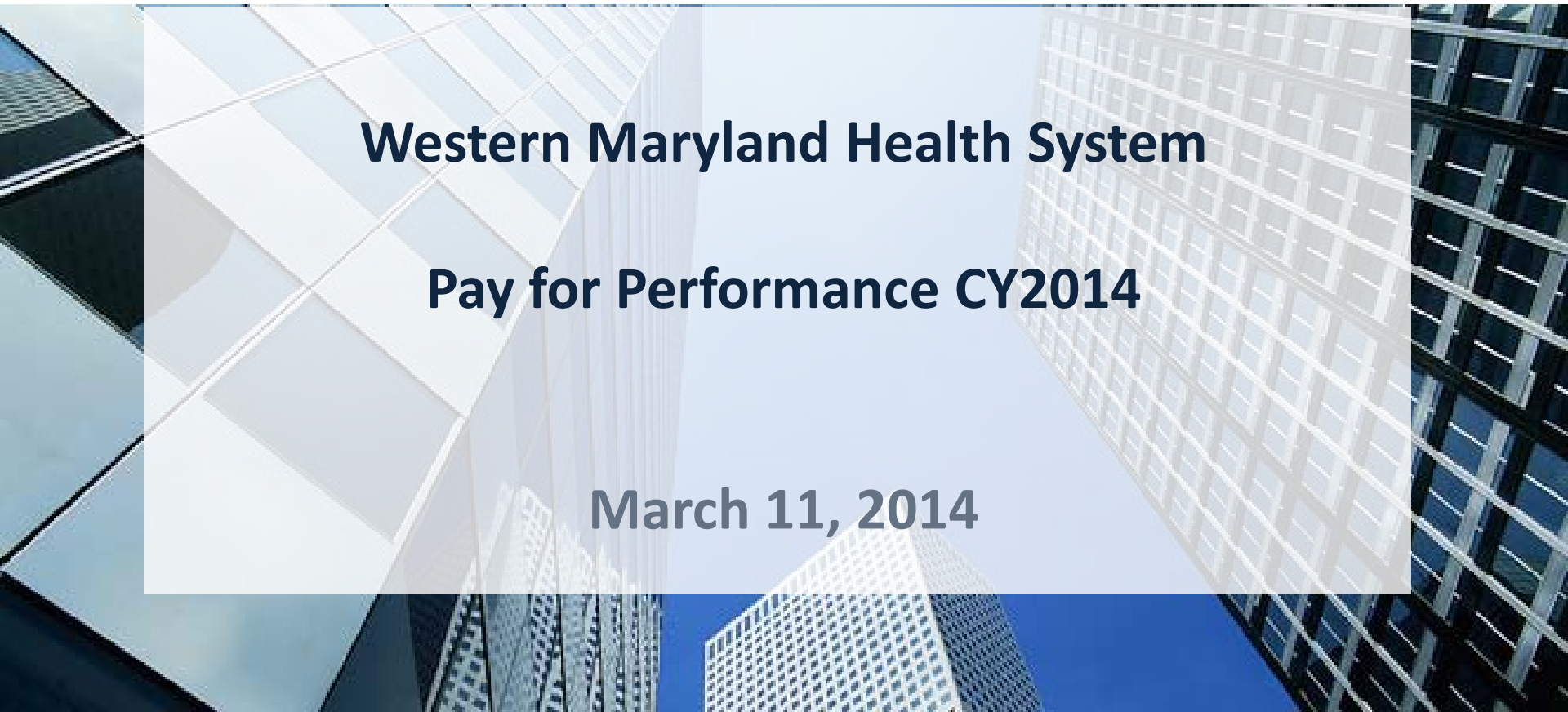


Western Maryland Health System

Pay for Performance CY2014

March 11, 2014

Background

- Western Maryland Health System (WMHS) is reimbursed under the Total Patient Revenue (TPR) model
- WMHS launched two Center of Excellence (CoE) programs (CHF and COPD) and a Diabetes Medical Home program
- These programs are designed to improve care delivery and care coordination for patients with chronic conditions, thus reducing acute exacerbations of the illness that require hospital care
- WMHS developed a Pay for Performance (P4P) methodology for primary care physicians who partner with WMHS to improve the care of selected patients with one of these three chronic conditions

Institute for Healthcare Improvement

BERKELEY RESEARCH GROUP

THE PROBLEM:

- 50% of health care expenditures in the U.S. are spent on 5% of the population
- This includes individuals with chronic conditions, and often, multiple medical and social needs
- Many of the needs are not complicated, but they are numerous and many are outside the scope of traditional health care service delivery

THE OPPORTUNITY

- Focus efforts on individuals with chronic conditions and/or multiple health and social needs
- Use care coordination, including patient navigators, community health workers, care managers and transition coaches
- Providers may be aware of patients' needs but not have the staff or capacity to meet those needs
- Payment structures in the health care system remain misaligned to deliver coordinated services and connect individuals with crucial supports

Source: Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs. Craig, C., Eby, D. and Whittington, J. Institute for Healthcare Improvement: 2011.

Targeted enrollment is critical to success

Chronic Disease Management: Evidence of Predictable Savings. **Health Management Associates, 2008.**

- "Targeting patients according to predictors of continued high utilization (e.g. recent hospitalization, frequent emergency room (ER) use, certain clinical indicators) substantially enhances the opportunity for savings."
- "Successful interventions include:
  - Targeting interventions to sicker patients who are likely to generate high costs in the future
  - Intensive time spent with the patient . . ., frequency of contact, face-to-face patient contact, early access to physicians, and sustained follow-up
  - Use of multi-disciplinary teams to provide support across multiple interventions, e.g. dietary, pharmaceutical, social service support, education, self-management, early symptom spotting and access to physicians to prevent exacerbations
  - Telephonic interventions that initially are time-intensive and frequent"

Effective Interventions to Reduce Rehospitalization.

Institute for Healthcare Improvement/ Commonwealth Fund, 2009.

- Project RED intervention was most effective for patients with higher rates of hospital utilization in the preceding 6 months.
- In the Commonwealth Care Alliance clinic for Medicaid patients a subgroup of enrollees with higher costs demonstrated cost decreases from $9,400 to $2,500 due to decreased utilization of hospital-based services.
- Kaiser Permanente chronic care coordination program sets eligibility criteria based on one or more of the following, and demonstrated reductions in hospital and ED use of about $1,900 per patient per year
  - Four or more chronic illnesses;
  - Recent hospitalization;
  - High utilization of the emergency department;
  - Recently discharged from a skilled nursing facility (SNF).

Process

- Program development
- Feasibility analysis

1 Plan

2 Design

- Funding
- Metrics
- Payments

4 Evaluate

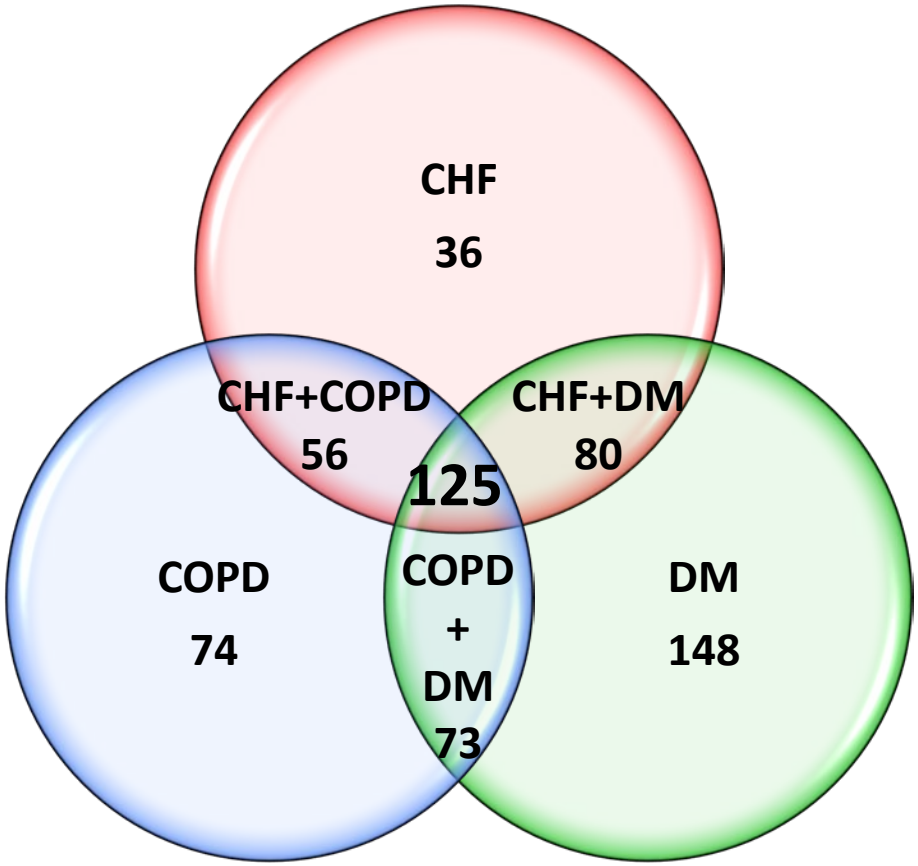
3 Implement

- Monitor results
- Reconcile payments

- Transparency
- Communication

Population Analysis

- 14,330 patients with CHF, COPD and/or diabetes
- 592 frequent fliers[1] (4% of population) drove 12% of costs
  - 258 (44%) have 1 condition
  - 209 (35%) have 2 conditions
  - 125 (21%) have 3 conditions
- Substantial overlap in the reasons these patients are admitted to the hospital
- 796 admissions for chronic Prevention Quality Indicators (PQIs) in all patients with CHF, COPD and/or diabetes
- 328 chronic PQI admissions within frequent flier population



[1] "Frequent fliers" are patients with 3 or more admissions to WMHS for any condition in CY2012

Prevention Quality Indicators

Prevention Quality Indicators (PQIs) are developed and maintained by the Agency for Healthcare Research and Quality and are a measure of the availability and effectiveness of community-based care

- WMHS's composite score for chronic PQIs is 36% higher than the U.S. average , although it is in line with the average for the lowest quartile income population
- Within the chronic PQIs, significant opportunities exist in CHF and COPD
- WMHS's pneumonia admission rate is 62% higher than the U.S. average for the lowest quartile income population

				Per 100K Population			
PQI Description	Numerator Dec201212 - Nov2013	Denominator	Admission Rate	WMHS	U.S.	U.S. Lowest Quartile Income	% Diff WMHS vs U.S. Lowest Income
PQI #1 Diabetes Short-Term Complications	68	60,657	0.1%	112	69	109	3%
PQI #3 Diabetes Long-Term Complications	107	60,657	0.2%	176	116	179	-1%
PQI #5 COPD or Asthma in Older Adults	273	38,754	0.5%	450	213	332	35%
PQI #7 Hypertension	60	60,657	0.1%	99	62	101	-2%
PQI #8 Heart Failure	255	60,657	0.6%	420	332	448	27%
PQI #13 Angina Without Procedure	10	60,657	0.0%	16	19	29	-43%
PQI #14 Uncontrolled Diabetes	8	60,657	0.0%	13	19	35	-62%
PQI #15 Asthma in Younger Adults	8	21,903	0.0%	13	119	194	-93%
PQI #16 Lower-Extremity Amputation among Patients with Diabetes	12	60,657	0.0%	20	33	52	-62%
PQI #92 Prevention Quality Chronic Composite	796	60,657	1.5%	1,313	963	1,433	-8%
PQI #11 Bacterial Pneumonia Admission Rate	384	60,657	0.6%	633	296	390	62%

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Patient-centered Care

WMHS provides direct care, education and care coordination to patients without PCPs

WMHS - Patient

WMHS Programs

Patients

Primary Care Providers

PCP - WMHS

PCP - Patient

WMHS provides direct care, education and/or care coordination to patients referred by PCPs

Physicians provide frequent, comprehensive care to target population

Design

Funding

- Funding methodology
- Funding levels

Metrics

- Types of measures, e.g., outcomes, processes, satisfaction
- Patient population(s), e.g., all, frequent fliers only
- Relative or absolute thresholds, i.e., progress or experience

Payments

- Provider eligibility, e.g., PCPs, specialists
- Per physician vs per capita
- All or nothing vs prorated per measure

Funding Methodology

- **Prefund the P4P payment pool with approximately $400,000**

	# Admissions	Charges	Costs	Funding
Reduce Chronic PQIs by 9%	72	$845,055	$507,033	$253,517
Reduce Pneumonia PQI by 9%	35	$438,607	$263,164	$131,582
	106	$1,283,663	$770,198	$385,099
Potential Annual Payment Per Unique Frequent Flier				$651

- **If PQIs are reduced by up to 17%, additional funding will be available**

	# Admissions	Charges	Costs	Funding
Reduce Chronic PQIs by 17%	135	$1,596,216	$957,729	$478,865
Reduce Pneumonia PQI by 17%	65	$828,481	$497,088	$248,544
	201	$2,424,696	$1,454,818	$727,409
Potential Annual Payment Per Unique Frequent Flier				$1,229[1]

[1] In 2009, CMS launched a pilot program for advanced medical home services which paid up to $100 PMPM ($1,200 PMPY) for full care management services for the most at-risk patients). http://www.healthleadersmedia.com/HOM-224120-4625/CMS-unveils-twotier-medical-home-care-management-fee

Payment Distribution Methodology

1: Measure reduction in PQIs and fund pool with dollars associated with percent reduction

2: Adjust maximum available payment per patient based on presence of one, two or all three chronic conditions

3: Measure patient- and condition-specific metrics

4: Calculate actual payment per patient

Payment Distribution Step 1

1: Measure reduction in PQIs and fund pool with dollars associated with percent reduction

Percent Reduction	Chronic PQIs	Pneumonia PQI	Total
9%	$ 428	$ 222	$ 651
10%	$ 476	$ 247	$ 723
11%	$ 523	$ 272	$ 795
12%	$ 571	$ 296	$ 867
13%	$ 619	$ 321	$ 940
14%	$ 666	$ 346	$ 1,012
15%	$ 714	$ 370	$ 1,084
16%	$ 761	$ 395	$ 1,156
17%	$ 809	$ 420	$ 1,229

Payment Distribution Step 2

2: Adjust maximum available payment per patient based on presence of one, two or all three chronic conditions

- Use Hierarchical Condition Categories (HCC) risk adjustment methodology to calculate the risk score for each patient
- Aggregate scores for patients with one, two or all three conditions
- Calculate median HCC score for each patient subgroup
- Apply payment variation weights to maximum per patient weights

Average HCC Weight	# of Conditions	Payment Variation
39% lower		
	1	11% lower
	2	
	3	20% higher
22% higher		

Payment Distribution Step 3

3: Measure patient- and condition-specific metrics

- Additional metrics[1] for all patients include:
  - Evidence of pneumonia vaccine (and booster 5 years later if applicable)
  - Interval (days) between hospital discharge and PCP visit
    - Within 7 days – 100%
    - Within 2 weeks – 50%
  - Medication reconciliation performed and documented during post-discharge PCP visit – Yes/No
- Condition-specific metrics are:
  - Diabetes - Hgb A1C < 8.0%
  - CHF – ACE or ARB for LVEF < 40%
  - COPD - spirometry results documented

[1] Metrics are based on measures endorsed by the National Quality Forum and WMHS policy. Pneumonia vaccination and medication reconciliation are used in ACO evaluation, PCP follow up visit within 7 days is WMHS standard and within 2 weeks is a Project RED recommendation

[2] HgbA1C is part of the ACO evaluation metrics. ACE/ARB for CHF and spirometry for COPD are both endorsed by the AMA

Payment Distribution Step 4

4: Calculate actual payment per patient

Sample scorecard for 100% scores but different risk categories

Measure	Category 1 Patient	Score	Category 2 Patient	Score	Category 3 Patient	Score
Pneumonia vaccine	Yes	1	Yes	1	Yes	1
Post-discharge follow up	Yes	1	Yes	1	Yes	1
Post-discharge med reconciliation	Yes	1	Yes	1	Yes	1
Hgb A1C	N/A		N/A		Yes	1
ACE or ARB therapy	N/A		Yes	1	Yes	1
Spirometry results documented	Yes	1	Yes	1	Yes	1
Score		4		5		6
Possible Score		4		5		6
Percent		100%		100%		100%
Total Available Distribution/Patient		$586		$651		$781
Payment		**$586**		**$651**		**$781**

Payment Distribution Step 4

4: Calculate actual payment per patient

Sample scorecard different patient scores but same risk category

Measure	Category 2 Patient	Score	Category 2 Patient	Score	Category 2 Patient	Score
Pneumonia vaccine	Yes	1	Yes	1	Yes	1
Post-discharge follow up	Yes	1	Within 8-14 Days	0.5	No	0
Post-discharge med reconciliation	Yes	1	No	0	No	0
Hgb A1C	N/A		N/A		N/A	
ACE or ARB therapy	Yes	1	Yes	1	Yes	1
Spirometry results documented	Yes	1	Yes	1	Yes	1
Score		5		3.5		3
Possible Score		5		5		5
Percent		100%		70%		60%
Total Available Distribution/Patient		$651		$651		$651
Payment		**$651**		**$456**		**$391**