



Understanding New Healthcare Delivery Systems: Accountable Care Organizations

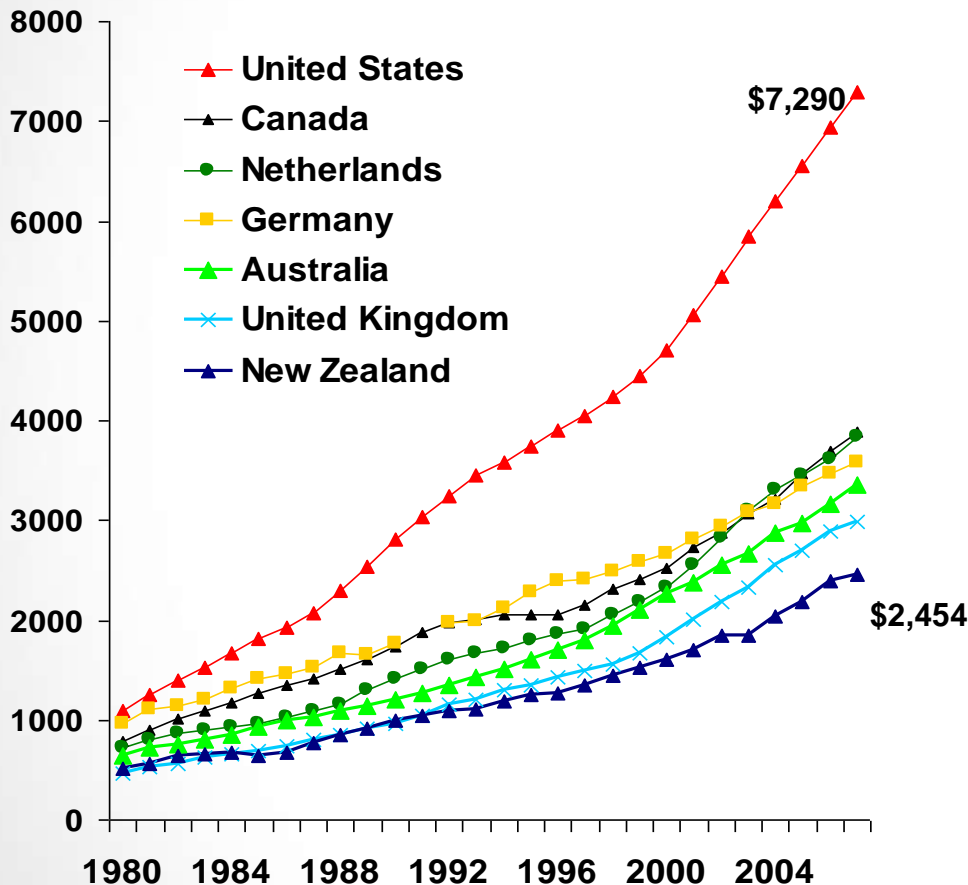
Frederick J. Bloom, Jr. MD MMM

Associate Chief Quality Officer – Geisinger Health System

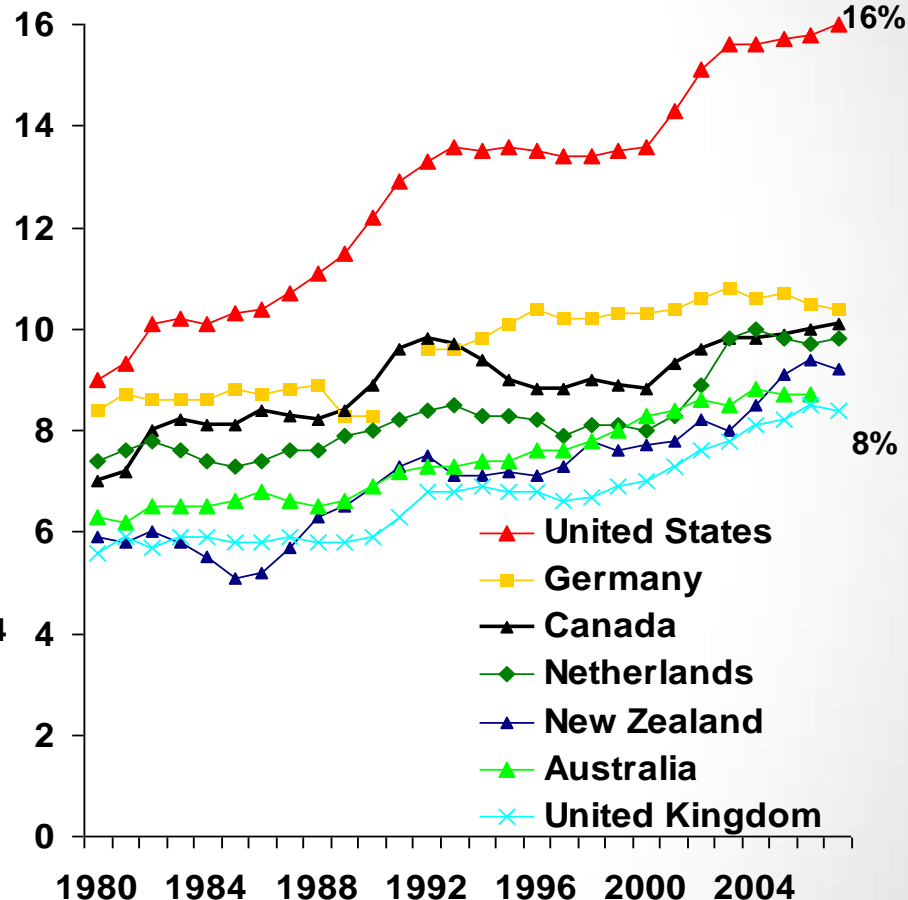
10/22/11

International Comparison of Spending on Health, 1980–2007

Average spending on health per capita (\$US PPP)



Total expenditures on health as percent of GDP

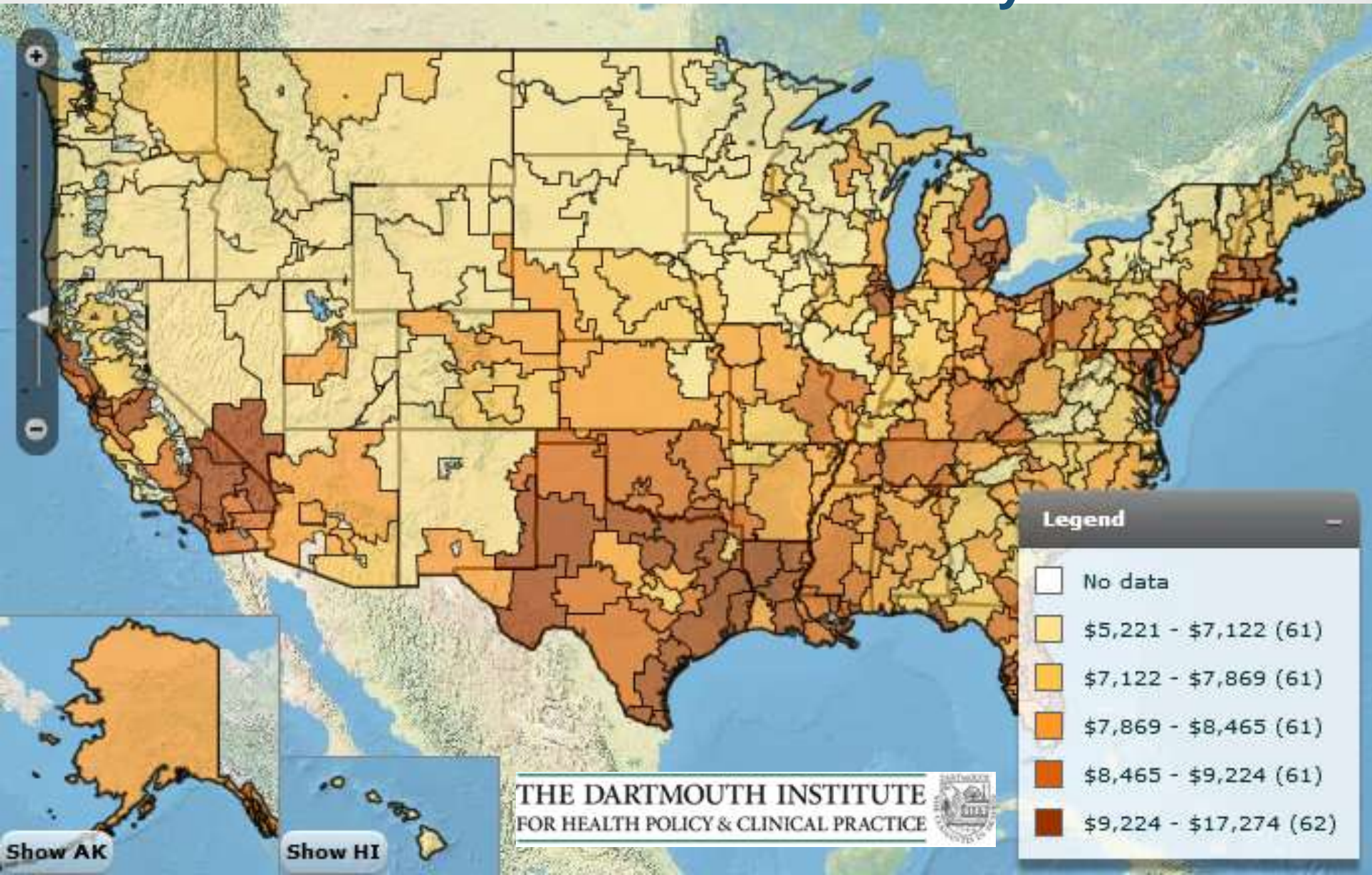


Note: \$US PPP = purchasing power parity.

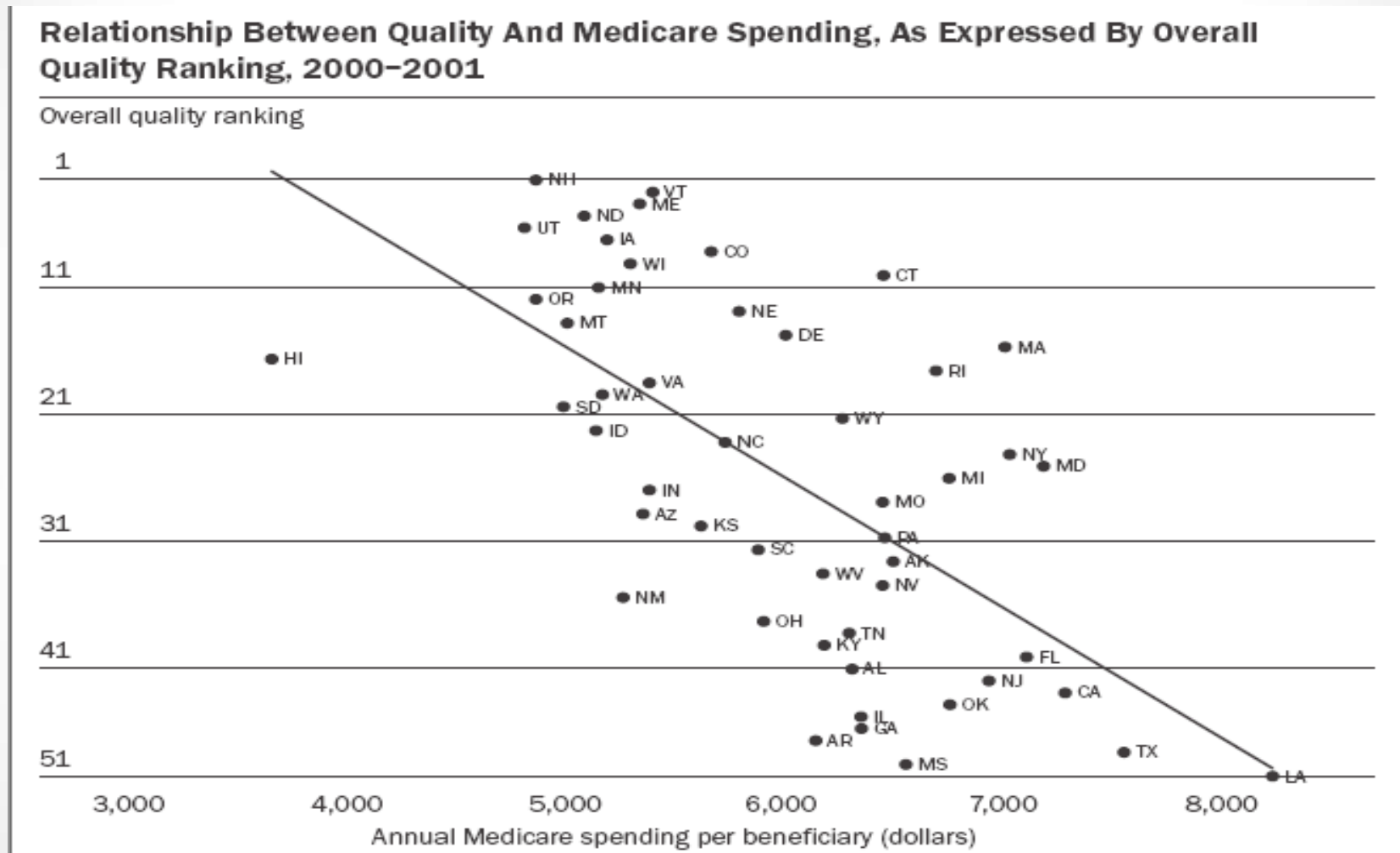
Source: Organization for Economic Cooperation and Development, *OECD Health Data, 2009* (Paris: OECD, Nov. 2009).

The Dartmouth Atlas

2007 Medicare Reimbursements by Enrollee



Higher Cost Associated with Lower Quality



Baicker K, Chandra A. Health Affairs Web Exclusive, April 7, 2004: W4 184-97.

Accountable Care Organizations

The Patient Protection and Affordable Care Act (PPACA)

One Hundred Eleventh Congress
of the
United States of America
AT THE SECOND SESSION

*Begun and held at the City of Washington on Tuesday,
the fifth day of January, two thousand and ten*

An Act

Entitled The Patient Protection and Affordable Care Act.

*Be it enacted by the Senate and House of Representatives of
the United States of America in Congress assembled,*

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the “Patient Protection and Affordable Care Act”.

【Note: This print is of the Patient Protection and Affordable Care Act (“PPACA”; Public Law 111–148) consolidating the amendments made by title X of the Act and the Health Care and Education Reconciliation Act of 2010 (“HCERA”; Public Law 111–152). The text of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 (S. 1790), as enacted (in amended form) by section 10221 of PPACA, is shown in a separate, accompanying document. This document has been prepared by the House Office of the Legislative Counsel (HOLC) for the use of its attorneys and its clients; it is not an official document of the House of Representa



3/23/2010



What is an Accountable Care Organization?

“The defining characteristic of an ACO is that a set of physicians and hospitals accept joint responsibility for the quality of care and the cost of care received by the ACO’s panel of patients”

MedPAC Report to Congress, June 2009

What is an Accountable Care Organization?

“An ACO is a provider-lead organization whose mission is to manage the full continuum of care and be accountable for the overall costs and quality of care for a defined population”

Rittenhouse DR, Shortell SM, Fisher ES “Primary Care and Accountable Care – Two Elements of Delivery Systems Reform”.

N Engl J Med 2009; 361:2301-2303

What is an Accountable Care Organization?

“Physicians and other clinicians, possibly in partnership with a hospital, in legal entities that agree to be accountable for the quality, cost and overall care of a specialized population of patients”

Thomas H. Lee, M.D., Lawrence P. Casalino, M.D., Ph.D., Elliott S. Fisher, M.D., M.P.H., and Gail R. Wilensky, Ph.D.

N Engl J Med 2010; 363:e23 October 7, 2010

Accountable Care Models

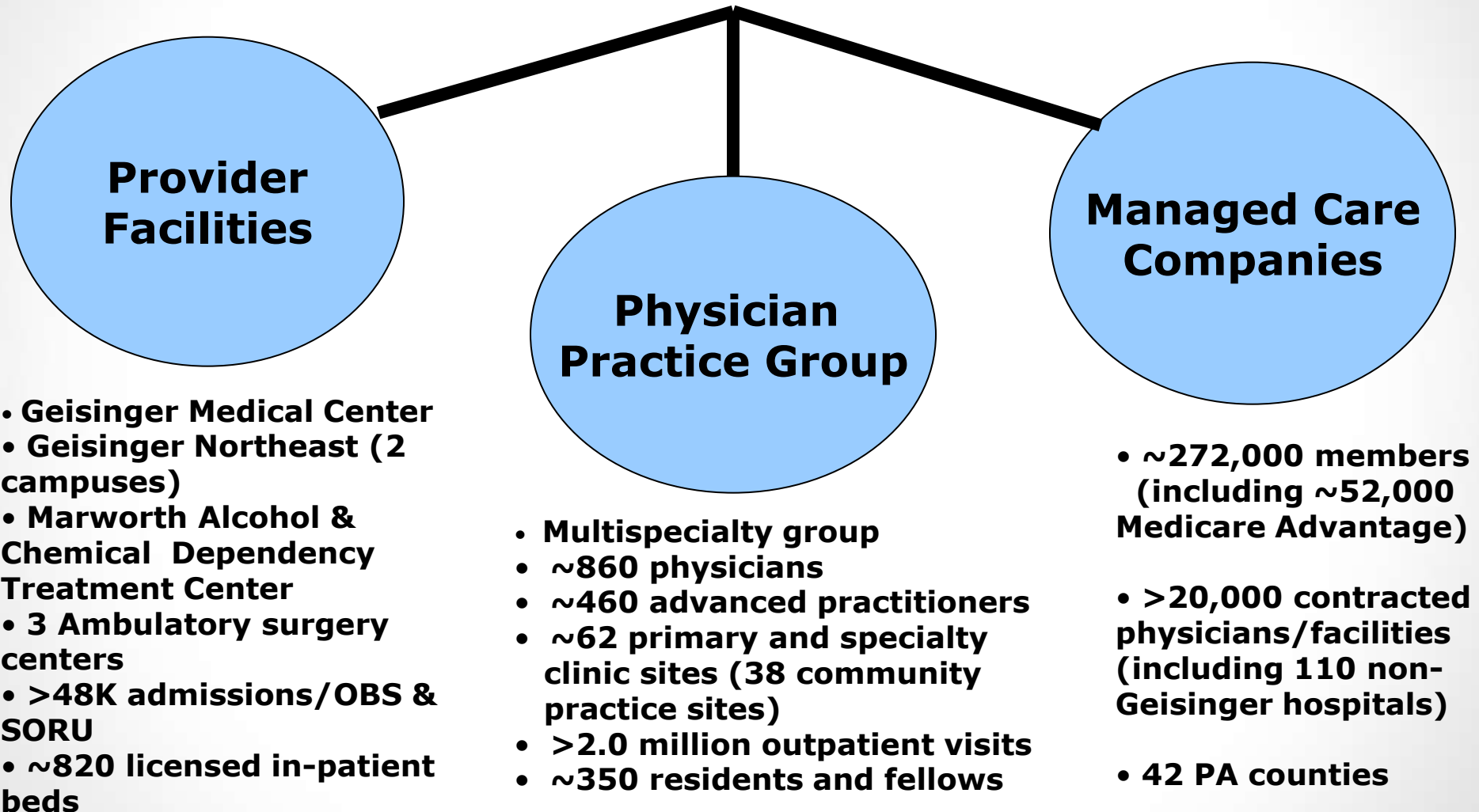
- Medicare Shared Savings Program
- CMS Physician Group Practice Demonstration
 - Transitions Demonstration
- Center for Medicare and Medicaid Innovation (CMMI)
 - Multi-Payer Advanced Primary Care Practice Demonstration
 - Pioneer Demonstration
 - Bundled Payments for Care Improvement
 - Comprehensive Primary Care Initiative

“We have long known that some places, like the Intermountain Healthcare in Utah or the Geisinger Health System in rural Pennsylvania, offer high quality care at costs below average.”

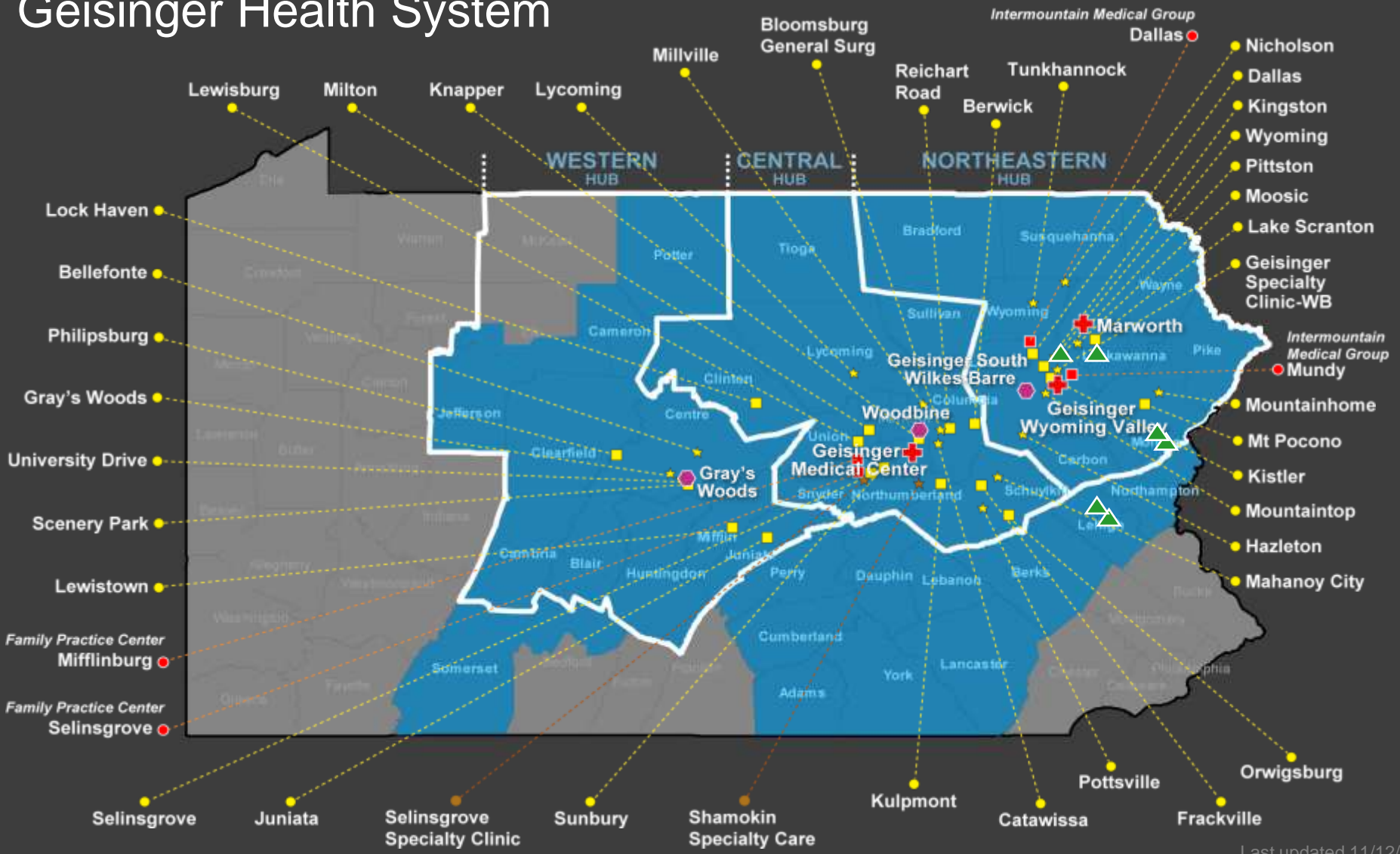
President Obama
Sept. 9, 2009

Geisinger Health System

An Integrated Health Service Organization



Geisinger Health System



Last updated 11/12/09

- Geisinger ProvenHealth Navigator Sites
- Contracted ProvenHealth Navigator Sites
- ★ Geisinger Medical Groups
- ★ Geisinger Specialty Clinics
- + Geisinger Inpatient Facilities
- ⬢ Ambulatory Care Facility
- Geisinger Health Plan Service Area
- ▲ Careworks Convenient Healthcare

Our Legacy



**“Make my hospital right,
make it the best.”**

Abigail Geisinger
1827-1921

“Geisinger Quality – Striving for Perfection”

Physician Group Practice Transition Demonstration

Centers for Medicare and Medicaid Services Physician Group Practice Demonstration Project

First value based purchasing demonstration applied to providers

Goals – Improve efficiency (decrease costs) while improving quality (measured on 32 quality metrics) for assigned vs. comparison group of Medicare beneficiaries in the same geographic location getting care from non-site providers.

- Improve coordination of Part A & Part B expenditures
- Align reimbursement with quality
- Reward for improving health outcomes

Centers for Medicare and Medicaid Services Physician Group Practice Demonstration Project

10 Physician Groups

All are groups of > 200 physicians

Long term commitment –

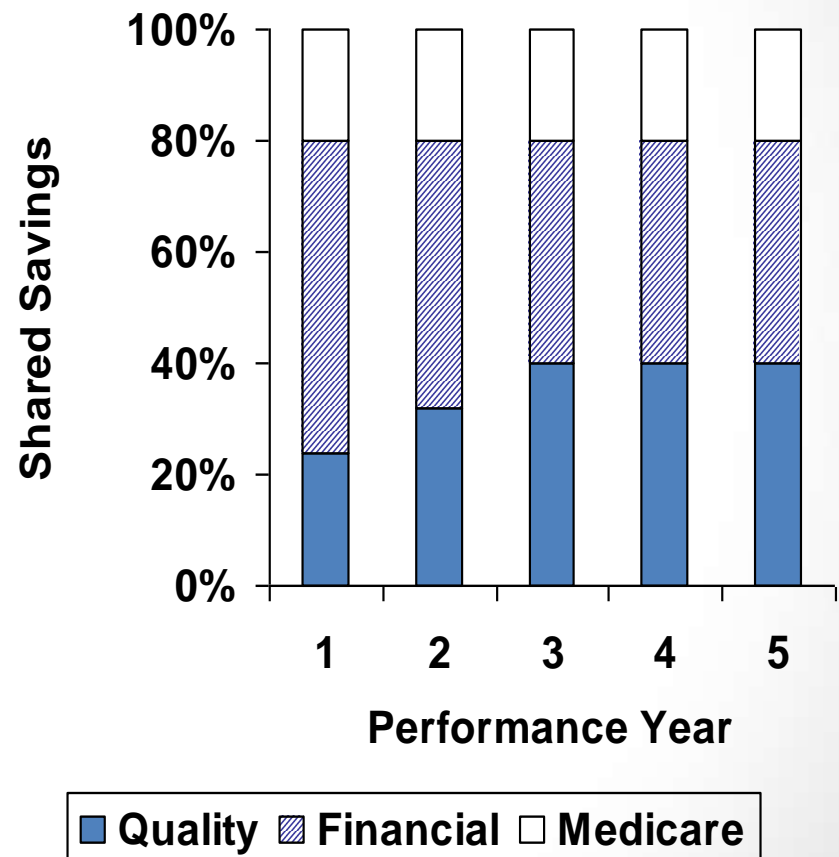
- Application 2003
- Baseline data 2004
- Originally 3 years starting 4/1/05
- Extended to 5 years (5th year completed 3/31/2010)
- Added risk adjustment cap in the 5th year
- Currently the next phase - PGP Transition Demonstration Project

PGP Demonstration Participants

- Dartmouth-Hitchcock Clinic– Hanover, NH
- Deaconess Billings Clinic- Billings, MT
- Forsyth Medical Group– Winston-Salem, NC
- Geisinger Clinic– Danville, PA
- Integrated Resources for Middlesex Area– Middletown, CT
- Marshfield Clinic– Marshfield, WI
- Park Nicollet Health Services– St. Louis Park, MN
- St. John’s Health System– Springfield, MO
- The Everett Clinic– Everett, WA
- University of Michigan Faculty Group Practice– Ann Arbor, MI

Shared Savings Methodology

- *If* assigned beneficiary total Medicare expenditure risk adjusted growth rate is $> 2\%$ below local market growth rate
- *Then* Groups Share up to 80% above the 2% threshold
- Shared Savings Capped at 5% of expenditures
- Risk Adjustment Capped at 10% above comparison group in year 5



PGP Demonstration Quality Measures

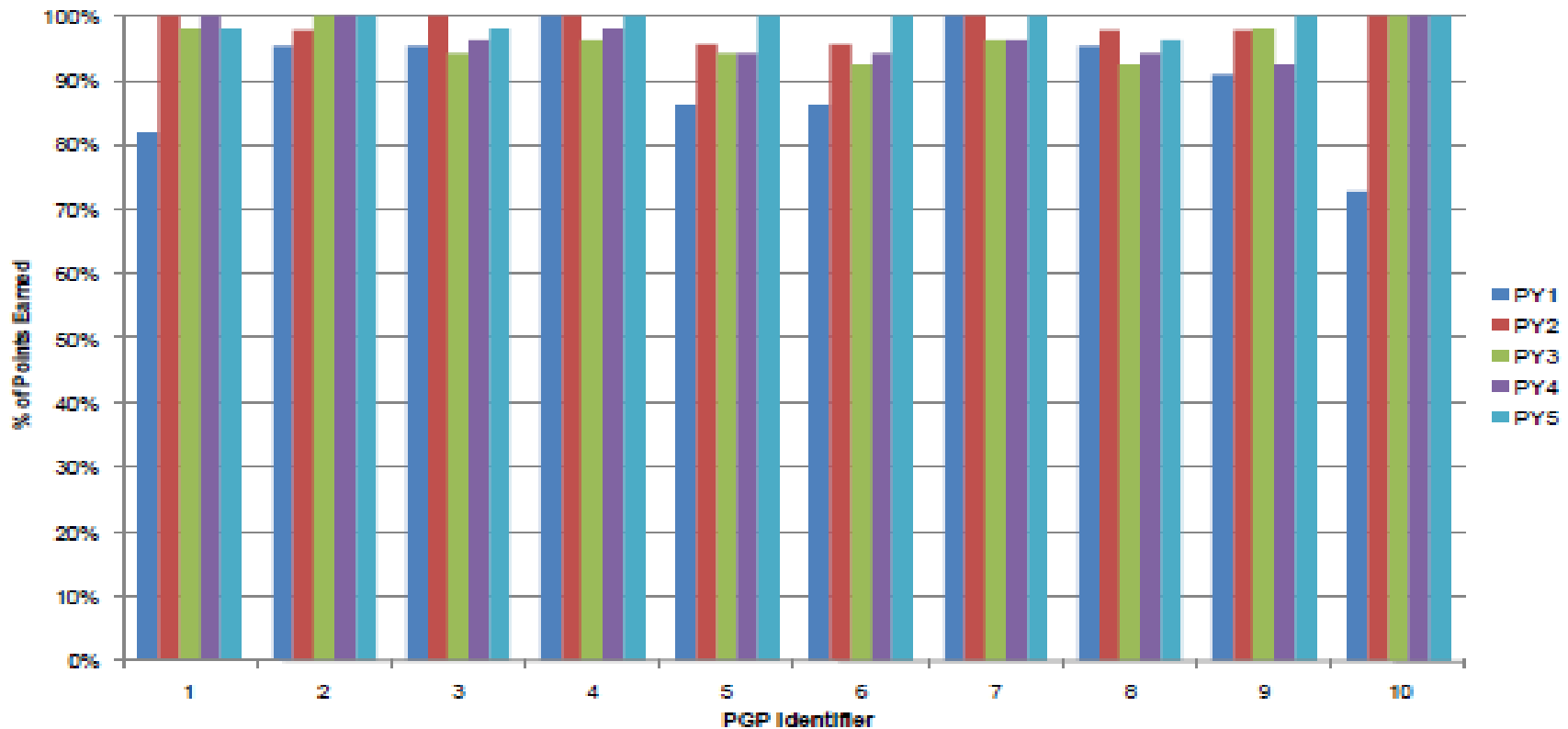
Diabetes Mellitus	Congestive Heart Failure	Coronary Artery Disease	Hypertension & Cancer Screening
<i>HbA1c Management</i>	LVEF Assessment	Antiplatelet Therapy	Blood Pressure Screening
HbA1c Control	<i>LVEF Testing</i>	Drug Therapy for Lowering LDL Cholesterol	Blood Pressure Control
Blood Pressure Management	Weight Measurement	Beta-Blocker Therapy – Prior MI	Blood Pressure Plan of Care
<i>Lipid Measurement</i>	Blood Pressure Screening	Blood Pressure	<i>Breast Cancer Screening</i>
LDL Cholesterol Level	Patient Education	<i>Lipid Profile</i>	Colorectal Cancer Screening
<i>Urine Protein Testing</i>	Beta-Blocker Therapy	LDL Cholesterol Level	
<i>Eye Exam</i>	Ace Inhibitor Therapy	Ace Inhibitor Therapy	
Foot Exam	Warfarin Therapy		
Influenza Vaccination	Influenza Vaccination		
Pneumonia Vaccination	Pneumonia Vaccination		

Note: Claims based measures in italics

PGP Demonstration Results - Quality

Figure 1: Percent of all possible points earned

Percentage of all possible points earned, Performance Year 1 (22 points), Performance Year 2 (45 points), Performance Year 3 (53 points), Performance Year 4 (53 points), and Performance Year 5 (53 points)



PGP Demonstration Results – Overall Financial

	Target minus Actual	Shared Savings Performance Payment	PQRI Earnings	Total Payments
Year 1	\$20,955,837	\$7,323,697	\$0	\$7,323,697
Year 2	\$34,478,988	\$13,840,014	\$2,951,299	\$16,791,313
Year 3	\$48,993,704	\$25,278,792	\$5,742,776	\$31,021,568
Year 4	\$69,427,208	\$31,679,844	\$8,148,519	\$39,828,363
Year 5	\$46,635,970	\$29,434,607	\$8,986,699	\$38,421,306
TOTAL	\$220,491,707	\$107,556,954	\$25,829,293	\$133,386,247

Source: RTI International

PGP Demonstration Results – PGP Shared Savings

PGP	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Billings	\$0	\$0	\$0	\$0	\$0	\$0
Dartmouth	\$0	\$6,689,879	\$3,570,173	\$328,798	\$0	\$10,588,850
Everett	\$0	\$129,268	\$0	\$0	\$0	\$129,268
Forsyth	\$0	\$0	\$0	\$0	\$0	\$0
Geisinger	\$0	\$0	\$1,950,649	\$1,788,196	\$0	\$3,738,845
Marshfield	\$4,565,327	\$5,781,573	\$13,816,922	\$16,154,242	\$15,832,603	\$56,150,667
Middlesex	\$0	\$0	\$0	\$0	\$0	\$0
Park Nicollet	\$0	\$0	\$0	\$0	\$5,673,177	\$5,673,177
St. John's	\$0	\$0	\$3,143,044	\$8,185,757	\$2,598,859	\$13,927,660
Univ. of Michigan	\$2,758,370	\$1,239,294	\$2,798,005	\$5,222,852	\$5,329,967	\$17,348,488
TOTAL	\$7,323,697	\$13,840,014	\$25,278,792	\$31,679,844	\$29,434,607	\$107,556,954

Source: RTI International

What does it take to be successful?

- More than 75% of Medicare spending occurs in patients with 4 or more chronic diseases. (CBO)
- 25% of Medicare beneficiaries consume 85% of the Medicare expenditures. (CBO)
- 10% of the US population consumes 65% of all health care spending. (CMWF Health Affairs 2007)

ProvenHealth® Navigator: Geisinger's Patient Centered Medical Home

- Transform primary care from transaction to value focus
- Act as Value Vehicle **(Integrator)** to improve quality and efficiency across the spectrum of care



Geisinger's PHN model has five core components

Patient-centered primary care

- Patient and family engagement & education
- Enhanced access and scope of services
- **PCP led team-based care**
- Chronic disease and preventive care optimized with HIT

Integrated population management

- Population segmentation and risk stratification
- Preventive care
- **GHP employed in-office case management**
- Disease management

Value care systems

- Micro-delivery referral systems
- **360°care systems** – SNF, ED, hospitals, HH, etc

Quality outcomes

- Patient satisfaction
- HEDIS and bundled chronic disease metrics
- Preventive services metrics

Value-based reimbursement

- Fee-for-service with P4P payments for quality outcomes
- Physician and practice transformation stipends
- Value-based incentive payments
- Payments distributed on Quality Performance

Primary Care Redesign

- Improving reliability and safety in health care is about designing consistent operational flows
- An electronic health record is a tool to help create consistent designs, but is not itself the answer
- Sustained improvement does not rely on individual memory, does not rely on vigilance and greater effort
- Reliable operational flows make sure that the care we all know should be provided, happens every time

Practice Redesign

All or None “Bundle” measure

Clinical process redesign – Eliminate,
Automate, Delegate, Incorporate, Activate

Clinical decision support – Health Maintenance
and Best Practice Alerts

Patient specific strategies using registry report
data

Care Gaps

Patient centered strategies – Patient report
cards

Compensation

Improving CAD Care for 15,355 Patients

	9/06	3/07	7/10	7/11
CAD Bundle Percentage	8%	11%	22%	24%
% LDL <100 or <70 if High Risk	38%	37%	49%	52%
% ACE/ARB in LVSD,DM, HTN	65%	66%	76%	77%
% BMI measured	79%	86%	99%	99%
% BP < 140/90	74%	74%	79%	78%
% Antiplatelet Therapy	89%	91%	92%	92%
% Beta Blocker use S/P MI	97%	97%	97%	97%
% Documented Non-Smokers	86%	86%	87%	87%
% Pneumococcal Vaccination	80%	80%	86%	86%
% Influenza Vaccination	60%	74%	78%	79%

Important Principles

Spreading the work out over a team, each with clearly defined and appropriate roles, improves reliability.

Measures are never perfect, but they improve with time and are vital to the change process.

Compensation helps focus attention, but it is not sufficient to drive change.

Integrated Population Management

Components	Core Activities
Population Segmentation	Predictive modeling Risk stratification
Health Promotion	Preventive care & Screenings
Disease Management	Self-management education Medication management
Case Management	Care coordination Exacerbation management TOC Tele-monitoring
Pharmacy Management	Brand vs. generic

Transitions of Care

Pt contact within 24-28 hrs post discharge

Telephonic outreach

- Medication reconciliation
- Ensure safe transition post discharge
 - with appropriate services in place
 - Home Health
 - DME
 - Safe to be in their home?
- Facilitate post hospital PCP appt within 3 - 5 days



Chronic Care Management

Heart Failure

Diuretic Titration
Protocol
Daily weights
Telemonitoring
Education
Self management
Outreach

COPD

Rescue kit
Symptom monitoring
Education
Self management
Medication
Outreach

Value Care Systems

Micro-delivery referral systems

- High volume specialties
- Ancillary services – Radiology, Lab

360 degree care systems

- Hospital care
- Home Health
- SNF's
- ER coverage
- Community resources

Expanded focus - The Medical Neighborhood



Quality Outcomes Program

Ten metrics for each practice

Chronic disease metrics

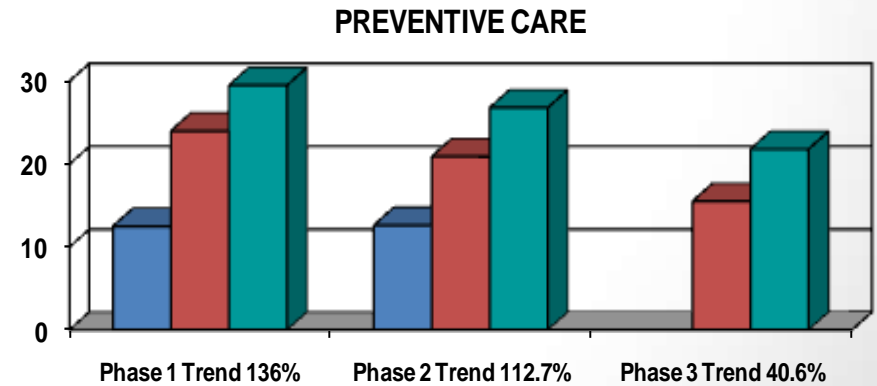
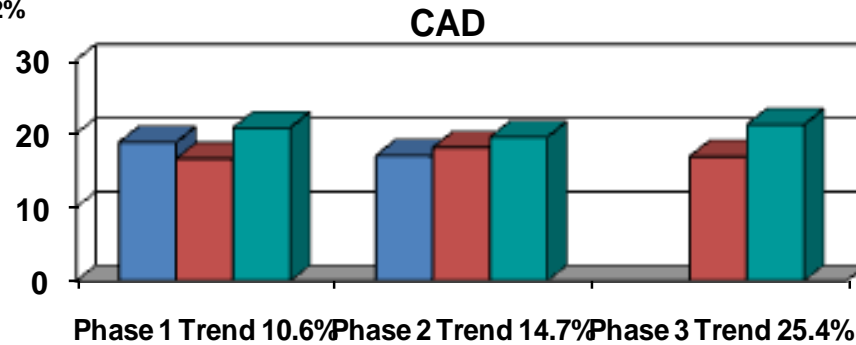
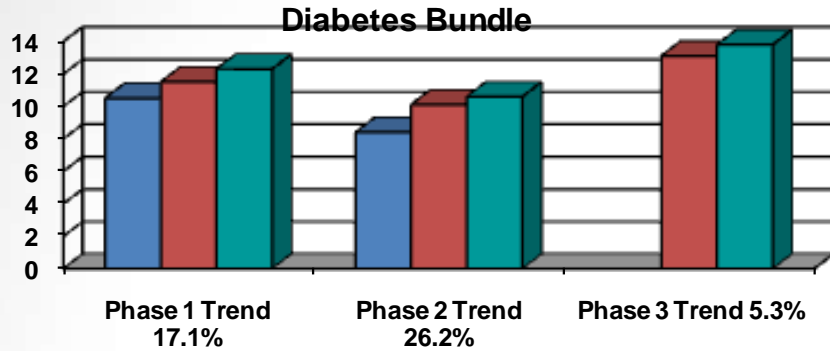
Prevention metrics

Encounters per patient

Post-hospitalization follow up rate

High risk patients with care plans

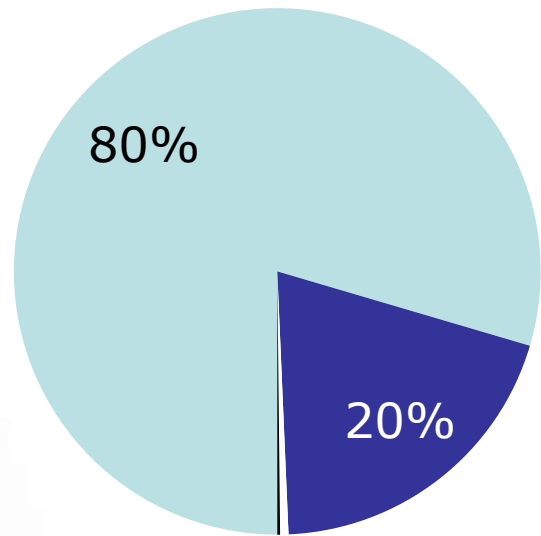
ProvenHealth Navigator[®] Quality Outcomes - 2009



Patient Satisfaction Survey CY2009

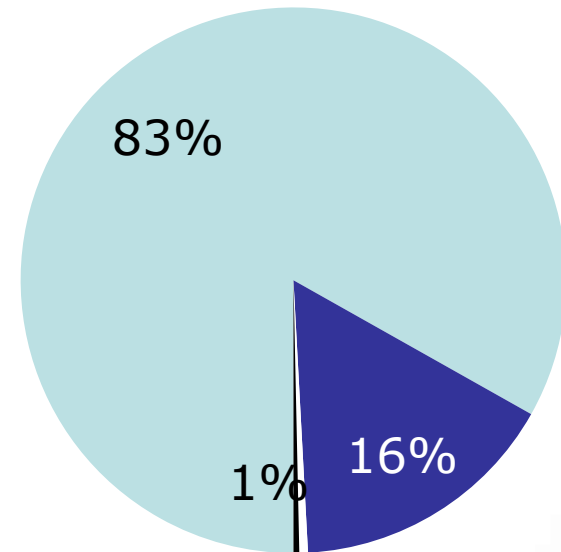
50% Overall Survey Return Rate

Timeliness of the CM responding to the patient's concerns



Very good Good
Poor Very poor

Effectiveness of the CM working with the patient



Very good Good
Very poor Poor

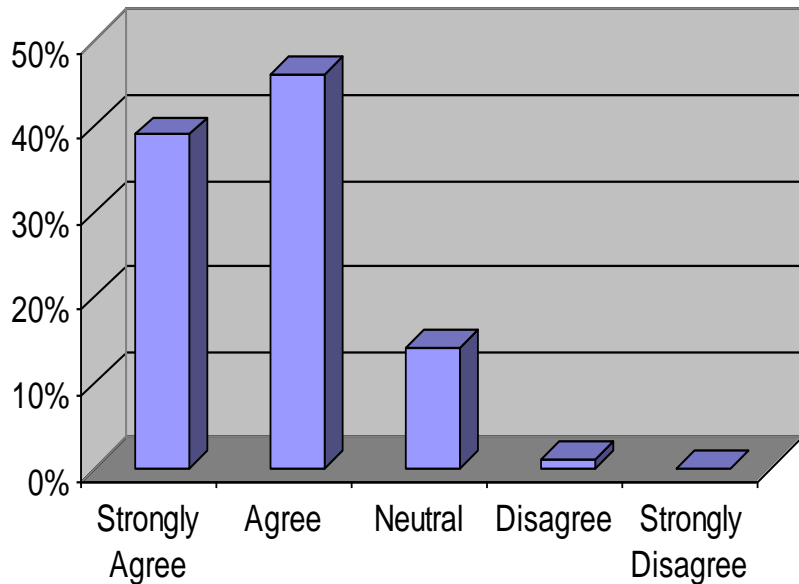
Results based on pilot & phase 2 sites - NAs excluded

| 38

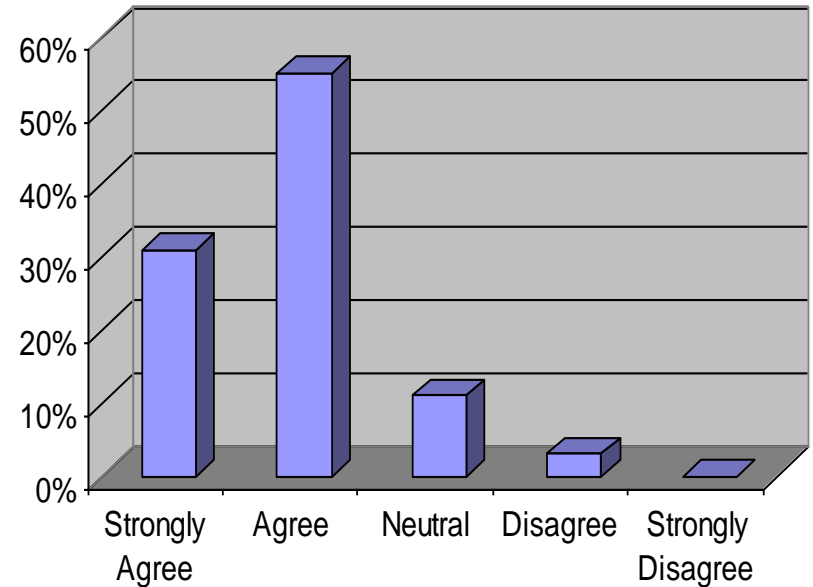
Provider Satisfaction Survey CY 2009

59% Overall Return Rate

Management/ Monitoring of all patients across all care sites has improved



Medical Home has allowed you to provide more comprehensive care than the previous system



Value Reimbursement System

Fee-for-service payments

Pay-for-performance payments

Physician stipends

Practice transformation stipends

Incentive payments

PHN Expansion

	Sites	MA members	Commercial members	Medicare members	Total
2007	3	3,100	800	2,000	31,000
2008	10	7,300	8,500	11,000	119,000
2008/9	12	4,600	7,000	7,800	94,000
2009	12	4,300	7,100	5,300	55,000
2010	9	1,700	4,600	3,000	61,000
Total	44*	21,000	28,000	29,100	360,000

* 37 Geisinger primary care practices & 7 non-Geisinger primary care practices



THE AMERICAN JOURNAL OF MANAGED CARE.

Value and the Medical Home: Effects of Transformed Primary Care

Richard J. Gilfillan, MD; Janet Tomcavage, RN, MSN; Meredith B. Rosenthal, PhD;
Duane E. Davis, MD; Jove Graham, PhD; Jason A. Roy, PhD; Steven B. Pierdon, MD;
Frederick J. Bloom Jr, MD, MMM; Thomas R. Graf, MD; Roy Goldman, PhD, FSA; Karena M. Weikel, BA;
Bruce H. Hamory, MD; Ronald A. Paulus, MD, MBA; and Glenn D. Steele Jr, MD, PhD

Am J Manag Care. 2010;16(8):607-614

PHN Results

■ **Table 4.** Estimated Effect of ProvenHealth Navigator on Admissions, Readmissions, and Spending^a

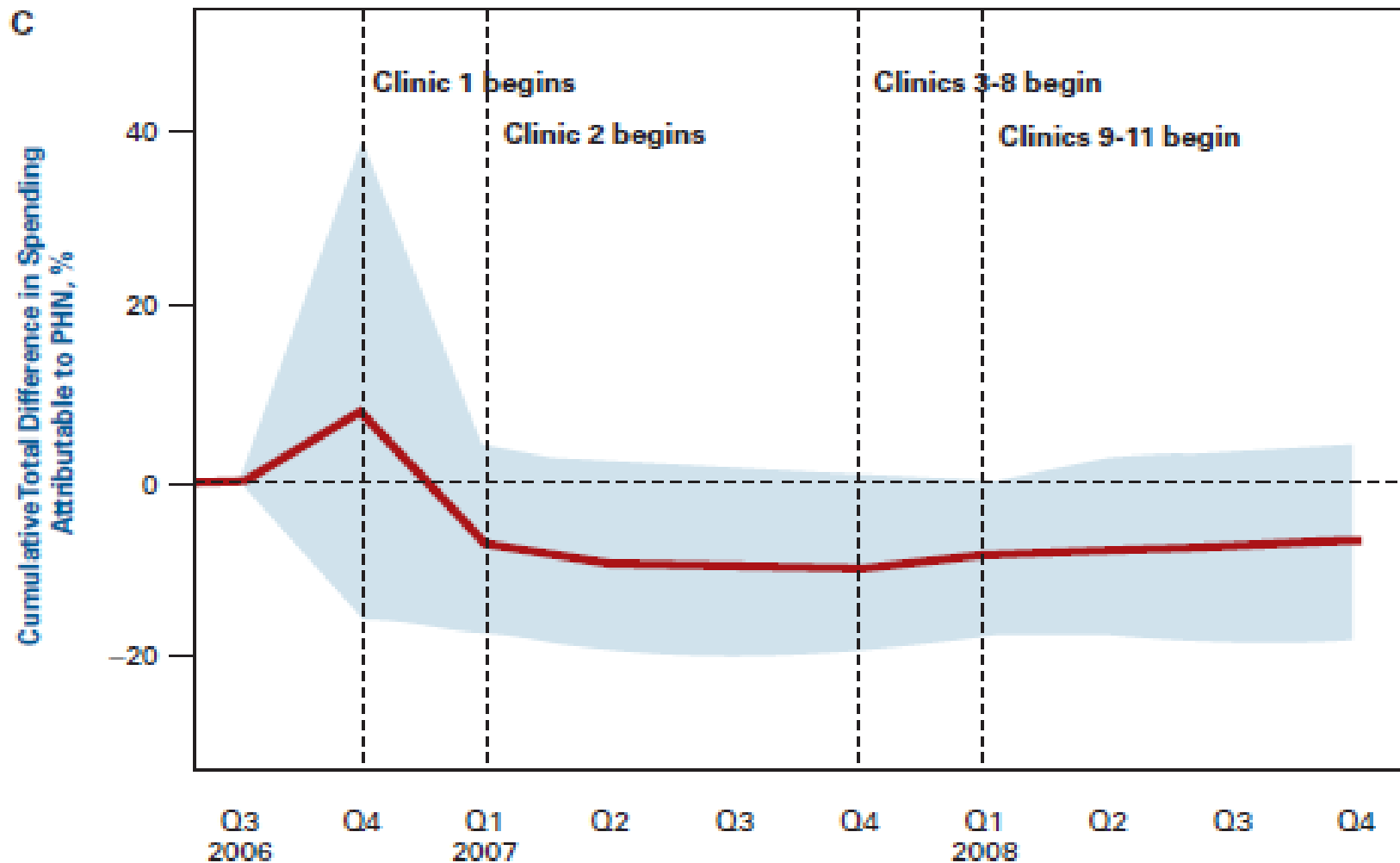
Variable	PHN Participants		Expected Difference Attributable to PHN	95% CI	P
	Active	Simulated			
Admissions per 1000 members per year	257	313	-56 (-18%)	-30% to -5%	<.01
Readmissions per 1000 members per year	38	59	-21 (-36%)	-55% to -3%	.02
Total costs PMPM, \$	107	116	-9 (-7%)	-18% to +5%	.21

CI indicates confidence interval; PHN, ProvenHealth Navigator; PMPM, per member per month.

^aTotal spending (plan payment plus member copayment) values exclude prescription drugs and are indexed to equal \$100 for non-PHN sites in January 2005 to protect confidentiality of spending figures. Results are reported for 2 groups: (1) PHN participants (active), representing only data from participants at PHN sites after implementation and (2) PHN participants without PHN (simulated), representing the expected outcomes from the previous group if the PHN had never been implemented.

(*Am J Manag Care.* 2010;16(8):607-614)

Consistent Cost Reduction Clinic After Clinic



PHN indicates ProvenHealth Navigator.

^aOutcomes for active PHN participants versus the expected outcomes for those participants if PHN had not been implemented. Shaded areas indicate 95% confidence intervals.

PGP Demonstration Design Flaws

- Shared savings started at 2% threshold
- Local Comparison Group
- Beneficiary Assignment Based on all outpatient E&M services (primary care and specialty)
- Risk Adjustment
- Poor Access to Data

PGP Transition – Final Design Overview

Performance Period: 2 years (1/1/11 - 12/3/12)

Beneficiary Assignment: Option for Primary Care Assignment

Comparison Population: National

- Baseline is weighted risk adjusted expenditures in past 3 years
- Trended forward based on national average growth rate (absolute per capita dollar increase – risk adjusted)

Risk Adjustment : Prospective

- Capped at +/- 0.4% in year 1 and 0.8% in year 2 relative to base year

Minimum Savings Requirement: 95% one sided

Shared Savings: 50% split from 1st dollar savings

- Quality Gated
- 25% withhold

CMMI Bundled Payments for Care Improvement

Payment of Bundle	Acute Care Hospital Stay Only	Acute Care Hospital Stay plus Post-Acute Care	Post-Acute Care Only	Chronic Care
"Retrospective" (Traditional FFS payment with reconciliation against a predetermined target price after the episode is complete)	Model #1	Model #2	Model #3	Model #7
"Prospective" (Single prospective payment for an episode in lieu of traditional FFS payment)	Model #4	Model #5	Model #6	Model #8

 = Current
  = Future

ProvenCare[®]

Geisinger's Bundled Episodic Care

ProvenCare[®] brings GHS national attention



The New York Times
National
7/19/07 (MAY 12, 2007)

In Bid for Better Hospital Care, Heart Surgery With a Warranty

BY HEER ABRAMSON

When it comes to medical care, consumers have a right to know what they are getting. That is what a group of health care executives is trying to learn in an experiment that some experts say is a radical new way to ensure hospitals and doctors provide high-quality care that can avoid costly mistakes.

The group, Geisinger Health System, has pioneered its approach to surgery. And taking a cue from the makers of PCs, washing machines and other products, Geisinger now fully guarantees its workmanship, offering a 100-day, no-questions-asked warranty on its heart surgery.

That is a move that has caught the attention of some of the nation's top medical leaders. It is also the only hospital in the country that is just beginning to offer such a guarantee on a major surgical procedure.

Geisinger is trying to address what it views as a flaw in the typical medical reimbursement system. Under the typical system, surgeons are given poor instructions when a patient is referred from the hospital, results are poor, and the patient is often left with a bill for the procedure. As a result, doctors and hospitals have little incentive to ensure they consistently provide the treatments that medical research has shown to provide the best results.

Geisinger's contract is that roughly half of American patients die or are left with serious complications from heart surgery. The new contract is that roughly half of American patients die or are left with serious complications from heart surgery.

The new contract is that roughly half of American patients die or are left with serious complications from heart surgery.

Geisinger's contract is that roughly half of American patients die or are left with serious complications from heart surgery.

Geisinger's contract is that roughly half of American patients die or are left with serious complications from heart surgery.



ProvenCare[®] CABG

One fee for the ENTIRE 90-day period including all surgery-related care:

- ALL surgery-related pre-admission care
- ALL inpatient physician and hospital services, including cardiologists, cardiac surgeons, anesthesia, consultants, etc
- ALL surgery-related post-operative care
- Cardiac rehab and smoking cessation
- ALL care for any related complications or readmissions within 90 days of discharge
- Packaged price incremented by 50% of historical average cost of post-op problems
 - Guaranteed payer savings
 - Geisinger upside based upon complication and readmission reduction and efficient care
 - Risk for complications thereby assumed by providers

Aligns incentives across provider, patient and payer

ProvenCare[®] CABG

How do you take a “Best Practice” and build it into your everyday workflow?



Key Process Redesign Principles

Eliminate any care steps that can be.

Automate any work that can be.

Delegate work that must be done to appropriately trained non-physician staff when possible.

Incorporate by creating tools to enhance the reliability of or efficiency of the care provided.

Activate and engage the patient.

ProvenCare[®] & the Electronic Medical Record (EMR)

Is patient 75 years of age or older & SBP >180mm/hg?

Pre-OP LV EF <25%?

Is patient on a Beta-Blocker?

Is patient on a Statin?

Does patient have dx of PVD; h/o TIA/CVA; Carotid Bruit on exam?

Has Carotid Doppler been done within the last 6 months?

Are Carotid Doppler Results available in EPIC?

Patient has Carotid Doppler requiring Vascular consult?

Vascular Consult completed and report in EPIC?

Has the patient had an Anterior Wall MI within the past 7 days?

Has the patient had an Inferior Wall MI with RV involvement within the past 7 days?

If yes to the previous question, has a consult with another Cardiac Surgeon and a Cardiologist taken

Patient Activation

Clinical, executive, and legal team developed a “Patient Compact” to engage patients and families

– Reflects bilateral commitment to optimize outcomes

- Engage as a “partner” in care process
- Promptly notify team of all issues
- Comply with recommended medications
- Complete cardiac rehabilitation
- Engage with GHS care management services
- Stop smoking
- Manage weight

Education workgroup revised all patient education materials to comply with ProvenCare® concepts

Clinical Outcomes

Comparison of before (n=132) and after (n=321) ProvenCare®

- 80% improvement in In-hospital mortality
- 61% reduction in re-intubations
- 63% reduction in deep sternal wound infection rate
- 40% reduction in neurologic complications
- 29% reduction in pulmonary complications
- 20% reduction in 30 day readmissions
w/ 8% reduction in ALOS

ProvenCare[®] CABG: Financial Outcomes

Hospital:

Net revenue increased 3.8%

Direct costs decreased 5.1%

Contribution margin increased 11.3%

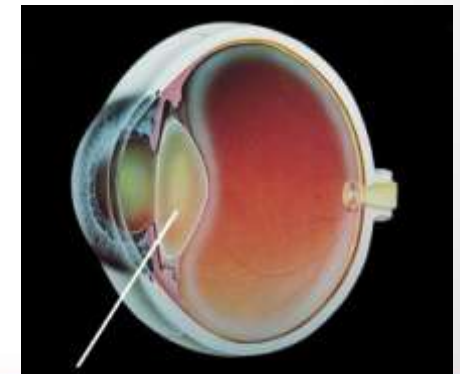
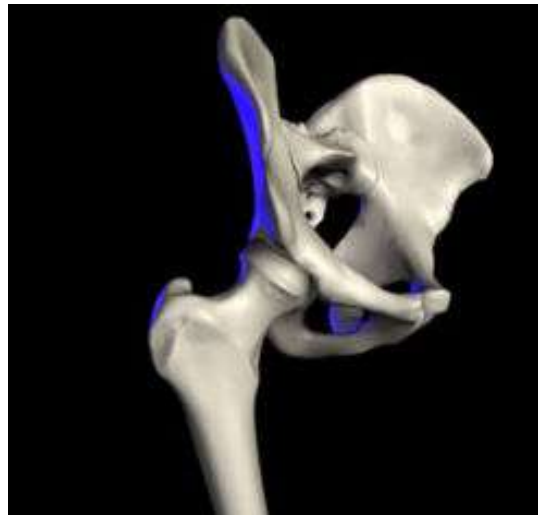
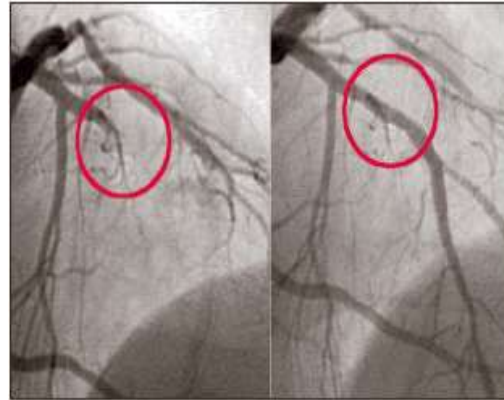
Total inpatient profit per case improved \$2560

Health Plan:

Cost 4.8% less per case for GHS CAB with ProvenCare[®] than it would have without

Cost 28 to 36% less for CAB with GHS than other providers

Other ProvenCare Acute Programs



Central teachers gain \$7G average

Super: Health-care savings balance raises in contract

By GARY PANG
Press Enterprise Writer

SOUTH CENTRE TWP. — Central Columbia teachers will see their average salary of \$53,417 jump up by \$7,000 under a new three-year contract, newspaper calculations show.

School directors recently gave 4.54 percent raises to their teachers, the largest in the area for the coming year.

But Superintendent Harry Mathias said the district can afford the pay increases because the teachers agreed to changes that will slash health insurance costs.

Teachers also agreed to pay more toward their health insurance.

The changes will let Central keep the lowest insurance costs among area school districts, he said.

The new contract costs \$8.3 million in the coming year, Mathias estimated. However, retirements would reduce expenses, he added.

Higher starting salary

Pay raises were set at 4.54 percent for the coming year; 3.62 percent in the contract's second year, 2010-11, and 4.36 percent in 2011-12.

These raises would push the average teacher salary up to \$55,842 in the coming year, \$57,864 in the second year and \$60,387 in the third year, calculations show.

Central also raised the starting salary for teachers. The \$33,638 figure would jump up in three years by \$4,774, calculations show.

The starting salary will be \$35,656 in the coming year, \$37,054 in the second year and \$38,412 in the final year, Mathias said.

But the contract isn't just about pay raises, he said.

New insurance

Back in April, Central was predicting a big rise in insurance premiums. To lower costs, the district switched from Capital Blue Cross to Geisinger Health Plan for all employees.

The switch will reduce costs by \$130,000 to \$140,000, Mathias estimated.

The union accepted the change as part of the new contract, Mathias said.

While other school districts are facing 7 to 8 percent increases in insurance costs, Central is dealing with just a 2.5 percent increase, the superintendent said.

Central's average health insurance cost is \$8,400 per teacher, Mathias estimated. He said other school districts are paying thousands of dollars more.

That's because many school districts get health insurance through the Northeast Pennsylvania School Health Trust, he said. Central, however, finds insurance and bargains on its own. That reduces district costs by \$500,000.

Teachers' concession

Teachers made another concession that might save Central an additional \$20,000, Mathias said.

Before, teachers could choose between an ordinary plan and a more expensive one. If they chose the pricier plan, they paid more money toward the upgrade, but the district picked up some of the additional cost.

Now if they choose a pricier insurance plan, they'll swallow all the extra expenses.

The pricier plan costs \$250 more for single employees and \$650 more for employees with families.

What they'll pay

Teachers had been paying 10 percent of their insurance premiums. That will increase to 11 percent in the first year of the new contract, then 12 percent the second year and 13 percent the third year.

Mathias gave examples of what they might pay in the coming year. These figures do not include the "buy-up" option.

- The premium for a single employee is \$4,500, with the employee paying \$500.

- The premium for a family plan is \$10,500, so the employee pays \$1,150.

The rate is different for non-teacher employees, Mathias noted. Support staff members pay 5 percent of their premiums, while administrators pay 6 percent of their premiums, plus .6 percent of their salaries.

Expense breakdown

The contract's cost of \$8.3 million for the coming year includes insurance expenses: \$1 million for teachers and \$800,000 to \$900,000 for everyone else, Mathias estimated.

In 2008-09, Central paid about \$7.17 million in teacher salaries and \$1 million in benefits, Mathias said.

Despite the recent raises, the Central board is not increasing taxes in the coming year under its recently passed budget.

Lessons Learned Along the Way

It is possible to improve patients' health while reducing costs

Requires change in primary care delivery model; the change is not easy

- Needs active, engaged providers
- Needs active, empowered team

Transitions of care create specific gaps and opportunities

Critical to have case manager embedded in primary care site

Linkage to every system of care needed

Payor/provider partnership essential to success

Questions?

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