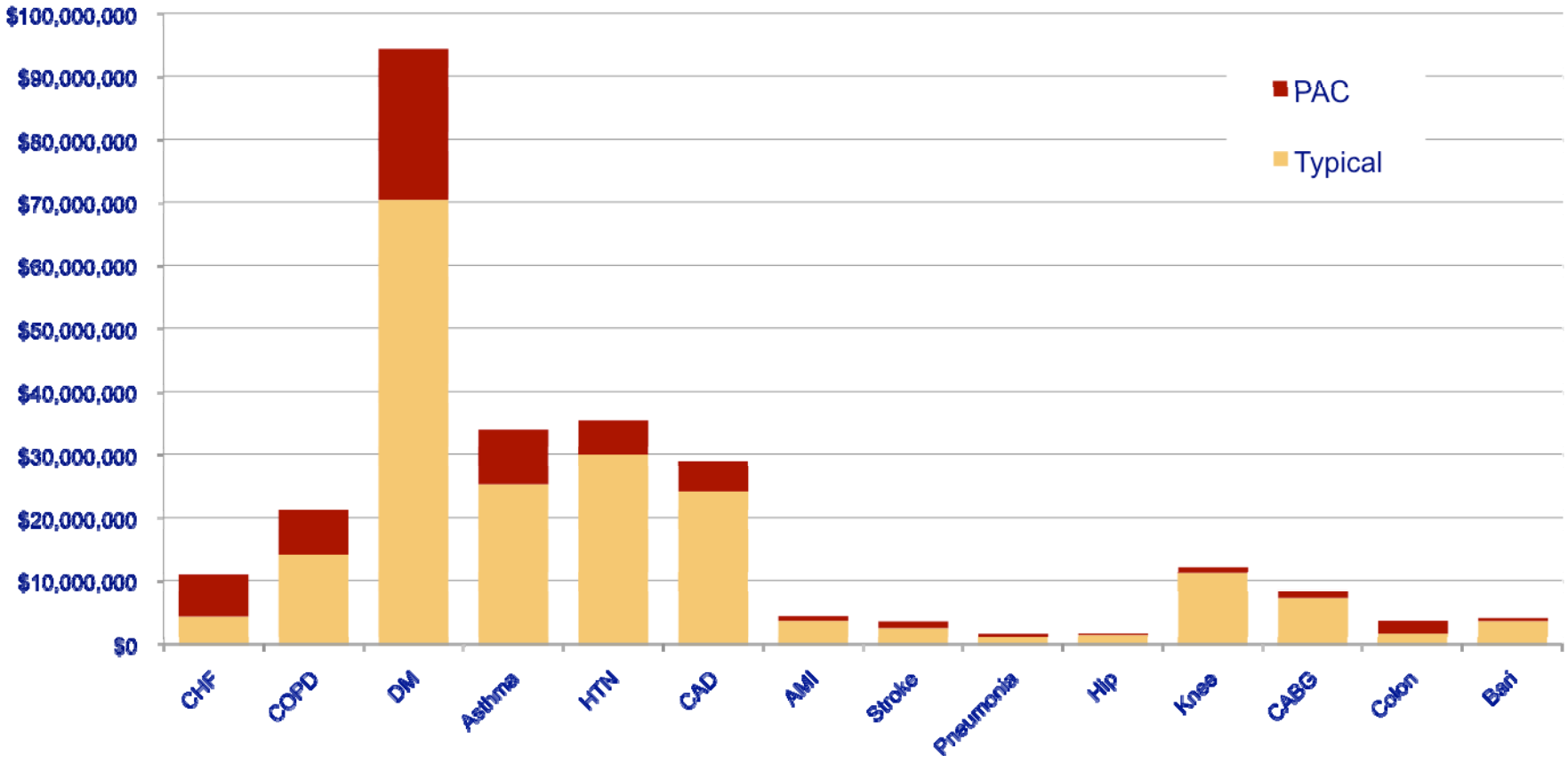
The Process

- Steering Committee
  - 18 members from across the system
  - Physician leadership, finance, IT, and PR
  - Decision making body
- Executive Committee
  - 6 members
  - Drive agenda, meet timelines, stay on track.

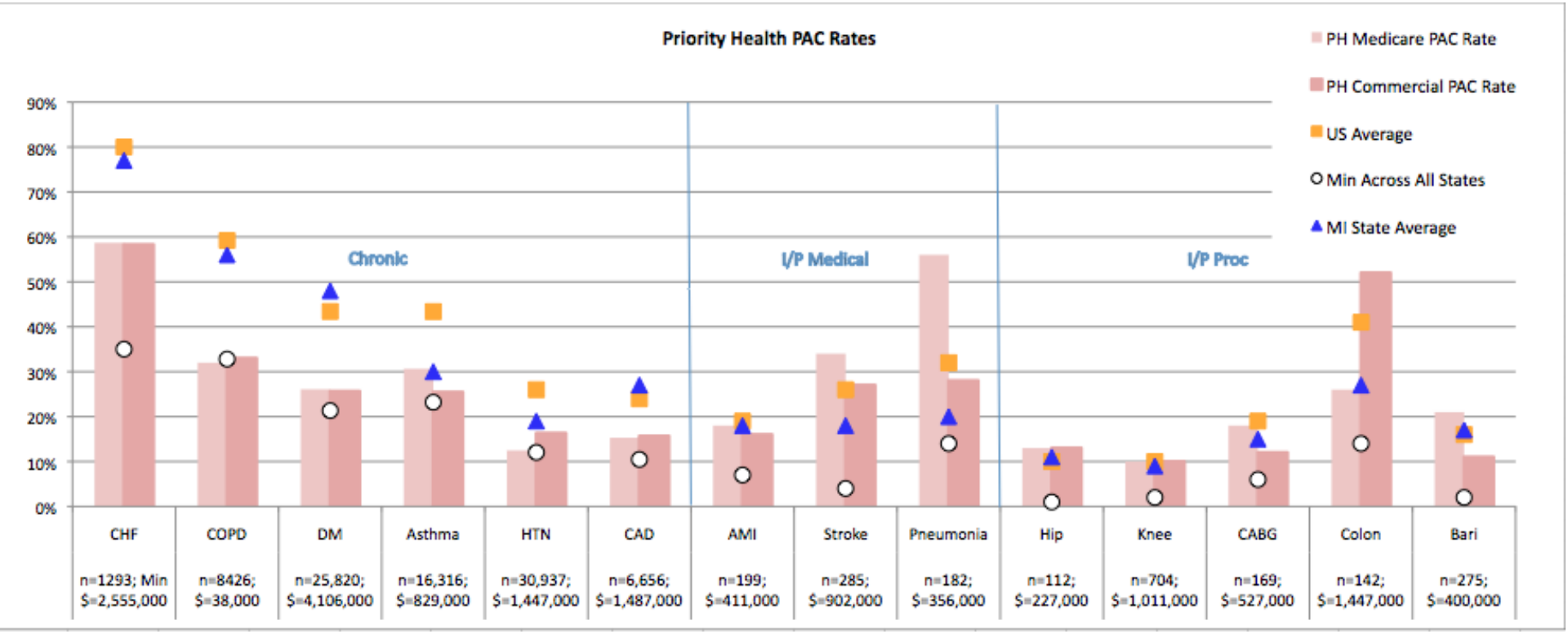
Major Milestones of Pilot

- 2009: Preparation
  - Establish joint operating teams & implement communications plan
  - Review plan-wide ECR data
- 2010: Development & reporting
  - Select ECRs
  - Develop baseline performance
  - Implement performance reporting system (Scorecards)
- 2011: Pilot program ‘go live’
  - Rollout pilot; initially no financial downside
  - Expand pilot to additional regional partners
- 2012: Full adoption
  - Full implementation of PROMETHEUS program with financial risk & rewards in place
  - Develop standardized methodology for comprehensive adoption of program aspects at conclusion of pilot

Total Costs Across All ECRs



PAC Rate Comparisons



Critical Questions—Next 60 Days

- Which ECRs will we work on? Decided 2/23/10:
  - CHF
  - Diabetes
  - Chronic lung disease
  - Colorectal surgery
- How will the payment model work?
  - Bonus arrangements for providers
  - Withhold?
  - “Reset” or stable payment rates after year 1?
- Can we fully implement in 2011, or must we wait until 2012?

Independence Blue Cross

Prometheus Payment
Pilot Project Overview

March, 2010

About Independence Blue Cross

Independence Blue Cross is a leading health insurer in southeastern Pennsylvania. Nationwide, Independence Blue Cross and its affiliates provide coverage to nearly 3.3 million people. For more than 70 years, Independence Blue Cross has offered high-quality health care coverage tailored to meet the changing needs of members, employers, and health care professionals. Independence Blue Cross's HMO and PPO health care plans have consistently received the highest ratings from the National Committee for Quality Assurance.

Independence Blue Cross supports comprehensive health care reform that would extend coverage to all Americans, reduce costs, and improve quality. We also advocate reform that builds on the current employer-based system that currently serves 170 million Americans. Learn more about our views on health care legislation now working its way through Congress by visiting our website at www.ibx.com/about_ibc/health_care_reform.

Independence Blue Cross is an independent licensee of the Blue Cross and Blue Shield Association.

Independence Blue Cross Pilot Project Background

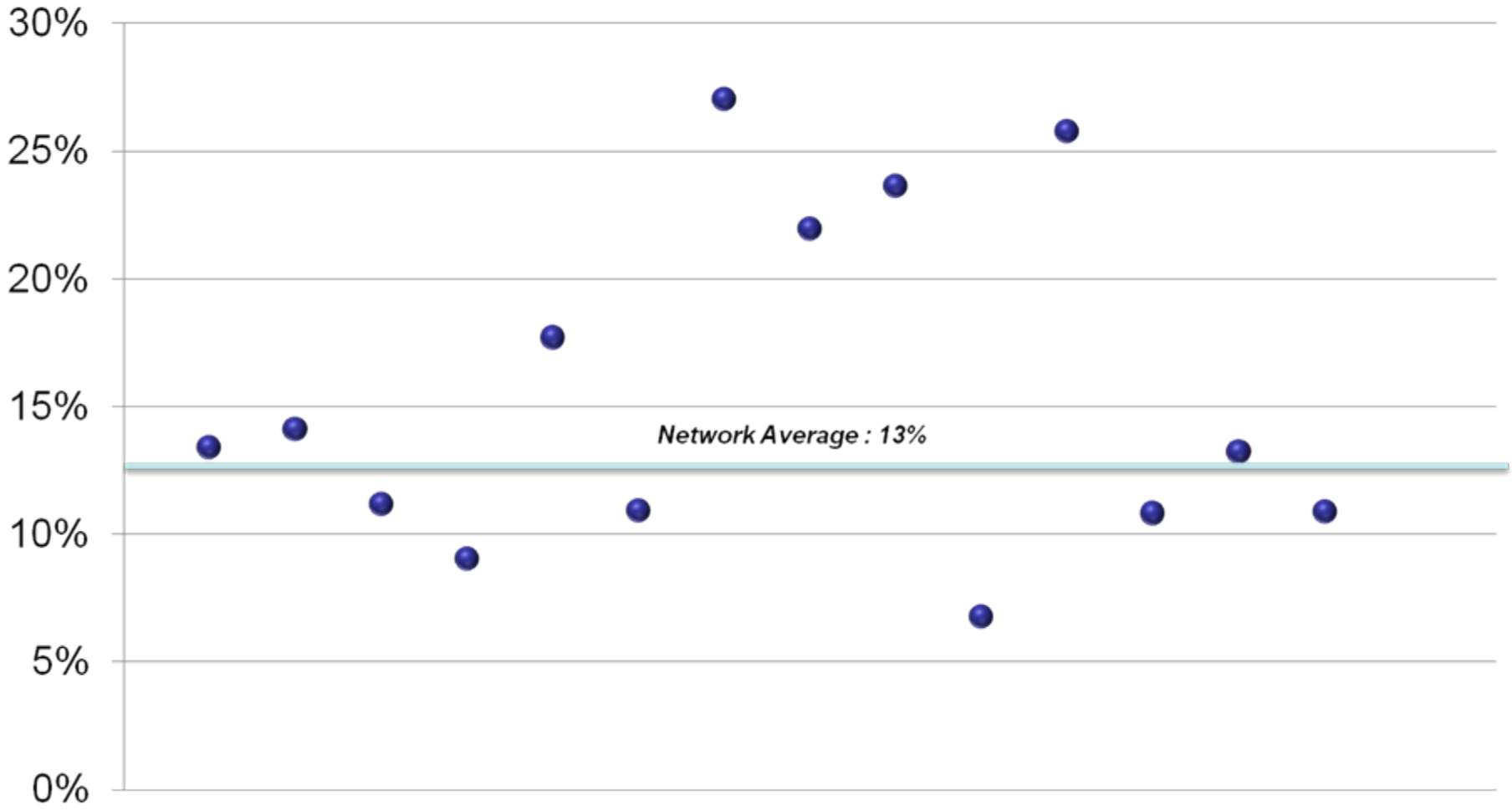
- Approached by multi-hospital health system in late 2008 to evaluate Prometheus Payment as potential P4P model
- Parties had recently concluded a difficult contract negotiation in early 2008
- IBC Motivation:
  - Provide revenue/profit opportunity outside of traditional unit cost increases
  - Medical cost containment via hospital / physician collaboration
  - Leverage 3rd party program to mitigate “trust” issues
- Hospital Motivation:
  - Get ahead of payment reform curve (i.e. expected CMS changes)
  - Provide mechanism for collaborating with medical staff
  - Provide differentiator in competitive Orthopedic market (entry of “premier” group)
- Pilot initially focused on Hip and Knee replacements for commercial population:
  - Hip replacements eliminated due to low volume
  - Medicare Advantage knee replacements added to increase opportunity
- Expectation is to “Go-Live” within the next few months

Implementation Process Overview

Key Activities	• Internal resource identification – Clinician & SAS Programmer • Mapping data warehouse output to Prometheus program • Data validation – Prometheus evaluation
Findings / Issues	• Data mapping time consuming but relatively straightforward • Multiple versions of Prometheus program as algorithms were being refined (as expected in pilot site) • Training and patience required to understand Prometheus data output
Other	• Important to have strong SAS resource and multidisciplinary team to evaluate results

Key Activities	• Evaluation of PAC Rates / Costs • Sample size evaluation - Stability of PAC Rates over time . IBC ran 3 Year model and currently updating it to include a 4th year
Findings / Issues	• Significant variation across network that was relatively consistent over time • Network potentially avoidable complication (PAC) rate of 13.4% vs. Prometheus benchmark of 10.3% • Hospital specific PAC rate range of 7% - 27% • Claims re-pricing required to bring historical rates to currently negotiated reimbursement • Based on provider allowed amount to partially control for benefit mix differences. Does not control for benefit caps/limits etc (i.e. 20 PT visits) • Identified a need to control for members with and without Rx benefit (relatively minor issue for Knee replacements) • IBC capitated programs (i.e. PT, Radiology) may require product specific rates (under evaluation)

PAC Allowed as % of Total Allowed
Hospitals with > 30 Cases



Key Activities	• Contract amendment • *ECR Negotiation*: Gross ECR Rate - PAC Reduction = Net ECR Case Rate • Administrative Terms: Term, settlement timing, issue resolution, etc.. • Quality Incentive component
Findings / Issues	• Contract Amendment – Prometheus template amendment generally acceptable to both parties. • Both parties approach has generally been to follow the standard Prometheus model rather than negotiate adjustments and increase administrative complexity • Quality incentive may be postponed due to existing quality P4P program in place between IBC and CKHS • Negotiation focus is PAC rate reduction (e.g. what % of PAC rate do you credit towards Net ECR Case Rate – Year 1, Year 2+) • Too early to determine how ECR Case Rate negotiation intersects with unit cost negotiations (i.e. will they try and make up shortfalls at next unit cost negotiation)

Key Activities	• Projected to "Go-Live" in mid 2010
Findings / Issues	• Continuing to evaluate back-end processes and funds flow • Will likely begin measurement period while reporting & settlement period is fleshed out • *IBC Risk vs. Other Party Risk*: Continuing to evaluate funds flow back to self-insured and other Blue plans (i.e. Blue-card). May need to exclude certain classes of patients / members due to use of retrospective cash payment that is not tied into claims system • Internal plan accounting will become more complex as dollars grow (i.e. rating / pricing, accruals, charge backs etc..)
Other	• In the context of overall provider relationship, knee replacements represents relatively small component. Will begin to evaluate applicability and willingness to expand to other procedural ECRs (current list covers approximately 15 - 20% of CKHS admissions)

Closing

- Process has been slow due to initial maturity of the ECR – Most of the review work done on the provider / Prometheus end (i.e. provider did chart reviews to evaluate algorithm).
- IBC will evaluate CKHS performance to determine if implementation across network is appropriate.
- Program appears complex at first – but at the end of the day it's a global case rate with a negotiated allowance for complications. Plans / Providers will ultimately decide how complex they want to make the program.
- Program evaluation needs to be looked at through a relative lens (i.e. what are the alternatives).
- Funds flow and employer group / broker education will become critical if program expands. Purchasers and their agents will need to look beyond provider discounts in evaluation of plan's network.
- ECRs will need to expand and include downside risk to ultimately become a key components of the Plan / Provider relationship.

Prometheus Payment Model Implementation

Employers' Coalition on Health (ECOH)

Rockford IL

March 2010

ECOH
EMPLOYERS' COALITION ON HEALTH

TIME
IN PARTNERSHIP WITH CNN

Monday, Jul. 06, 2009

Cutting Health-Care Costs by Putting Doctors on a Budget

By Kate Pickert

What if you went to your doctor, suffering from congestive heart failure, and your doctor had been given a limited budget from your insurance company to treat you? If he were to go over cost, he would pay out of his own pocket. If he spent less than the allotment — and you were satisfied with your treatment — he would keep some of the change.

This is the guiding principle of a pilot payment model called Prometheus, which, by January 2010, will be used to calculate insurance coverage for 80,000 workers in Rockford, Ill., and has already caught the eye of the White House. Why? Because it turns the current insurance reimbursement system on its ear. See the top 10 medical breakthroughs of 2008.

A major problem with American health care today is what policy experts call "perverse incentives." Doctors and hospitals bill insurers for every individual service — every office visit, MRI or hour of operating-room time — a "fee for service" model that drives health-care inflation by rewarding providers who order potentially unnecessary tests, perform potentially unnecessary surgeries and even make mistakes. A hospital readmission caused by avoidable complications just means more billable expenses.

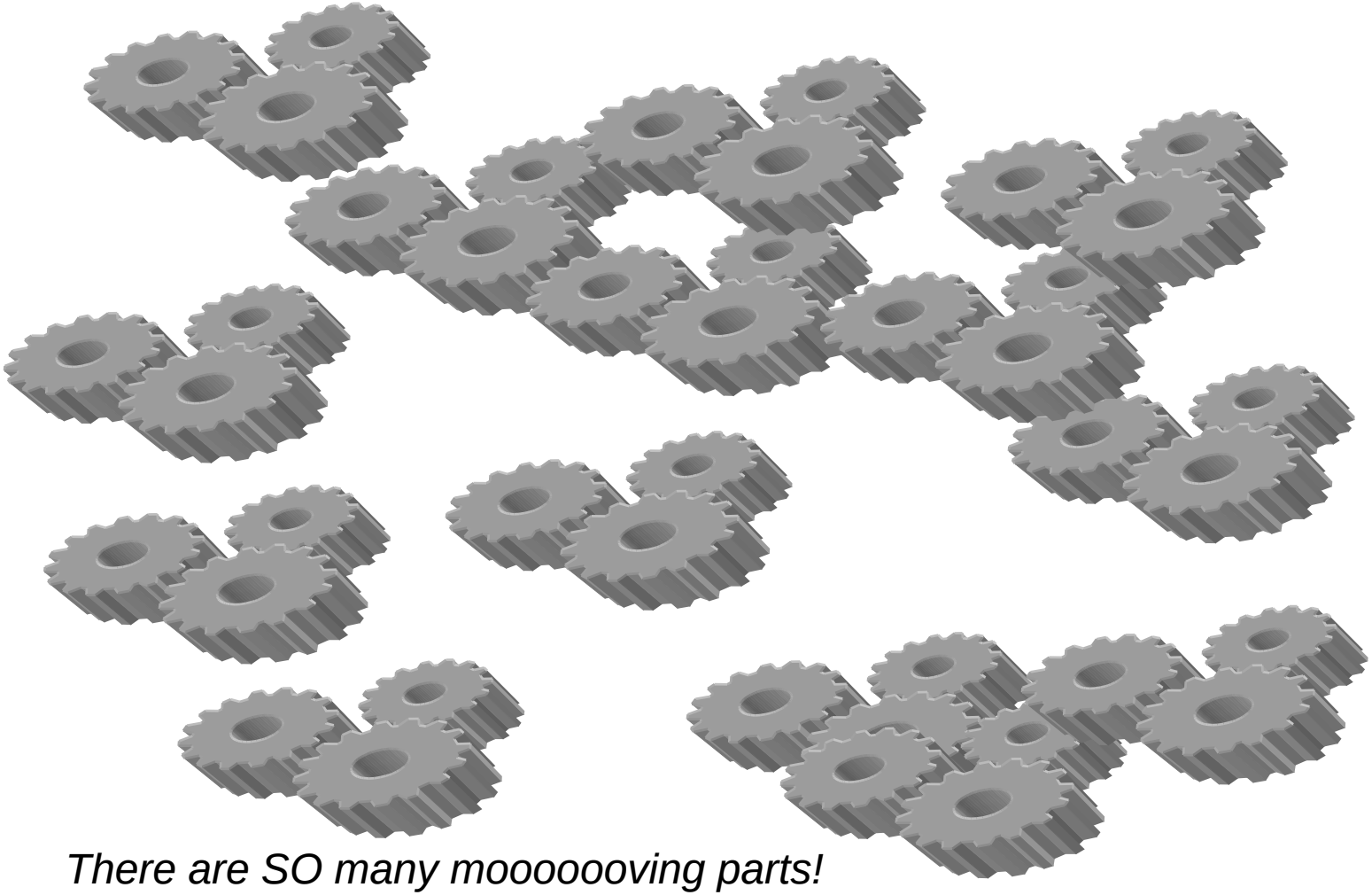
In contrast, Prometheus, funded by a $6 million grant from the Robert Wood Johnson Foundation, calculates compensation for hospitals and doctors based not on the specific treatments a patient receives but on the care a patient *should* receive "per episode." (Prometheus's calculation model is an open-source program that is already garnering interest from insurers in Minnesota, Pennsylvania and elsewhere.)

Taking the congestive-heart-failure example, here's how the payment scheme would work: A slightly overweight 60-year-old heart-failure patient comes in with coronary-artery disease and acid-reflux disease. According to a Prometheus algorithm, this patient should cost $20,750 a year to treat — including office visits, medications, blood-pressure monitoring and an allowance for complications. The incentive for the heart patient's doctor to spend less than $20,750 is that he gets to keep a portion of the difference (assuming that the patient was managed properly and is happy with the outcome). And the best way to keep costs low is to offer the best care: If the doctor is negligent in monitoring the patient's condition or fails to counsel the patient fully about proper diet and exercise, that patient could have a heart attack — requiring more treatments — and the doctor would take a financial hit. "The more defects you prevent, the more money you make," says Francois de Brantes, the health-payment-reform guru who coordinates Prometheus. "The fact that anybody has a leg amputated for diabetes" — something that's preventable with proper treatment — "is revolting, so you make that a financial blemish."

Latest From The Rand Corporation

NEJM: RAND Health Finds Promise in PROMETHEUS Bundled Payments
A November *New England Journal of Medicine* Perspectives article by researchers at RAND Health found that "bundled" approaches to reforming U.S. health care payment, such as that of the PROMETHEUS Payment model, offer the greatest promise for reducing national health care expenditures. In a quantitative estimate of the likely 10-year impact of the most popular and nationally applicable payment reform policy options currently being considered, **the researchers estimated that "under optimistic scenarios and with broad use of the PROMETHEUS Payment model for six chronic conditions and four acute conditions or procedures requiring hospitalizations, national health care spending could be reduced by 5.4 percent between 2010 and 2019."** This was nearly three times as high as the estimated change for the closest other policy option, hospital rate setting through regulatory agencies, and only assumes a modest decrease of 25-50 percent of potentially avoidable complication (PAC) costs by providers. •
Read the article: http://content.nejm.org/cgi/content/full/361/22/2109

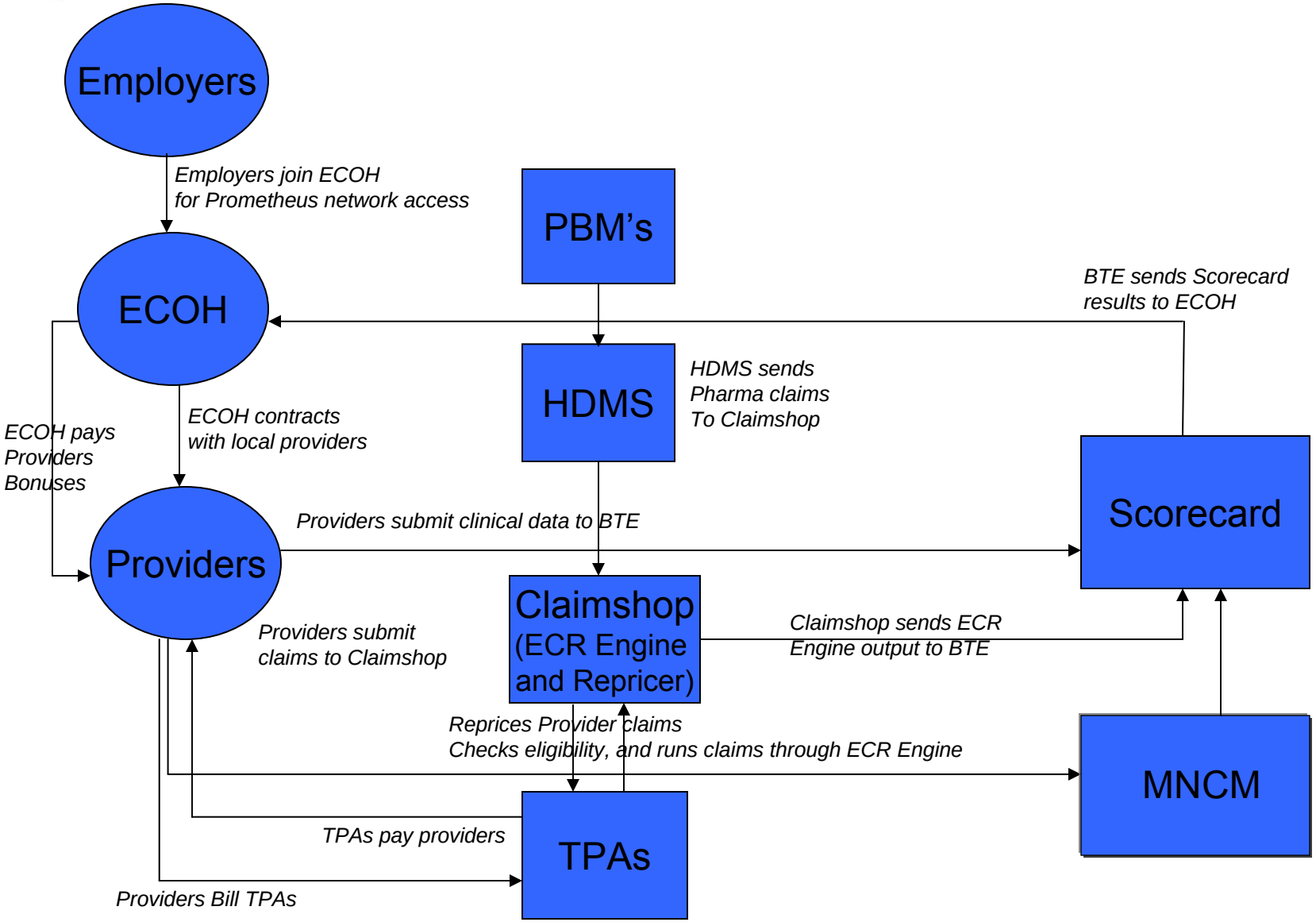
“Narrowize”



There are SO many moooooooving parts!

ECOH is the definition of “moving parts”

- 120 Independent Employer-sponsored ERISA Plans
- 2 Health Carriers – more coming
- 13 Pharmacy Benefit Managers (PBMs)
- 24 Third Party Administrators (TPAs)
- 22 Hospitals and thousands of Physicians
- Repricing Vendor
- Data Warehouse Vendor


Employers
Employers join ECOH
for Prometheus network access
PBM's
ECOH
BTE sends Scorecard
results to ECOH
HDMS
HDMS sends
Pharma claims
To Claimshop
ECOH contracts
with local providers
ECOH pays
Providers
Bonuses
Scorecard
Providers submit clinical data to BTE
Providers
Claimshop
(ECR Engine
and Repricer)
Providers submit
claims to Claimshop
Claimshop sends ECR
Engine output to BTE
Reprices Provider claims
Checks eligibility, and runs claims through ECR Engine
MNCM
TPAs pay providers
TPAs
Providers Bill TPAs

ECOH Population breakdown

	Eligibility		Cases Modeled	
Episodes used to develop ECRs*	All eligibility	% Prevalence	# in ECR*	% in ECR*
Diabetes Mellitus (DM)	6,188	7.2%	2,768	32.8%
Congestive Heart Failure (CHF)	567	0.7%	244	2.9%
Chronic Obstr Pulm Disease (COPD)	2,715	3.2%	792	9.4%
Asthma	3,731	4.3%	490	5.8%
Hypertension (HTN)	14,271	16.6%	4,152	49.2%
Coronary Artery Disease (CAD)	2,306	2.7%		0.0%
Total	**29,778**	**34.7%**	8,446	28.4%
Total # of patients in the ECOH data	**85,842**	100.0%	8,446	100.0%
Acute Myocardial Infarction (AMI)	169			

*ECR= Episode Case Rate

Average Costs across ECRs

	Diabetes	CHF	COPD	Asthma	HTN
# Unique Patients	2,768	244	770	490	4,152
Total Dollars Modeled	$20.1 M	$ 5.2 M	$ 3.5 M	$ 0.65 M	$ 6.6 M
Average Dollars for ECR	$7,255	$21,421	$4,580	$1,328	$1,579
Average Typical	$2,156	$6,000	$1,838	$907	$994
Typical Professional	$1,487	$5,158	$1,544	$610	$587
Typical Pharmacy	$669	$842	$294	$297	$406
Average PAC	$5,100	$15,421	$2,742	$412	$586
PAC stays	$1,883	$10,906	$1,672	$152	$281
PAC professional	$3,195	$4,496	$1,043	$261	$294
PAC Pharmacy	$22	$20	$27	$9	$11

Extrapolating from the models, total opportunity is $57 M -- $55 pmpm

	Diabetes	CHF	COPD	Asthma	HTN	Overall	Total Patients
# Patients Modeled	2,768	244	770	490	4,152	8,424	
Total Dollars Modeled	$ 20.1 M	$ 5.2 M	$ 3.5 M	$ 0.65 M	$ 6.6 M	$ 36.0 M	
Total PAC Dollars found	$14.1 M	$3.8 M	$ 2.1 M	$ 0.21 M	$ 2.4 M	$ 22.6 M	
Extrapolating to Whole Database							
# Patients in Database	6,188	567	2,715	3,731	14,271	27,472	85,842
Total Estimated Dollars	$ 44.9 M	$ 12.1 M	$12.4 M	$ 4.96 M	$ 22.5 M	$ 96.97 M	
Total Estimated PAC Dollars	$ 31.6 M	$ 8.7 M	$ 7.4 M	$1.6 M	$ 8.4 M	$ 57.67 M	**pmpm = $55**

Biggest Potential for Savings

Net opportunity estimation

- Current typical spend across all chronic patients estimated at $40 MM
- Revised typical based on increase in Rx spend and underuse fix in ECRs at $67 MM
- Total revised PAC opportunity is Total spend for chronic ($97 MM) less revised typical ($67 MM) = $30 MM
- $15 MM for physicians in allowance

  and **$15 MM for ECOH**

Status of Prometheus in Rockford

Active ECR's in 2010:

- SwedishAmerican Health System:
  - Diabetes, Hypertension, CAD
- OSF St. Anthony Medical Center:
  - Diabetes, Hypertension, CAD
- Rockford Health System:
  - Diabetes, CHF

How did you do that?!

- Competitive market among health systems
- Reputational incentive a very strong factor
- Show us *our data*!
- Strong history of Constructive Engagement
- Belief that “Medicare is coming”
- “It’s the right thing to do”
- The Method is elegant

Hurdles:

- Show me the money: Employer and Provider
- You want what out of our medical record?!!!
- The *N* issue
- Will you (ECOH) distribute the payments?
- My patients are (no longer sicker, they are now) non-compliant.

The “Scorecard”

- Individual Hospital and Physician quality measures used to pay incentives
- Measures will be available for ECOH member use
- Actionable measures of provider trading partner performance have been a purchaser goal for more that 15 years….

ECR Performance Measures

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

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	89.26%	13.39	
Blood Pressure Control		15	79.87%	11.98	
LDL Control		10	66.67%	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	

Each ECR has a clinical domain of performance measures, weights and calculations

Bonus Opportunities

ECR	# of Patients	Overall Episode Price	Actual Spend Observed	Bonus Opportunity
COPD	25	$34,423	$27,827	$6,596
Diabetes	50	$201,300	$176,358	$24,942
CHF	10	$87,977	$73,723	$14,254
Asthma	35	$71,863	$60,745	$11,118
CAD	70	$176,623	$154,547	$22,076
HTN	310	$600,329	$529,127	$71,202
Overall	**500**	**$1,244,378**	**$1,022,327**	**$150,188**

Doctor	E&M %	BTE Score (70%)	Downstream Score (30%)	Total Score	Bonus Share
Jones Internist	40	70.91	63	68.54	**$41,175**
Schweitzer Cardiologist	30	64.32	63	63.92	**$28,799**
House Pulmonologist	15	58.94	63	78.54	**$13,560**
Salk Nephrology	15	72.57	63	69.69	**$15,699**

The Challenge

How do we accumulate shared savings for health systems?

2010 Solution: Quarterly escrow by employer

Quarterly Escrow Calculation

By employer x plan member x ECR

Example:

Rockford Fastener Inc. =

# of Employees x 50% of PAC reduction dollars for CAD

2 x .5 ($100) = $100

Shared Savings Payment to Providers

Trigger 1: 2010 PAC spend is at least 6% less than PAC for ECR at that health system in 2009

Trigger 2: 2010 total spend is ≤ the 2009 spend for ECR at that health system

"Shared Savings"/Quarterly Escrow Payment:

50% of all reductions in PAC's once triggers are met

Reconciliation: Q1, 2011 con't

- Scoring system qualifies physician for shared savings
  - % of quality score creates a weight

Weight x escrow $ = shared savings to health system

- Remainder is refunded to the employer or carried into the next year

Questions?

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