PROMETHEUS Pilots Quarterly Webinar

July 14th, 2010

Agenda

Speaker	Topic	Time
Doug Emery: Program Implementation Manager Western Region, HCI3	Introductions and review of agenda	1:00 – 1:10PM
Marty Michaels: Director, Professional Services Network Management Chad Heim: Sr. Director Health Informatics	HealthPartners: *Year one report and issues around contracting for episodes*	1:10 – 1:30PM
Kevin M. Fosnocht, MD, FACP: Assistant Vice President Quality and Patient Safety	Crozer-Keystone Health System: *Contracting for episodes and clinical re-engineering*	1:30 – 1:50PM
Cheryl Britcher: Sr. Administrator, Medical Programs	Priority Health: *Key Decision Points*	1:50 – 2:00PM
Michael Moses: Program Support and Business Process Automation Leader	HCI3: *New TA Tools and Resources*	2:00 – 2:20PM
	Q&A	2:20 – 2:30PM

HealthPartners AMI Package Payment Year 1 Implementation

M. Michael, C. Heim

AMI Package Payment
Overview

- ECR Selection
- Preparation
- Provider Engagement
- Payment Model
- Implementation

ECR Selection

- Selection Criteria:
  - Ease of implementation
  - Event driven condition
  - Clearly defined start/end date
  - Community accepted care guidelines
  - Provider interest
  - Playbook availability
- Selected AMI for pilot

Model Preparation

- Used PROMETHEUS Playbook for Model
  - Made some changes based on our data
- In our market, each hospital had a single cardiology group performing professional services
  - Patients were attributed to the hospital where the actual AMI care occurred
  - We then treated the hospital and single cardiology group as one administrative unit and built model to interact with this single unit
- Met with Cardiologists on the Model first
  - Physician buy-in important

Provider Engagement

- Introduced concept to medical directors and administrators

Result:

- Varied levels of provider engagement
- Open source model provided credibility and uniform approach amongst payers
- General interest in learning the model and feedback was easily provided

- Shared model definitions with providers including; variables, PACS, and volumes

Result:

- New drugs were added to the playbook
- Moved complications to comorbidities
  - left bundle block branch
  - conduction disorders
- Ability to understand what was present on admission vs. complication during inpatient stay

- Shared final model definitions with providers before doing regression

Payment Model

Inpatient:

- Final regression model defines 49% of the payment variance and the remaining 51% is random
- The following procedures/services contributed to variation in the payment of AMI:
  - PTCA
- The following medical conditions/comorbidities contributed to the variation in payment:
  - Congestive heart failure-non hypertensive
  - No demographic variables contributed to variation in the payment of AMI

Professional & Follow-up Services:

- Final Regression model defines 64% of the payment variance and the remaining 36% is random
- The following medical **conditions/comorbidities** contributed to the variation in payment:
  - Coronary artherosclerosis and other heart disease (*Coronary Atherosclerosis, Percutaneous transluminal coronary angioplasty status, Old myocardial infarction*)
  - Symptoms; signs; and ill-defined conditions (*Care involving other specified rehab procedure--V-code*)
- The following **procedures** contributed to variation in the payment of AMI:
  - Inpatient physician services (*Physician catheterization services, Physician PTCA service*)
  - Other physician services (*Emergency medicine visit services*)
  - Radiology and radionuclear diagnostic services (*Radiological diagnostic services*)
  - Cardiac rehab/PT services (*Cardiac rehab services*)

Payment Model

- PACs calculated at the provider level (hospital/cardiology group)
  - PAC dollars divided equally among the cases in the baseline year
- Added a budget neutrality factor for each group, to make the regression payment equal to the FFS payment in the baseline year
- Statistical transformation formula example: *payment=(budget neutrality factor)*(0.25*(sum of estimates)+1)^4*
- The final payment for each case is: ***inpatient + professional & follow-up +PAC allowance***

Payment Model Implementation

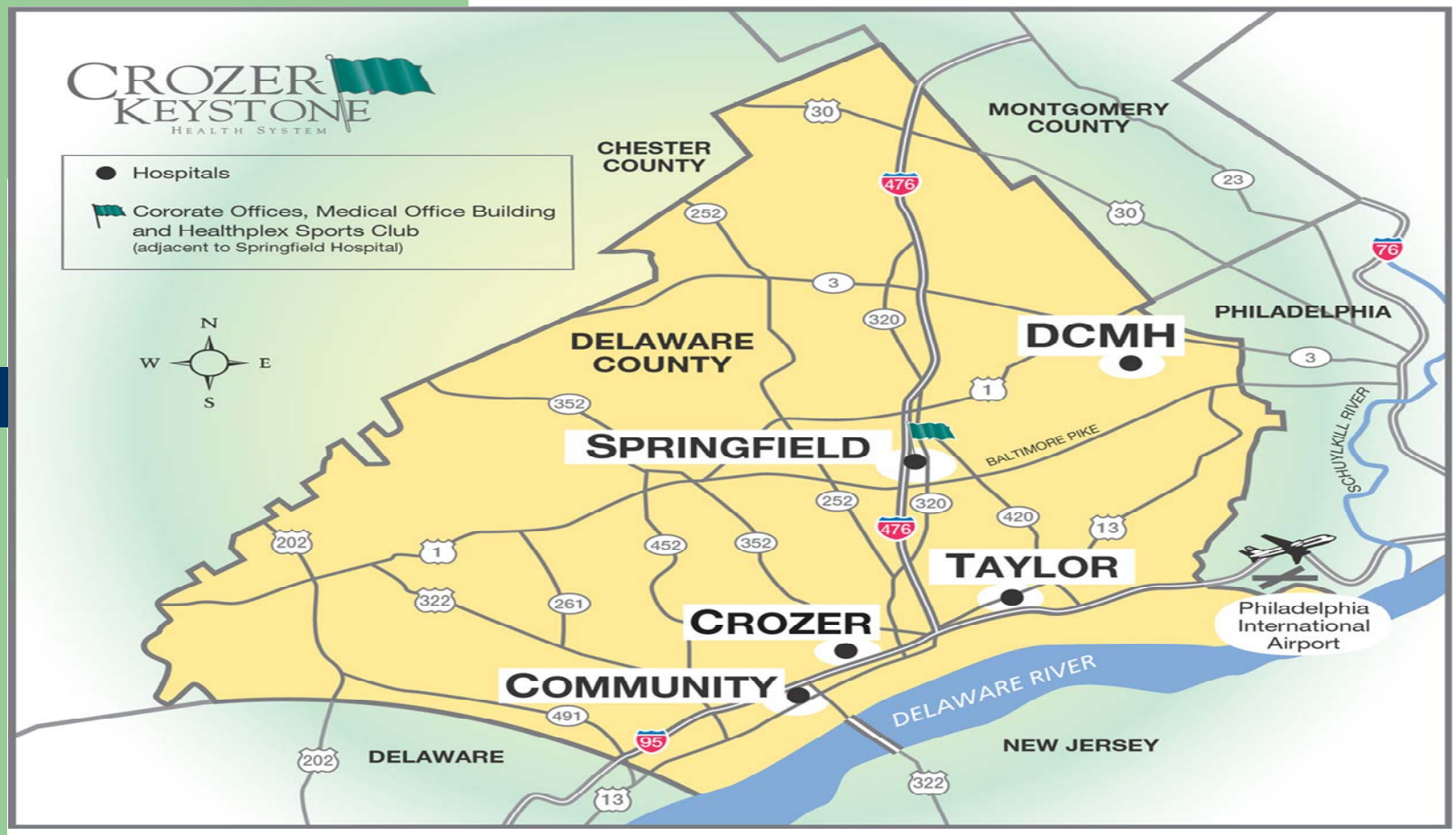
- FFS with withhold, with upside potential—we haven't implemented a "live" payment model
- Regression model is run against claims data to determine actual payment versus regression model payment
- Overall, the 2009 data showed we would have paid about 2% more using the regression model over the FFS model on the groups included in the pilot (not including any upside payment).
  - Some variation on case by case basis, but overall the FFS and regression model matched.

PROMETHEUS Quarterly Pilot Forum

July 14, 2010

Kevin Fosnocht, MD
AVP Quality and Patient Safety
Crozer- Keystone Health System

CROZER-KEYSTONE
HEALTH SYSTEM



5 Hospitals
730 licensed beds
43,000 admissions
133,000 ED visits
3,700 births

Home Care 81,000 visits
Hospice 13,500 visits
Employees 6,800

Medical Staff 1,300
Outpatient Network 725,000 visits
55 practice locations
32 primary care
300 employed physicians
Residency programs 7

*** FY 2009 data**

CROZER KEYSTONE
HEALTH SYSTEM

CKHS and Clinical Integration: A Strategic Goal

- Expanding Ambulatory Care Network
- Formalized physician-led governance
- Expanding outpatient EMR and other clinical IT technologies
- Patient Centered Medical Home designation
- Multi-disciplinary Joint Ventures
- Engaging Payers
- Joint Commission disease-specific certification

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Rationale for Total Joint Replacement

- Discrete episode of care with significant inpatient component.
- High-volume condition.
- Independent providers.
- More mature service-line
  - Defined forward-thinking clinical leaders
  - Cost-accounting mechanism
  - Process and outcome measures developing
- Supported TJC certification efforts (obtained 2010)
- Payers agree.

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Total Joint Replacement

- Premier Orthopedic & Sports Medicine Associates
  - Large regional “supergroup” comprised of multiple orthopedic divisions, including 30 orthopedic surgeons.
  - The divisions share business infrastructure and clinical/financial interests in ancillaries but each division runs their local offices independently.
  - Approximately 900 total joint replacement surgeries annually within CKHS.
  - Engaged physician leader in one of their divisions.

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Total Joint Replacement: Continuous Performance Improvement

- Partnered with the Human Motion Institute (Accelero)
- Defined physician, nurse, and administrative leaders
- Successful Joint Commission Disease Specific Certification

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Total Joint Replacement: Continuous Performance Improvement

- Metrics
  - Volume
  - Revenue/Cost Variables
  - ALOS
  - Payer Mix
  - Discharge Destination
  - Complications

CROZER-KEYSTONE HEALTH SYSTEM

Total Joint Replacement: Continuous Performance Improvement: PROMETHEUS

- Primary Opportunities based on PAC analysis:
  - Readmissions
  - Post-operative ED visits
  - (validated data thus far is for “stay” portion of the ECR; awaiting “professional” portion)
- Impetus for Clinical Outcome Measurement
  - Post operative functional status assessment

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CKHS/Physician Practice/ Payer/PROMETHEUS

- ECR “price” not yet established, as PAC data not yet completed and updated fee schedule not yet incorporated.
- Flow of potential “gainsharing funds” not yet established, as extent of aggregate savings will determine specifics.
- The significant cost of establishing legal framework for gainsharing factors into evaluation of model for funds flow.

CROZER-KEYSTONE HEALTH SYSTEM

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HEALTH SYSTEM

How the Prometheus Payment System Works

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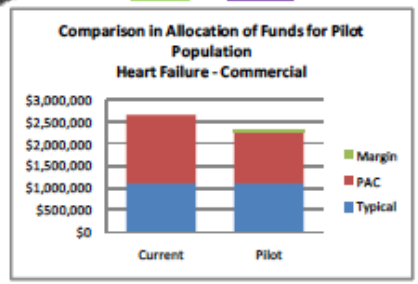
Budget



Assumption: About 60% outcome measures; 40% process

Fee for service throughout the year

Numerator – patients that meet measure
Denominator – Patients with the condition during scoring period

Excel

Diabetes Care			
Clinical Measures	Points per Measure	Num/Den Result	Points Awarded
Poor control measures			
HgBA1c Control	15	X 88.26%	= 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			
Ophthalmologic 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
Total	100		68.80

Reflects patient volume as percent of patients paid under ECRs

Assumption: 70% of physician's score

Table 2. Quality Threshold Scoring

	Possible Points	Actual Points	% of Patients	Weighted Score (Actual points x % of patients)
COPD Care	100	91.85	40.0%	36.40
Hypertension Care	100	68.85	15.0%	10.28
Cardiac Care	100	74.80	7.5%	5.61
Diabetes Care	100	68.80	15.0%	10.32
Heart Failure Care	100	58.71	2.5%	1.47
Asthma Care	100	33.79	20.0%	6.76
Total	600	396.90	100%	70.91

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Table 3. Hospital Scoring

CABG Care	Points Per Measure	Score	Points Achieved
Outcomes			
Leapfrog Survey Result	20	90%	18
Process			
Leapfrog Survey Result	10	75%	7.5
CMS Hospital Compare	10	90%	9
Volume			
Leapfrog Survey Result	20	90%	18
Patient Safety/Surgical Infections			
Leapfrog Survey Result	10	75%	7.5
CMS Hospital Compare	10	90%	9
Patient Experience of Care			
CMS Hospital Compare	20	90%	18
Total	100		63

(.7 x 70.91) + (.3 x 63) = 68.54

Assumption: 30% of physician's score is based on score of hospital to which he / she refers

Assumption: Quality Threshold = 50. Since quality score > 50, eligible for PAC pool funds

Performed better than budgeted, so physician eligible to get difference ($204,275)

Score card managed by Bridges to Excellence

Quality score based on care provided to all patients receiving care for conditions

Rewards performance across all ECRs

5

Assumption: Balance of funds given to performers of top 25%

Tender

Bonus: $204,275 x 46.35% X 40% (%E&M) = $37,872

4

68.54 – 50 = 18.54 (achieved)
90 – 50 = 40 (possible)
18.54 / 40 = 46.35%

Distribute rewards based on percent of office visits (E&M)

Doctor	E& M %	Provider Score (70%)	Hospital Score (30%)	Total Score	% Eligibility Based on Min/Max	Bonus Share
	A	B	C	D=(B*.7)+(C*.3)	E=(D-50)/(90-50)	$204,275* A*E
Dr. Jones - Internest	40%	70.91	63	68.5	46.35%	$37,872
Dr. Lee - Cardiologist	30%	64.32	63	63.9	34.75%	$21,295
Dr. Baker - Pulmonologist	15%	58.94	63	60.2	25.50%	$7,814
Dr. Rastogi - Nephrologist	15%	72.57	63	69.6	49.00%	$15,014

Share

Table 4. Payment Effects

		Budgeted based on hx		Actual performance	
Type of ECR	Number of ECRs	Total Budget for Typical	Total Budget for PAC	Total Actual for Typical	Total Actual for PAC
COPD	25	34,182	4,115	37,512	12,567
DM	50	185,611	64,309	152,201	32,649
CHF	10	55,898	43,210	57,096	42,876
Asthma	35	21,862	10,508	21,643	1,506
CAD	70	154,166	25,224	137,208	22,598
HTN	310	844,898	39,470	735,061	25,432
Totals	900	$1,295,736	$186,837	$1,140,670	$137,628
Variance				$155,066	$49,209

Gosfield, Alice G. ;,de Brantes, Francois, "Prometheus Payment: What's the Score?", www.prometheuspayment.org

New HCI3 Web Site

- Focus is on providing technical assistance to pilot sites
- One-stop for tools and resources
  - Automated PAC rate analysis and feedback
  - Pilot implementation plans
  - Model contract
  - All reports and published papers

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