POPULATION BASED PAYMENT®

Presented to:
The Commonwealth of Pennsylvania’s Other Critical Reforms Sub-Committee of the Health Care Reform Implementation Advisory Committee

November 17, 2010
Population Based Payment®

A framework and process for compensating health care practitioners for providing an agreed upon set of services for a specified population of covered beneficiaries for a specific period of time.
Program Features

Enables payors and providers to:

• Continue to submit claims and receive payment using standard industry billing and reimbursement arrangements
• Use providers’ claim history to establish financial benchmarks
• Utilize HEDIS measures and other population based metrics to monitor and improve performance
• Incentivize high cost providers to participate in PBP arrangements
• Move unorganized providers into FTC compliant clinically integrated joint ventures
• Encourage the use of available HITECH Act funding for EHR adoption
Program Characteristics

• Clinically integrated provider panels
• Historical medical claim cost experience is actuarially determined
• Clinical guidelines are in place
• Performance targets are established for:
  – Quality/Outcomes
  – Efficiency
• Established mechanisms are in place for routine and ad hoc reporting
• Financial benchmarking designed to recruit and improve the productivity of under-performing practices
Requirements for Clinical Integration:

• Evidence of utilization management and quality assurance programs
• Evidence of practice standards and clinical protocols
• Demonstrated use of a management information system
• Credentialing plans which focus on maintaining a high quality, cost conscious provider panel
• Evidence of capital investments to achieve clinical integration and operational efficiencies via monitoring programs and sanctioning as necessary
Population Based Payment®

Historical Claim Cost and Target PMPM:

<table>
<thead>
<tr>
<th>Description</th>
<th>Premium</th>
<th>Target</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Cost</td>
<td>$291.28</td>
<td>$230.70</td>
<td>$5.92</td>
</tr>
<tr>
<td>Total Members</td>
<td>10,656</td>
<td>10,656</td>
<td>$63,083</td>
</tr>
</tbody>
</table>

US Healthcare Solutions®
Strategy • Contracting • Network Management
## Population Based Payment® - Financial Model

<table>
<thead>
<tr>
<th>Practice</th>
<th>PMPM</th>
<th>Members</th>
<th>Monthly Cost</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice 1</td>
<td>$203.66</td>
<td>2,801</td>
<td>$570,460</td>
<td>$39,766</td>
</tr>
<tr>
<td>Practice 2</td>
<td>$224.61</td>
<td>3,695</td>
<td>$829,919</td>
<td>$52,458</td>
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<tr>
<td>Practice 3</td>
<td>$261.54</td>
<td>679</td>
<td>$177,585</td>
<td>$9,639</td>
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<tr>
<td>Practice 4</td>
<td>$291.92</td>
<td>1,146</td>
<td>$252,024</td>
<td>$16,269</td>
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<tr>
<td>Practice 5</td>
<td>$429.38</td>
<td>617</td>
<td>$264,924</td>
<td>$8,759</td>
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<tr>
<td>Practice 6</td>
<td>$255.31</td>
<td>558</td>
<td>$142,461</td>
<td>$7,921</td>
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<tr>
<td>Practice 7</td>
<td>$244.85</td>
<td>1,160</td>
<td>$284,025</td>
<td>$16,468</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$236.62</strong></td>
<td><strong>10,656</strong></td>
<td><strong>$2,521,401</strong></td>
<td><strong>$151,284</strong></td>
</tr>
</tbody>
</table>

### Target Savings

- Target Savings of $5.92 \( \times (10,656 \times 12) \) = $757,002

### Provider Gain-share

- Provider Gain-share after first 2.5% = 50/50
- 1% reduction = $2.37 \times 0.5 = $1.18 \times (10,656 \times 12) = $151,284
Summary

• Provider Payments should be based upon improvements against historic trend performance:
  – Outcomes
  – Cost

• Successful provider panels can be expanded through **targeted recruitment efforts** - strategically introducing higher cost physician practices to clinically integrated physician panels
References


• The Managed Care Information Center. Successful Clinical Integration. Initiatives in Physician Organizations: How to Build a FTC Compliant Program. February 27, 2008.