Financing Medical Homes with Unique Risk Adjustment Models

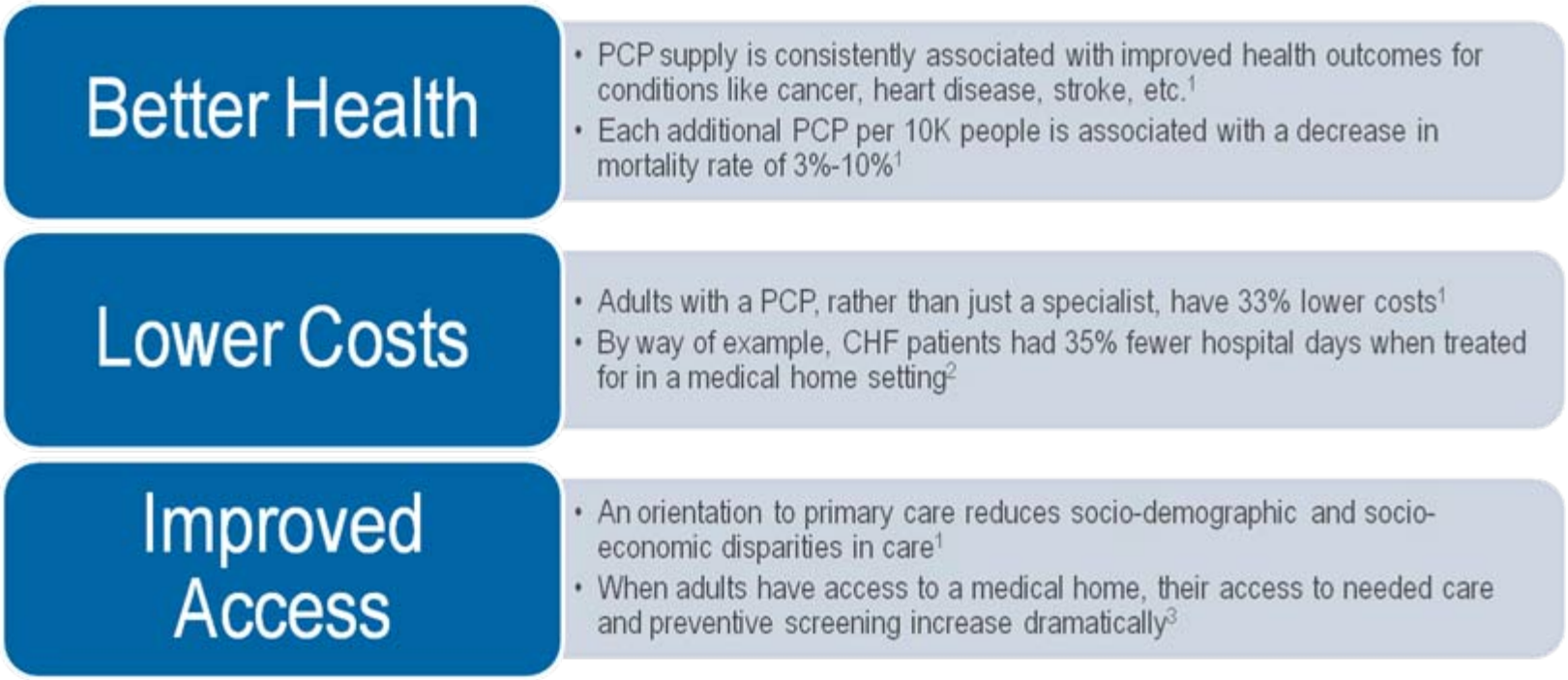
Jordan Bazinsky

Verisk Health

Agenda

- Why Primary Care? And why a “Medical Home”?
- Financing in the Context of Medical Homes
- Evaluating Medical Homes using Risk Adjustment Technology
- Paying for Medical Homes using Risk Adjustment Technology

Renewed Focus on Primary Care: The Foundation for Healthcare Delivery



Sources: (1) Starfield, Barbara. Presentation to the Commonwealth Fund Primary Care Roundtable, 10/3/06. (2) RWJ sponsored evaluation of the effectiveness of the chronic care model in improving clinical outcomes and patient satisfaction. (3) Beal, A.C. et. al. Closing the Divide: How Medical Homes Promote Equity in HC: Results from The Commonwealth Fund 2006 Health Care Quality Survey, June 2007.

Healthcare Reform Further Pushes "Primary Care Medical Homes" into the Spotlight

Healthcare Legislation Provisions Enable Medical Home Pilots

Payment Model Flexibility

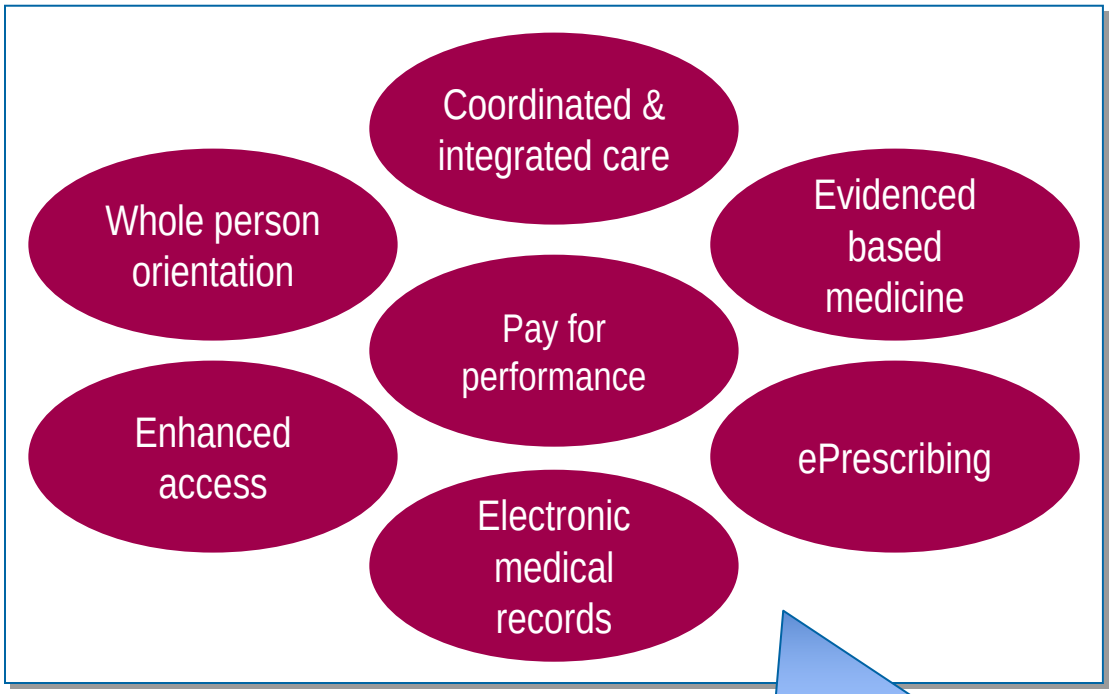
- Creation of Center for Medicare and Medicaid Innovation
- Ability to create novel payment pilots in federally-funded programs

Increased Funding for Community Health Centers

- Increased funding for National Health Service Corps (~$300M)
- Additional funding for residency slots for training PCPs (~$200M)

Despite Prevalence in Literature, Defining Medical Homes Often Proves Elusive

Characteristics of the Medical Home



None of these processes, tools or aspirations necessarily lead to cost savings in the context of a fee-for-service financing model

Operational changes supporting the medical home may lead to clinic labor cost increases of ~20-30%.[1]

Sources: (1) Dr. Baron, PCPCC Stakeholders Working Meeting, 7/16/2008 & Group Health Cooperative experience.

NCQA Provides Formal PCMH Criterion, Although Cost Containment Not Among Them

Elements assessed

1. Access and communication
2. Patient tracking and registry functions
3. Care management
4. Patient self-management support
5. Electronic prescribing
6. Test Tracking
7. Referral Tracking
8. Performance reporting and improvement
9. Advanced electronic communications

Scoring

Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
3	75 – 100	10 of 10
2	50 – 74	10 of 10
1	25 – 49	5 of 10
Not recognized	0 - 24	<5

Medical Homes Rely on Innovation from Two Distinct Domains

	Issue	Innovation
Delivery System	• Fragmentation of health care service delivery • Poor quality • Lack of access • Cost	• The Medical Home, *mostly….*
Delivery Financing	• Underpayment for primary care and prevention • Misaligned incentives • Ineffective quality and efficiency performance programs	• Resurgence of non fee-for-service reimbursement models

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Why Primary Care? And why a “Medical Home”?

Financing in the Context of Medical Homes

Evaluating Medical Homes using Risk Adjustment Technology

Paying for Medical Homes using Risk Adjustment Technology

Aligning Economic Incentives Requires New Perspective on Paying for Care

Risk

Purchaser: Employers and government	Payor: Commercial, Medicaid & Medicare	Providers: Hospitals, Doctors	Consequences
Purchaser pays annual premium that buys insurance and access to *discounted* provider services	• Payor negotiates discount off unit-cost with providers, in exchange for directing volume • Commercial payors attempt to manage utilization through provider profiling	• "Baseline" costs are calculated annually on a cost-plus basis,* leading to price inflation • The highest margin "units" are typically procedures • Docs make more money with more procedures	• Health care system produces a high volume of high-cost services that are not necessarily linked to value • Under-reimbursement of preventative services
	• Payor negotiates bundled payment for certain services • Pay-for-outcomes incents appropriate utilization and preventative services	• Primary care incentivized to "right size" care: e.g., too much and they lose money, too little and the patient seeks care in ER… and they lose money	• Utilization optimized • Pay-for-outcomes incentivizes quality • Costs lowered

Current

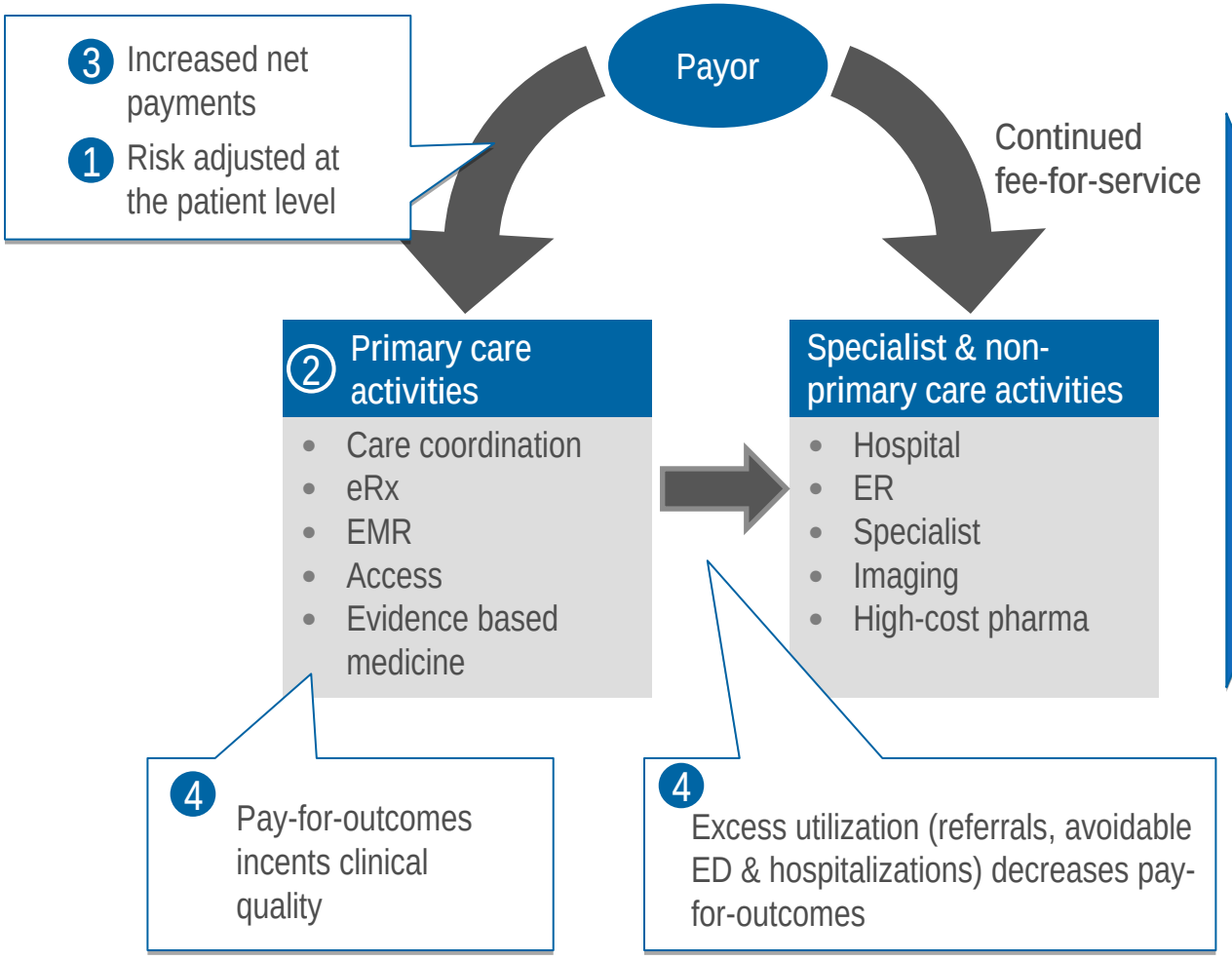
Future

* RB-RVUs (resource based relative value units) are calculated by the RUC (Relative value Update Committee): 23 of the 29 members are appointed by national medical societies, 2 from the AMA). RVU calculations are based on physician work, practice expense and malpractice costs – essentially cost-plus. RUC recommendations are approved by MedPAC.

Any Bundled Payment Model Must Address Key Factors to be Successful

	Key issues
1 Perform outstanding risk adjustment	• Sick patients cost more. To prevent adverse selection, payment levels must take into account illness burden at the member level (and, the sickest patient are where the greatest cost saving opportunities)
2 Bundle payments for primary care activities	• Full risk transfer is not financially viable for most practices • Primary care physicians cannot control all risks (e.g., a catastrophic car accident) so some costs must be carved out
3 Make robust primary care profitable	• Key activities of the medical home are not reimbursed • Medical homes typically result in 25-30% more labor cost • The tyranny of the RVU
4 Pay for outcomes	• Outcome bonuses based on clinical quality metrics should account for substantial additional revenue • These must also be risk adjusted to avoid adverse selection • Avoid formal UM as cost management lever

Macro View: Alignment of Economic Incentives in the Medical Home

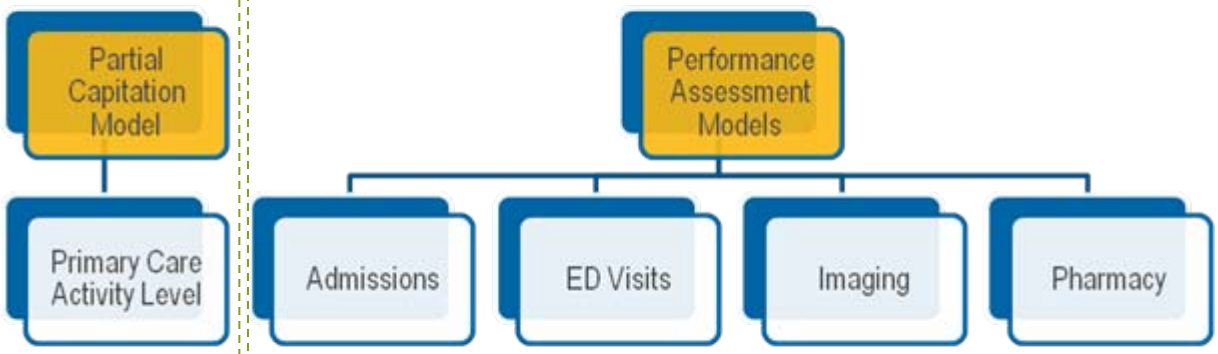


- Primary care physician incentivized to "right size" primary care activities
- Financing approach is feasible for small practices - not under direct financial risk for catastrophe cases
- Does not create the need to control specialist utilization directly

Verisk Health Has Developed Risk-Adjustment Models Specific to Medical Homes

Used for setting partial capitation rates by measuring Primary Care-specific risk.

Used for profiling physicians and supporting pay-for-performance programs. Offsets negative incentives of capitation by promoting good outcomes.



- Models can be used **retrospectively** to evaluate Medical Home performance.
- Models can be used **prospectively** to finance care delivered in the Medical Home.

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Case Study: Evaluating the Performance of Spring Health Plan's Medical Home Pilots

SHP in Brief

- HQ in the Midwest
- Asked VH assistance in evaluating performance of physician groups at its medical home pilots

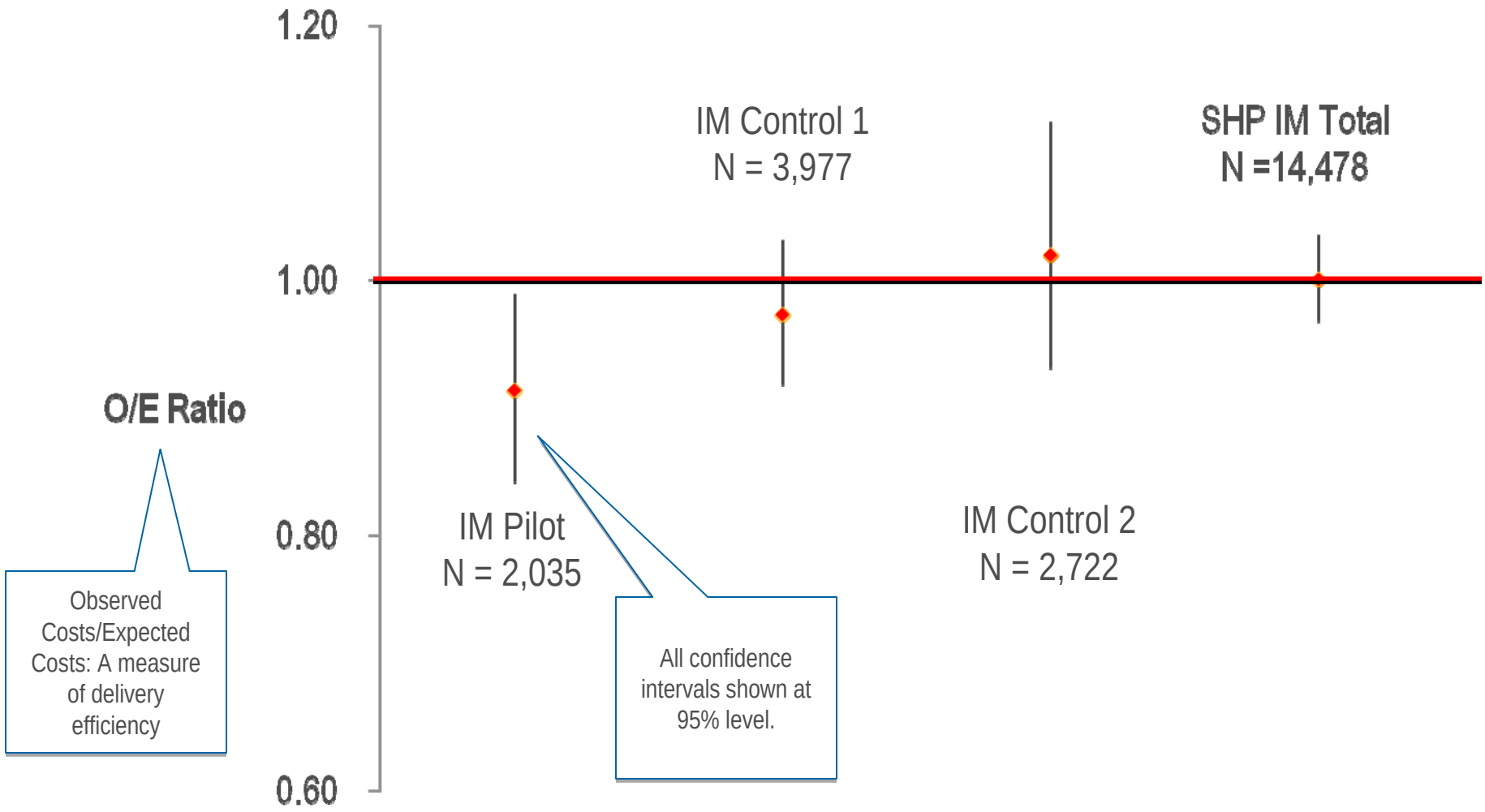
Compare Pilot and Control Practices

- Total member population ~100K
- Two practices, one internal medicine and the other family medicine, chosen as PCMH pilot sites
- Pilots ran throughout 2009

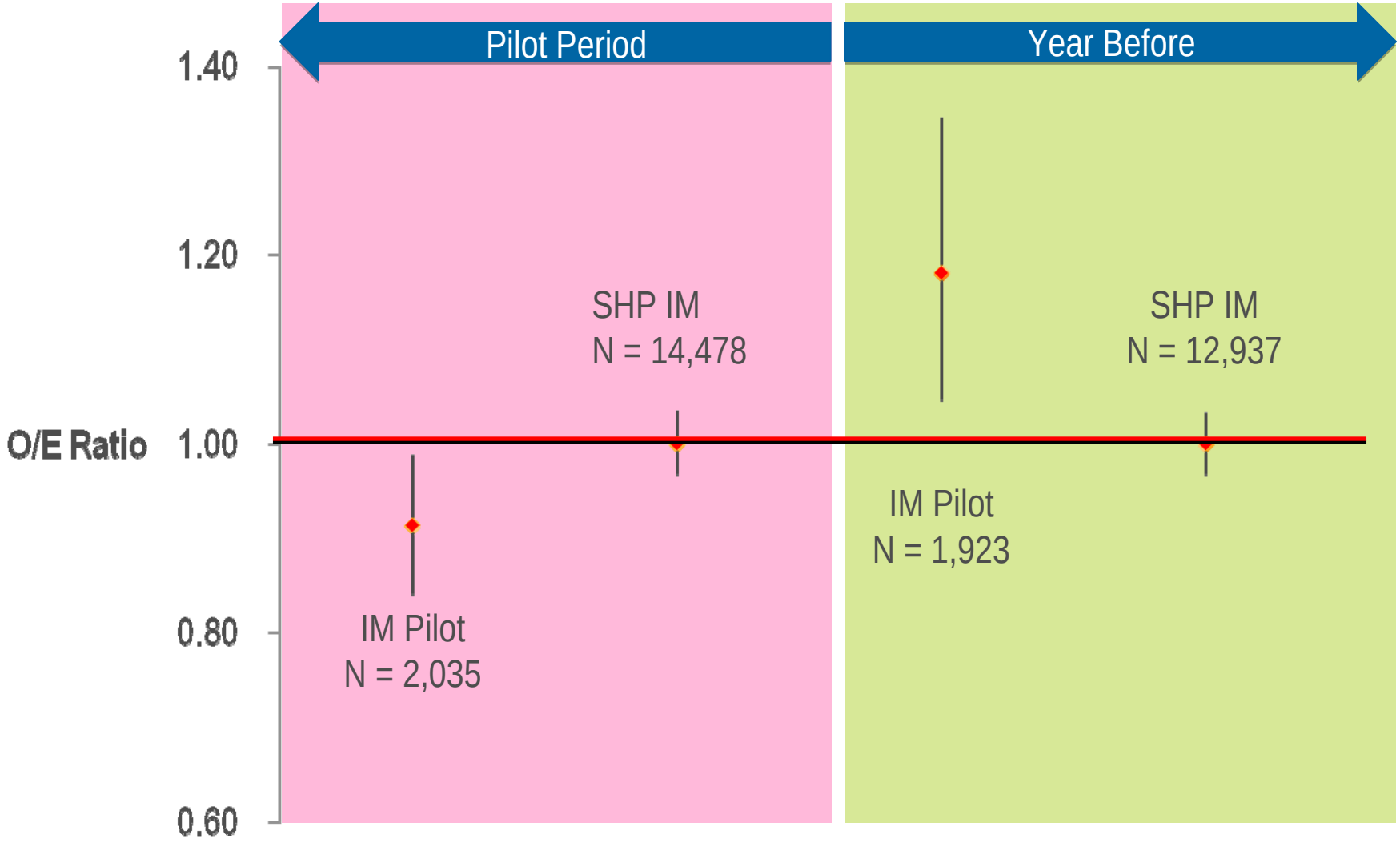
Measure Performance for Compensating Pilots

- Previously, performance metrics were unadjusted for illness burden
- As such, comparisons between pilots were being done on an "apples-to-oranges" basis
- Left plan in poor negotiating position with practices
- Nonetheless, needed more sophistication than a typical risk-adjustment model

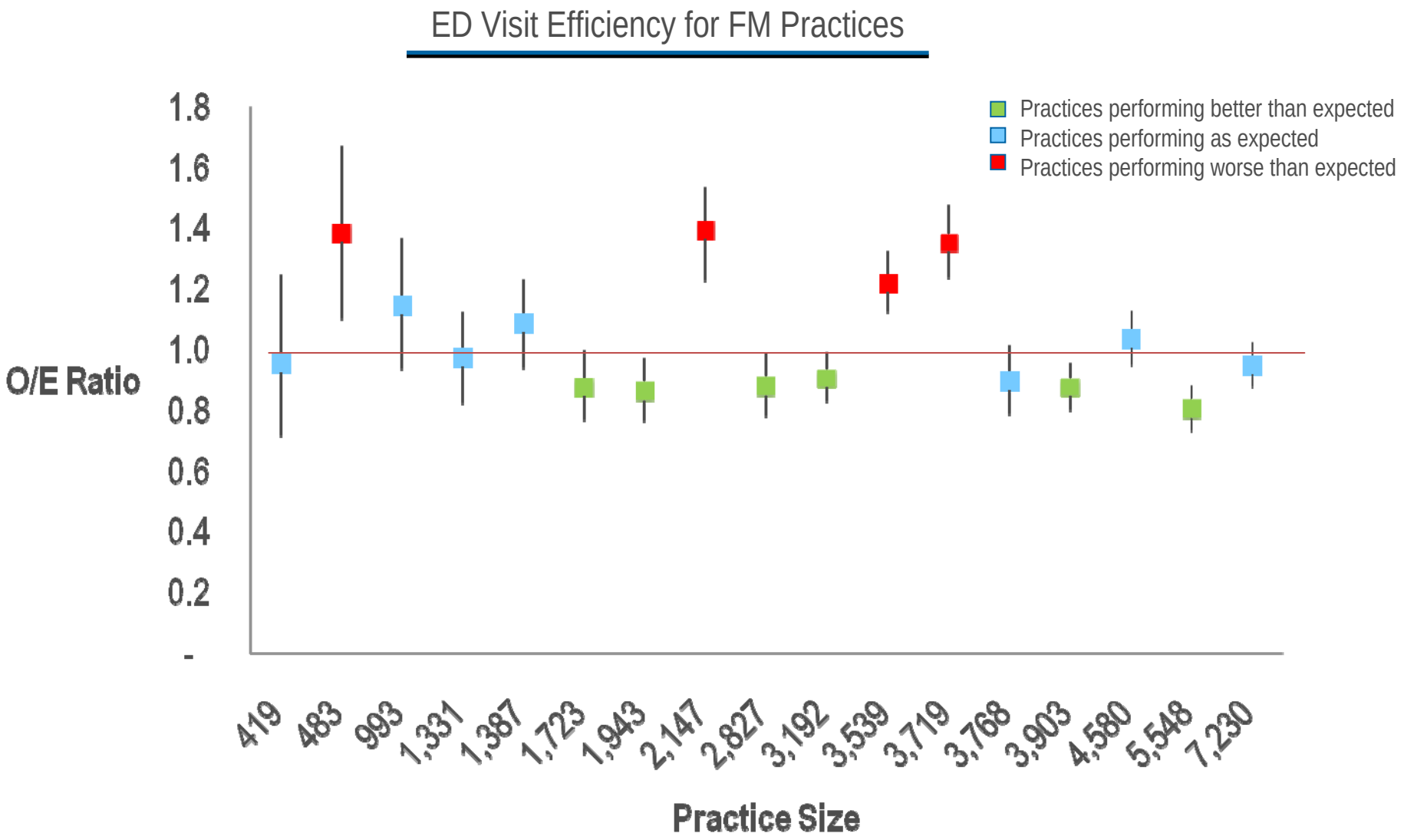
Models Indicated Significance of Pilot Cost Efficiency Relative to Control Groups



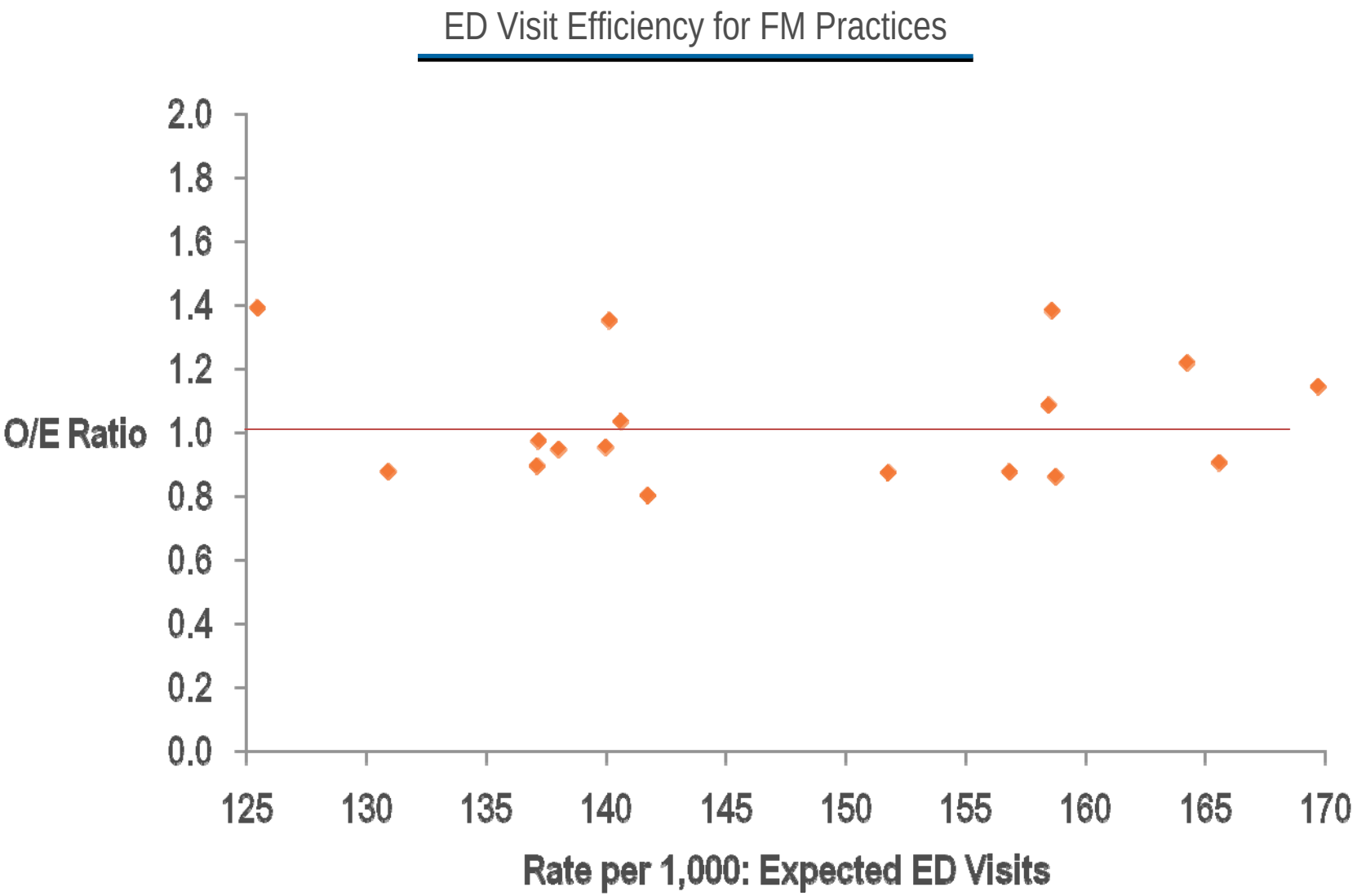
Moreover, Models Illuminated Year-over-Year Cost Efficiency Changes within Study Group



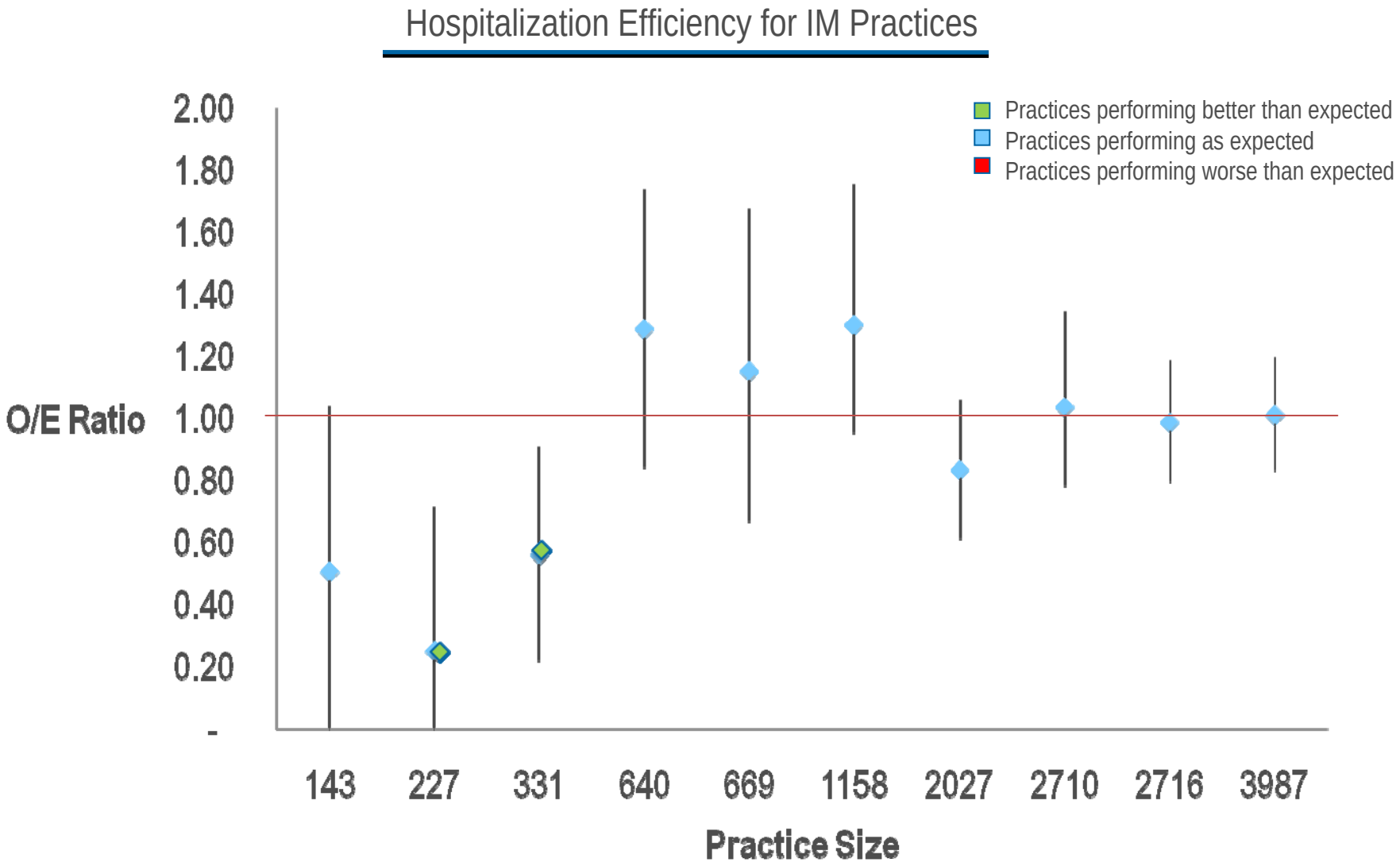
Risk-Adjusted ED Visits Allowed Plan to Evaluate Performance of All IM and FM Practices



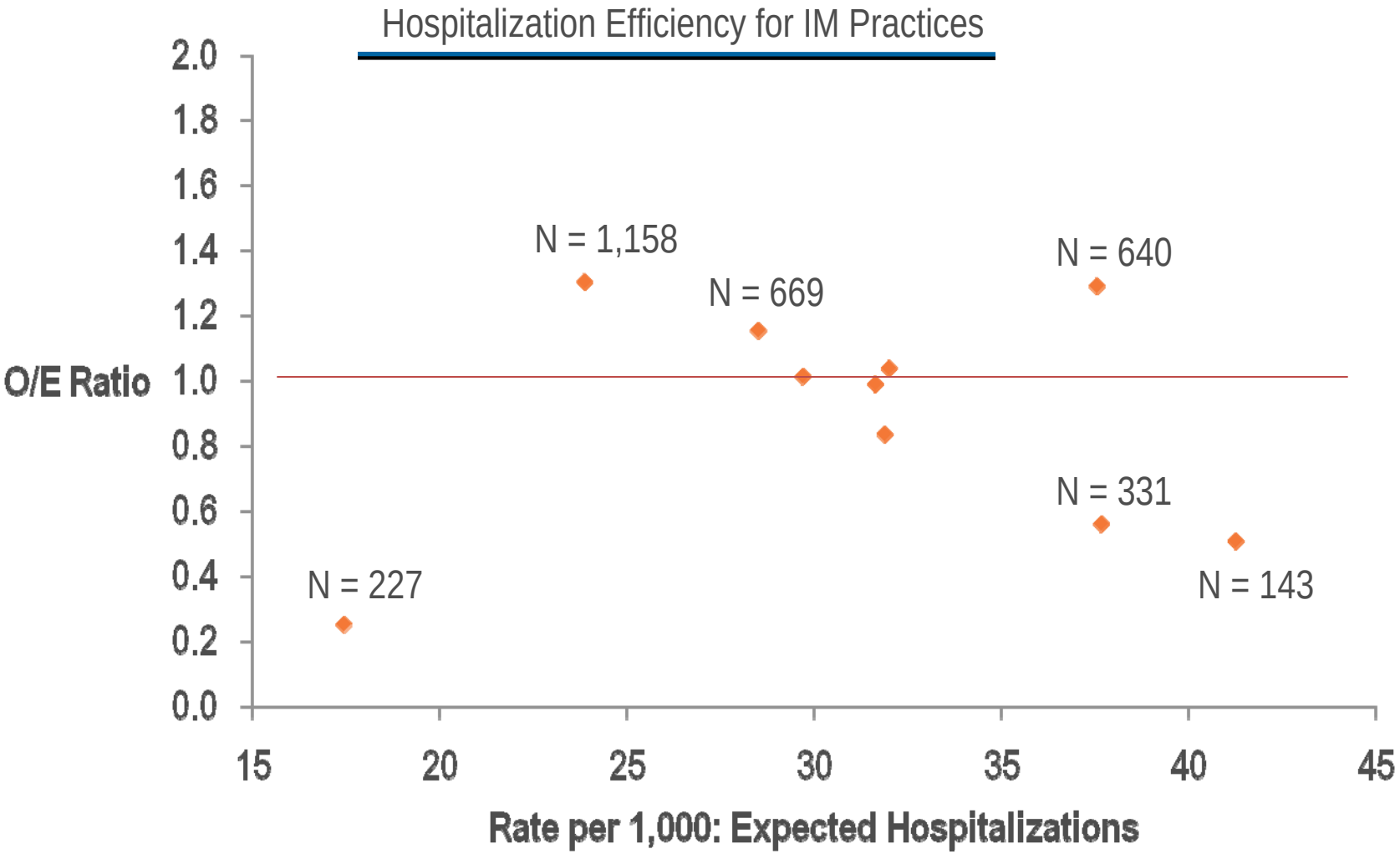
No Systematic Bias Created in ED Visit O/E Ratio Scatter by Risk Adjustment Method



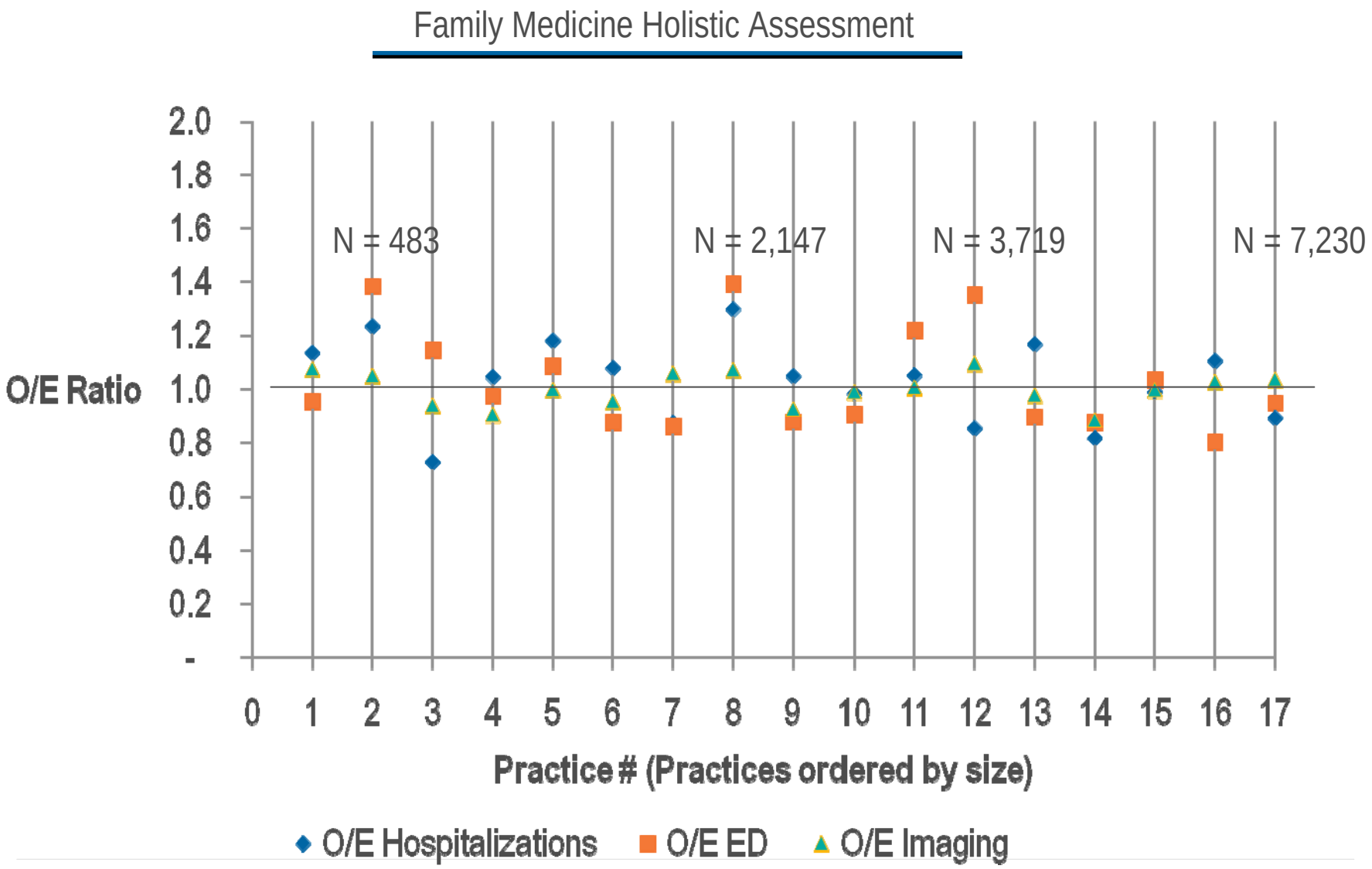
Risk-Adjusted Hospitalizations Provided Less Differentiated View of Practices



No Systematic Bias Created in Hospitalization
O/E Ratio Scatter by Risk Adjustment Method



Not Surprisingly, Outcomes Performance Tends to Cluster – Incentive for Plan to "Get it Right"



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Predicting Primary Care-Specific Risk: The Primary Care Activity Level

A Risk-Base Comprehensive Payment

- Provide stable, predictable funding to support population management
- Avoid creating incentives for PCPs to shirk on attracting and treating high cost, chronically ill
- Payments are population based = illness burden per month (quarter) not on episodes of treatment

Predicated on a Vision for Primary Care

- Move away from fee-for-service (FFS) reimbursement
- Provide the primary care team with adequate resources to support desired activities
- Let clinical professionals decide how to use resources (proper locus of control)
- Measure and reward cost savings and quality

PCAL is a proxy for the level of activity a person's primary care will require. It approximates the level of resources needed for high quality care for a diverse patient population.

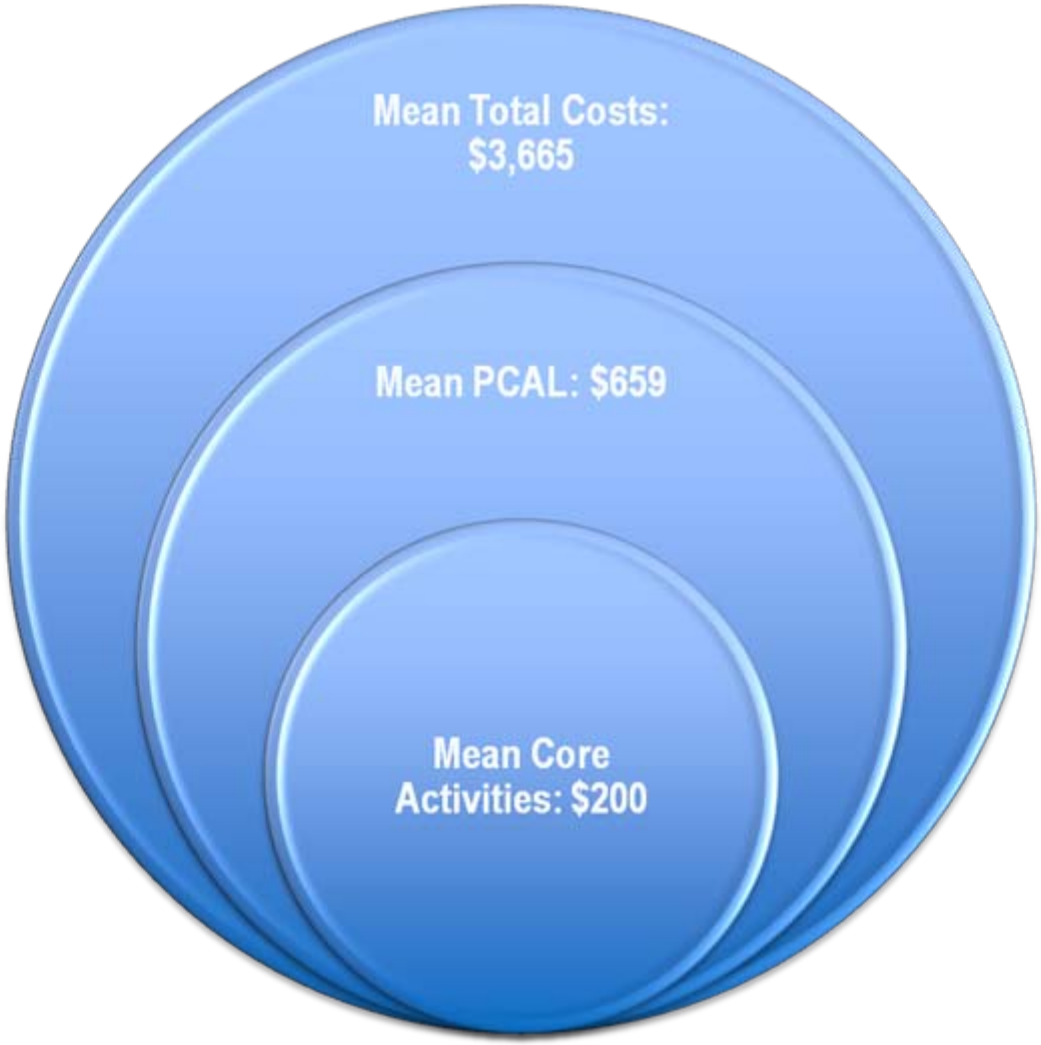
Activities Divided into Various Categories of Primary Care Utility

- Some activities are easy to determine as core primary care activities, while others are easily categorized as clearly not primary care.

- However, some services are in a gray-zone that we call “semi-core” primary care activities; these have a lower weight attached to their costs.

- Thus, to determine the activities included in PCAL, we categorized all CPT- 4 and HCPCS procedure codes into one of three groups:
  - Core Primary Care Activities
  - Semi- Core Primary Care Activities
  - Non-Core Activities

Constructed PCAL Accounts for 18% of Average PMPY Costs



Case Study: Innovative Payment Mechanisms for Edward Health Plan's Medical Home Pilots

EHP in Brief

- HQ in the Northeast
- Looking for innovative mechanism for compensating physicians and aligning incentives in its medical home pilots

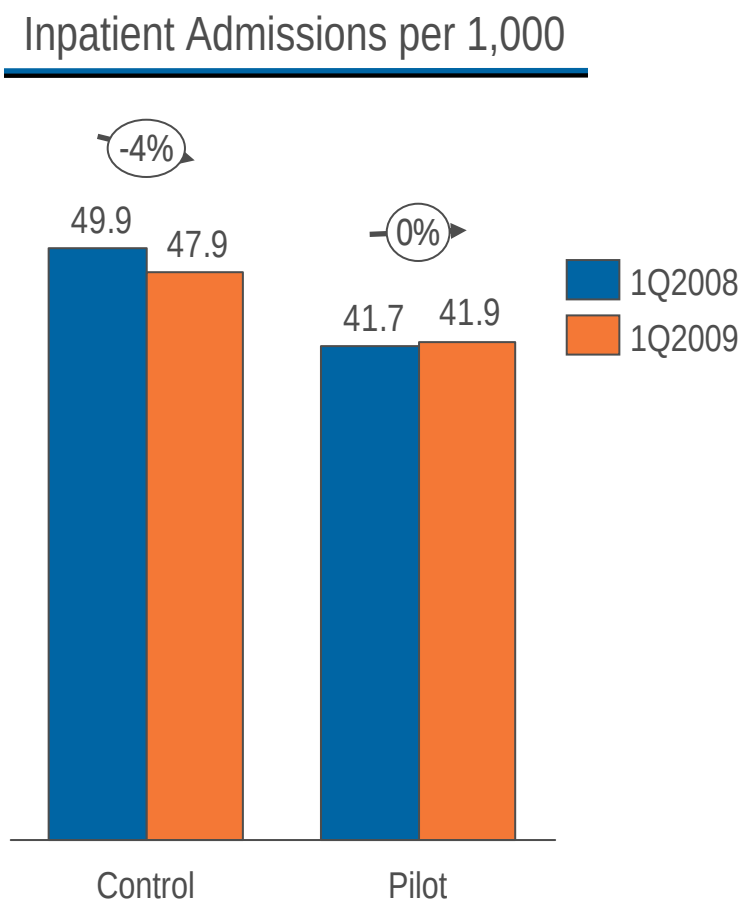
Pilot Aspired to Several Goals

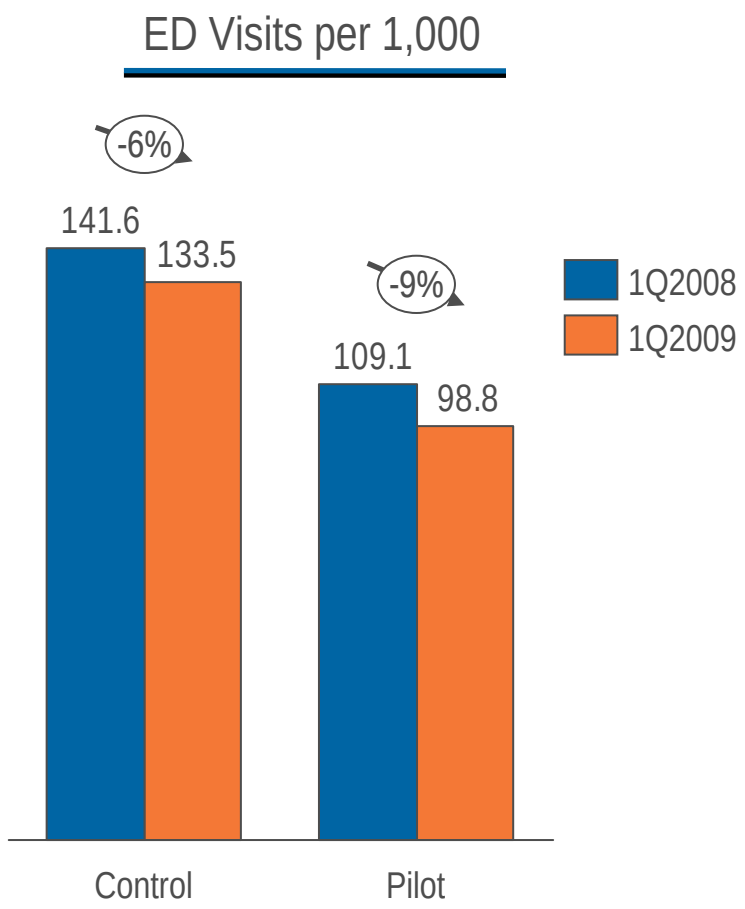
- Offer bundled payments for comprehensive care
- Align financial incentives between the Plan and Providers
- Create opportunity to increase PCP income 35%-50%

Implementing Pilot Required A Custom Predictive Model

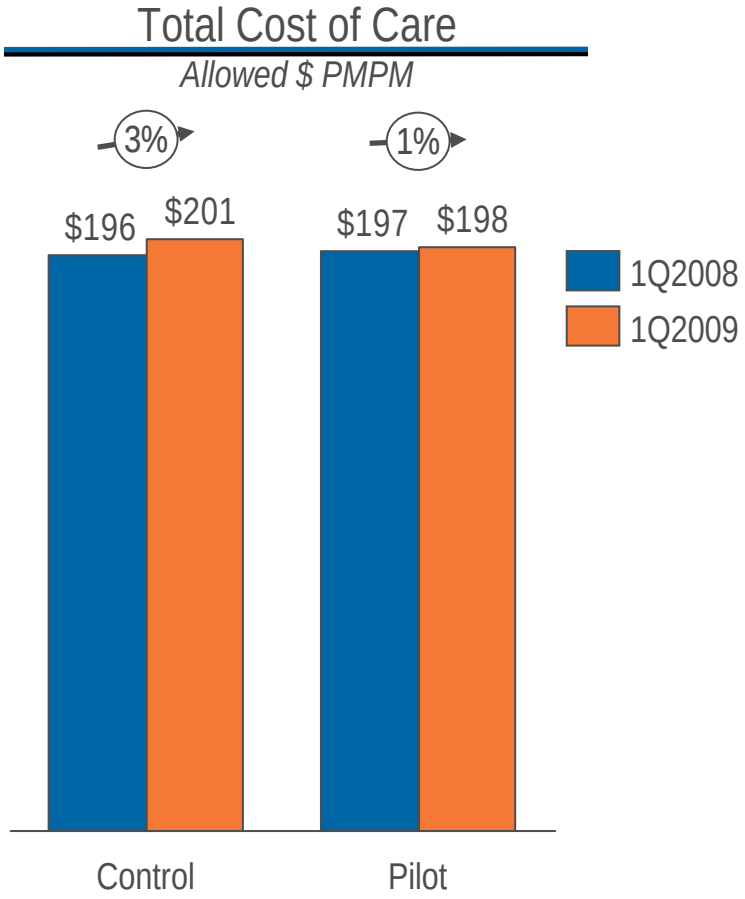
- Risk-adjustment model specifically designed to create a partial capitation payment rate
- Balanced by common quality measures (e.g., HEDIS performance) for P4P bonus payments

Early Impact on Outcomes





Early Impact on Costs



- Pilot Group Actual: $198
- Pilot Group with Core Trend 3% Applied: $202
- Value Created: $4.10 PMPM

Questions