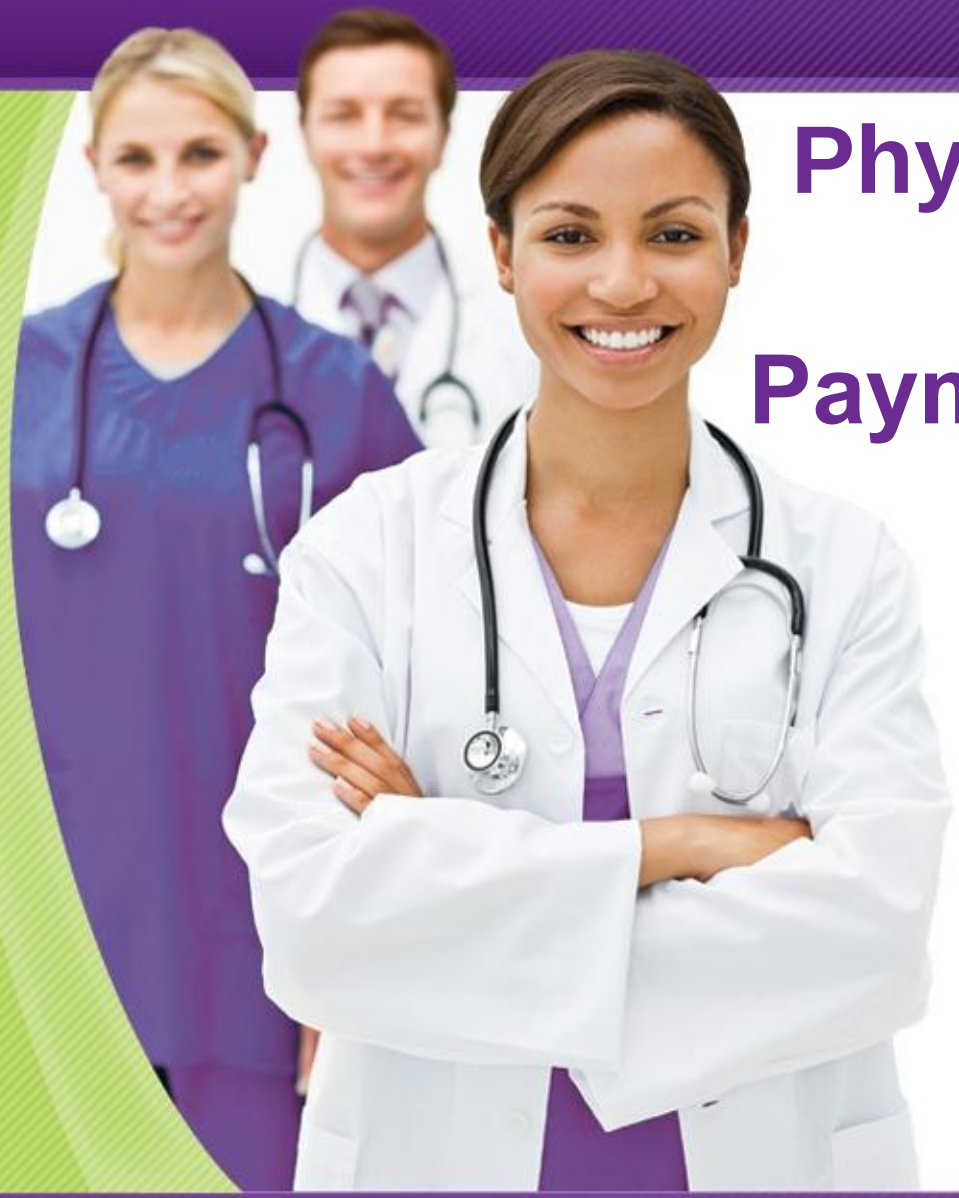


Physician Incentives, Unbundling of Payments and the "C" Word:

Facing the Impending Realities of Healthcare Payment Reform

AMGA IQL Conference
October 2012

Our Focus Today

- ***The Structure:*** Introducing Dean Health System
- ***The Catalyst:*** The Realities of Healthcare driving an imperative for transformational change
- ***The Dilemma:*** Attempting to deliver value when incentives reward volume.
- ***The Future:*** The “new normal”….. Payment Reform.

The Structure

Introducing Dean Health System

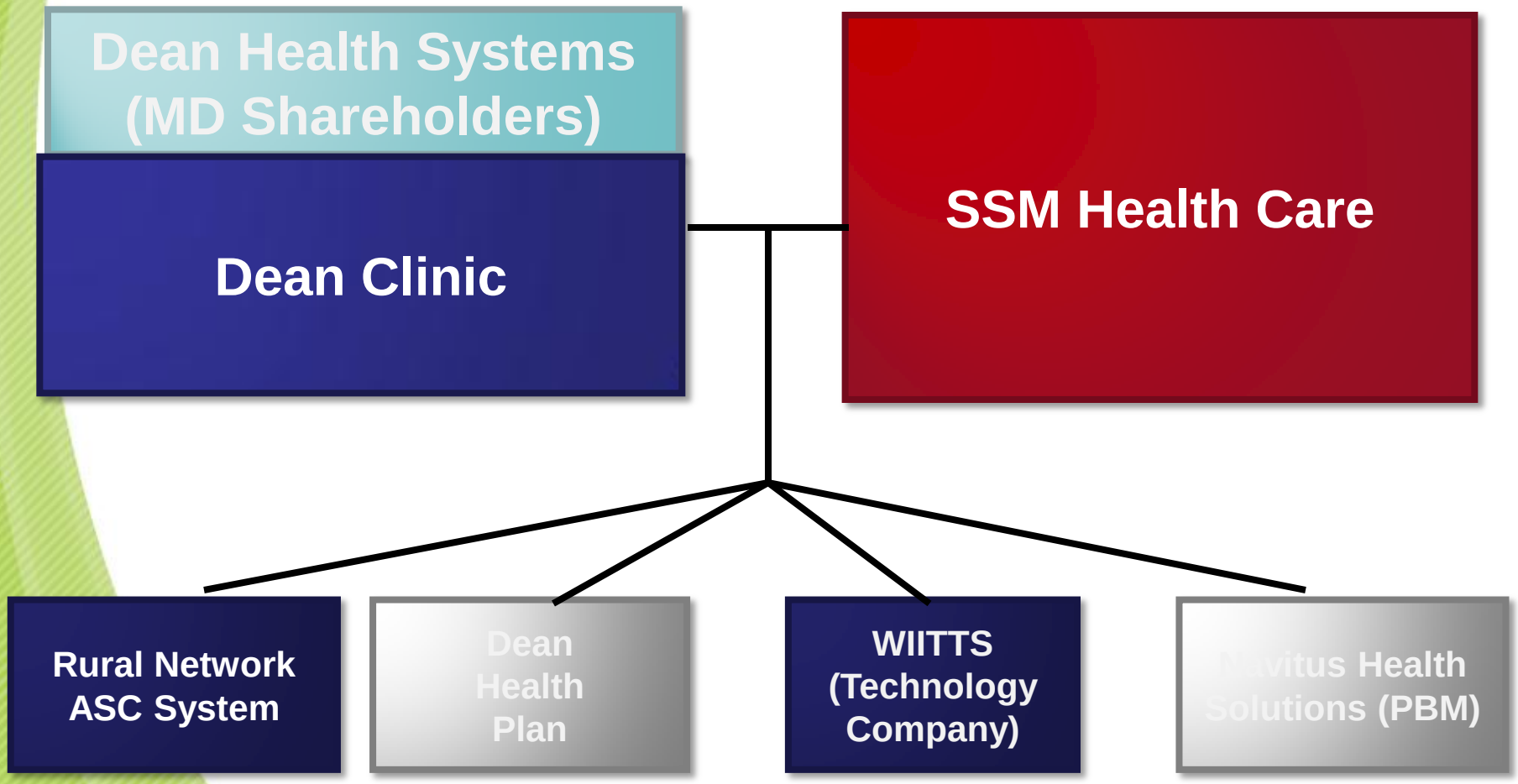
Heritage

Partners who Care
for over 100 years …

Dean™

Dean CLINIC

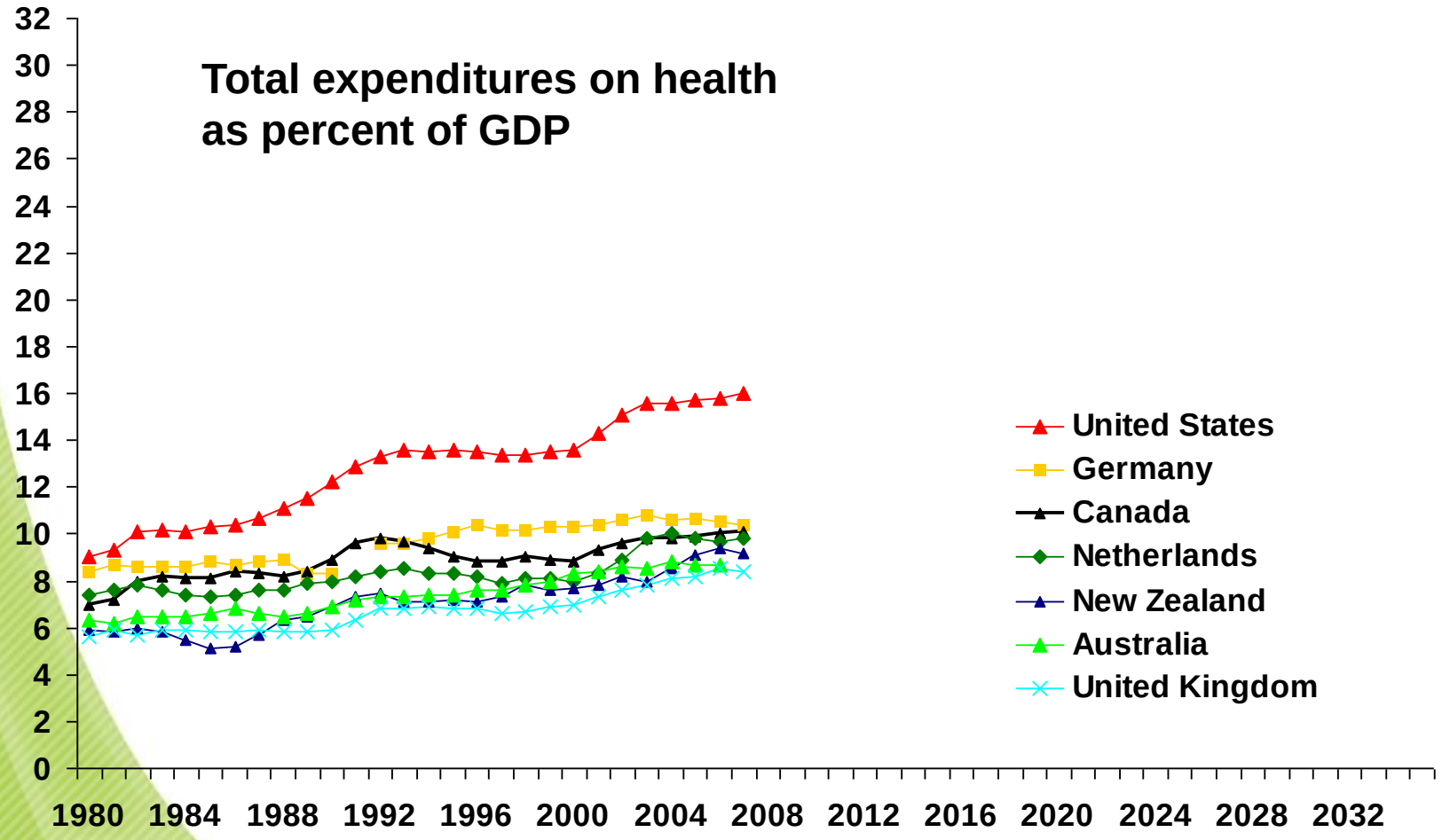
Dean and SSM:
A Virtually Integrated System



The Future

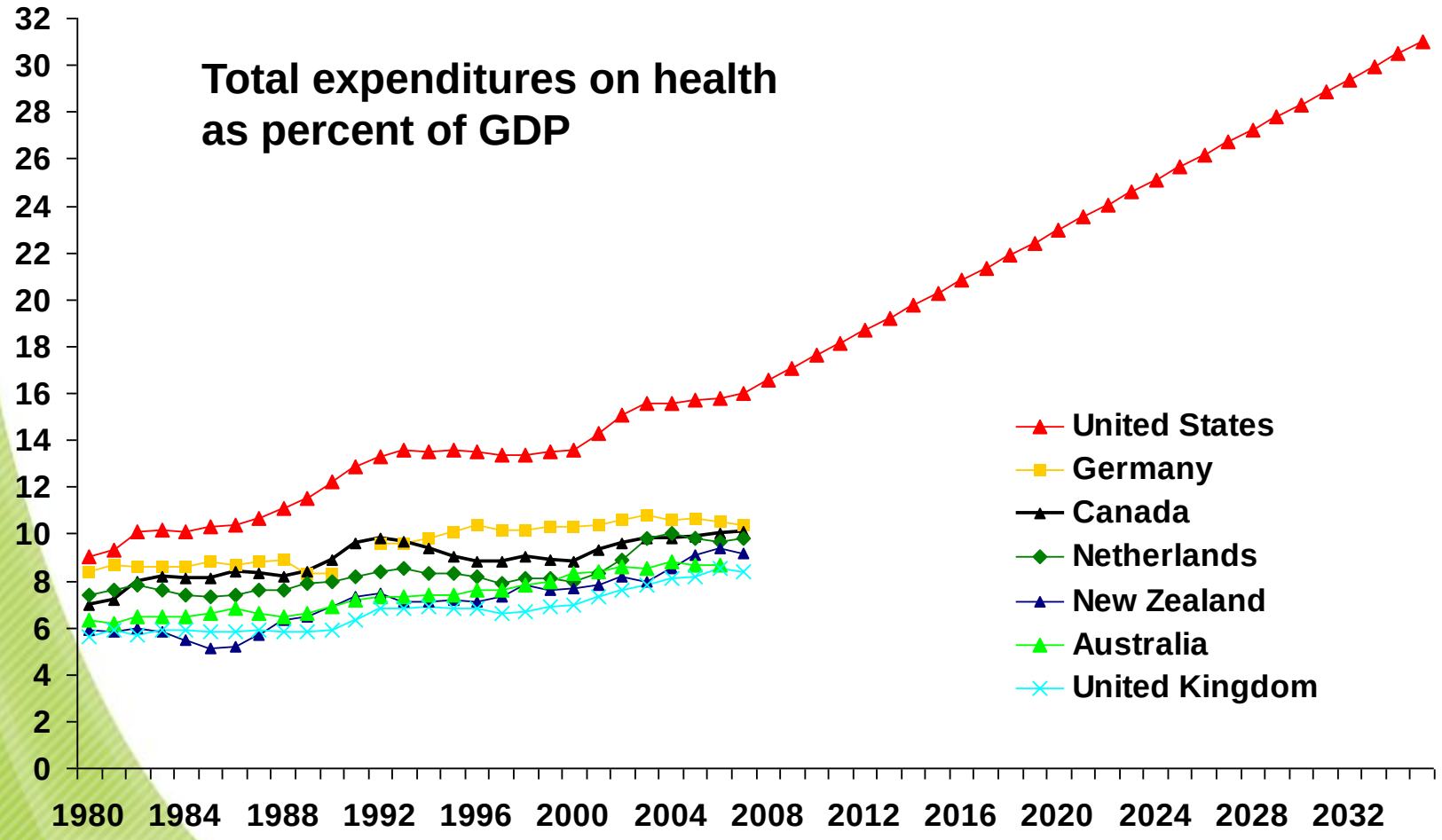
The Realities of Healthcare driving an imperative for transformational change

We're the world's leader
(in the cost of care that is…)



Source: Commonwealth Fund 2010 Mirror, Mirror on the Wall

“Unsustainable Trends tend not to be sustained”….. Herbert Stein



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We're not quite getting what we pay for

	 NETH	 UK	 AUS	 GER	 NZ	 CAN	 US
OVERALL	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Quality	*2*	*3*	*4*	*5*	*1*	*7*	*6*
Access	*1*	*2*	*6.5*	*3*	*4*	*5*	*6.5*
Efficiency	*3*	*1*	*2*	*5*	*4*	*6*	*7*
Equity	*1*	*2*	*4*	*3*	*6*	*5*	*7*
Long, Healthy, Productive Lives	*4*	*6*	*1*	*3*	*5*	*2*	*7*
Health Expenditures/ Capita (2007)	**$3,837**	**$2,992**	**$3,357**	**$3,588**	**$2,454**	**$3,895**	**$7,290**

Source: Commonwealth Fund 2010 Mirror, Mirror on the Wall

Or *are* we?

THE NEW YORKER

ANNALS OF MEDICINE

THE COST CONUNDRUM

What a Texas town can teach us about health care.

BY ATUL GAWANDE

JUNE 1, 2009

It is spring in McAllen, Texas. The morning sun is warm. The streets are lined with palm trees and pickup trucks. McAllen is in Hidalgo County, which has the lowest household income in the country, but it's a border town, and a thriving foreign-trade zone has kept the unemployment rate below ten per cent. McAllen calls itself the Square Dance Capital of the World. "Lonesome Dove" was set around here.

McAllen has another distinction, too: it is one of the most expensive health-care markets in the country. Only Miami—which has much higher labor and living costs—spends more

Costlier care is often worse care.
Photograph by Phillip Toledano.

- Volume over value
- Illness over wellness
- Indiscriminate payment irrespective of outcomes/quality
- Errors and inefficiency
- Redundancy
- Treatments not supported by evidence-based guidelines

Non-Alignment of Incentives was transformative at Dean

FFS

Capitated

FFS

Capitated

Dean CLINIC

Dean's Vision and Focus

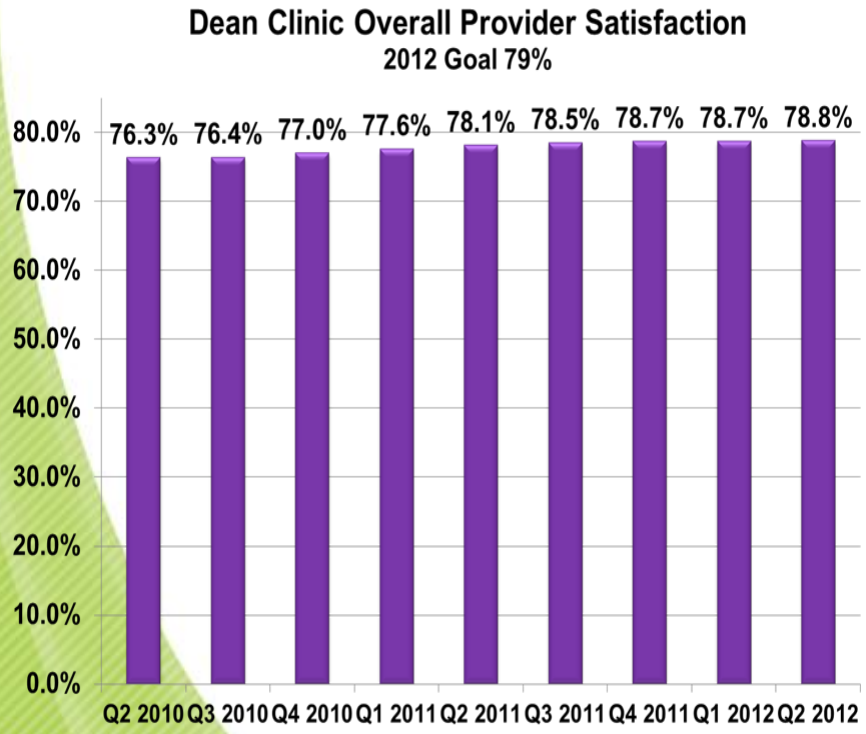
- Our Vision: "We are passionate about keeping our patients healthy, exceptional at caring for them when they are sick, and efficient in providing them with the best value and service."

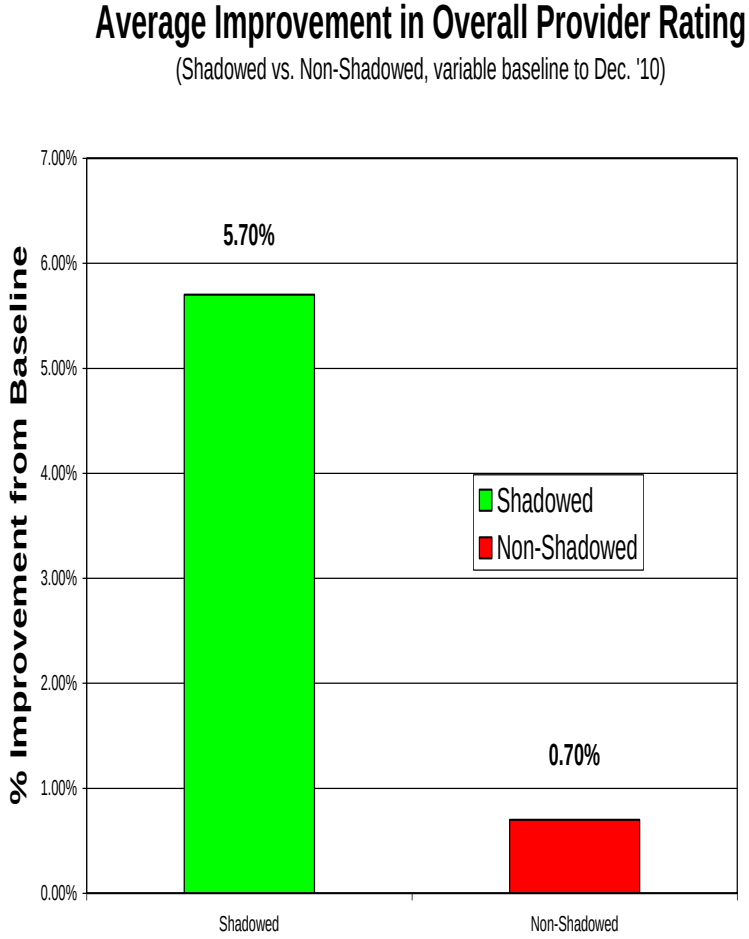
- Our Focus: **Let the rest of our industry focus on Volume. We're focusing on Value.**

  - Delivering Effective Care
  - Delivering Patient-Centered Care
  - Delivering Efficient Care

Delivering Value through Service Improvement

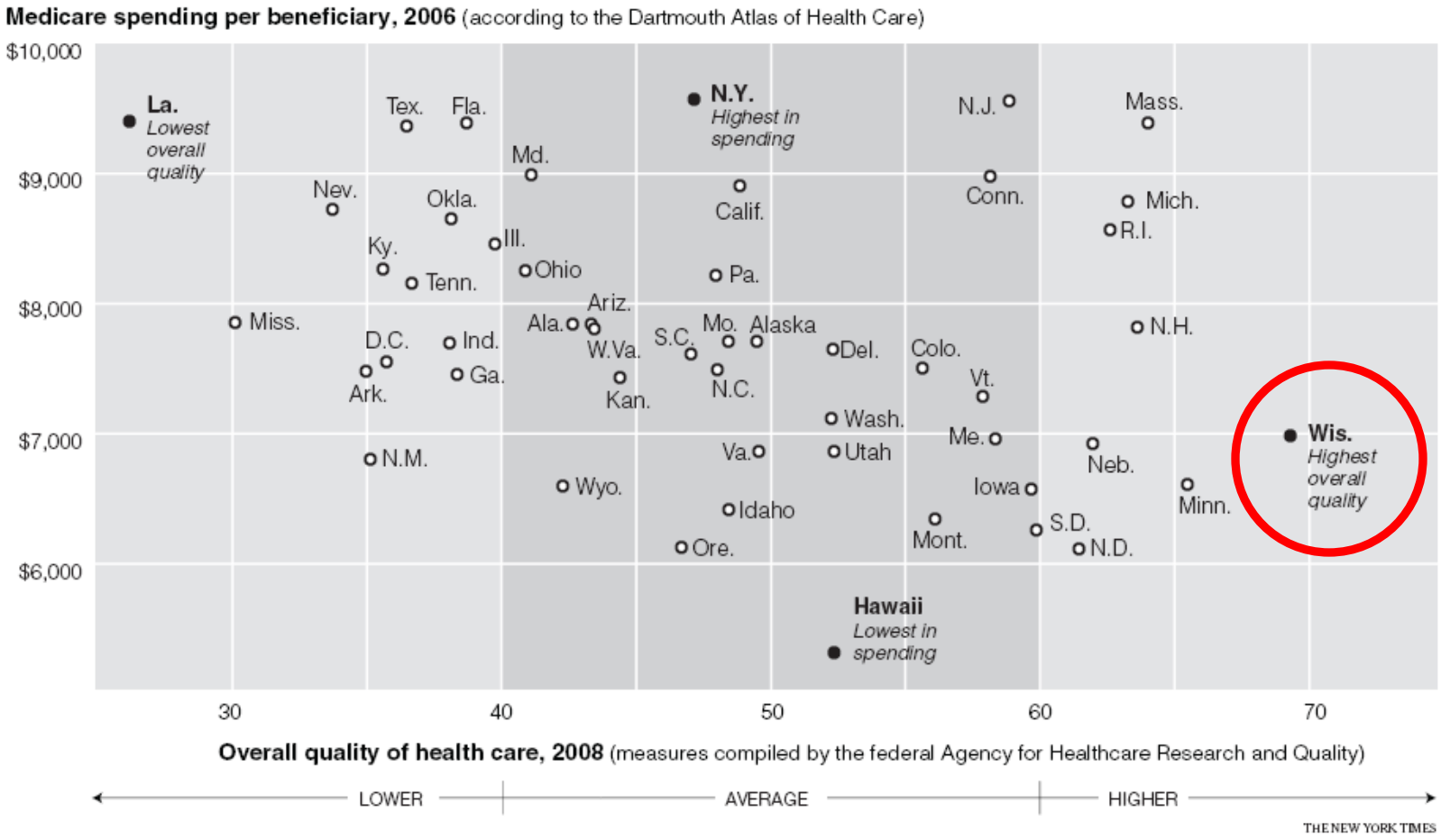
"Using any number from 0-10, where 0 is the worst doctor possible and 10 is the best doctor possible, what number would you use to rate your doctor?





Delivering Value through Quality:

Where we stand in the nation



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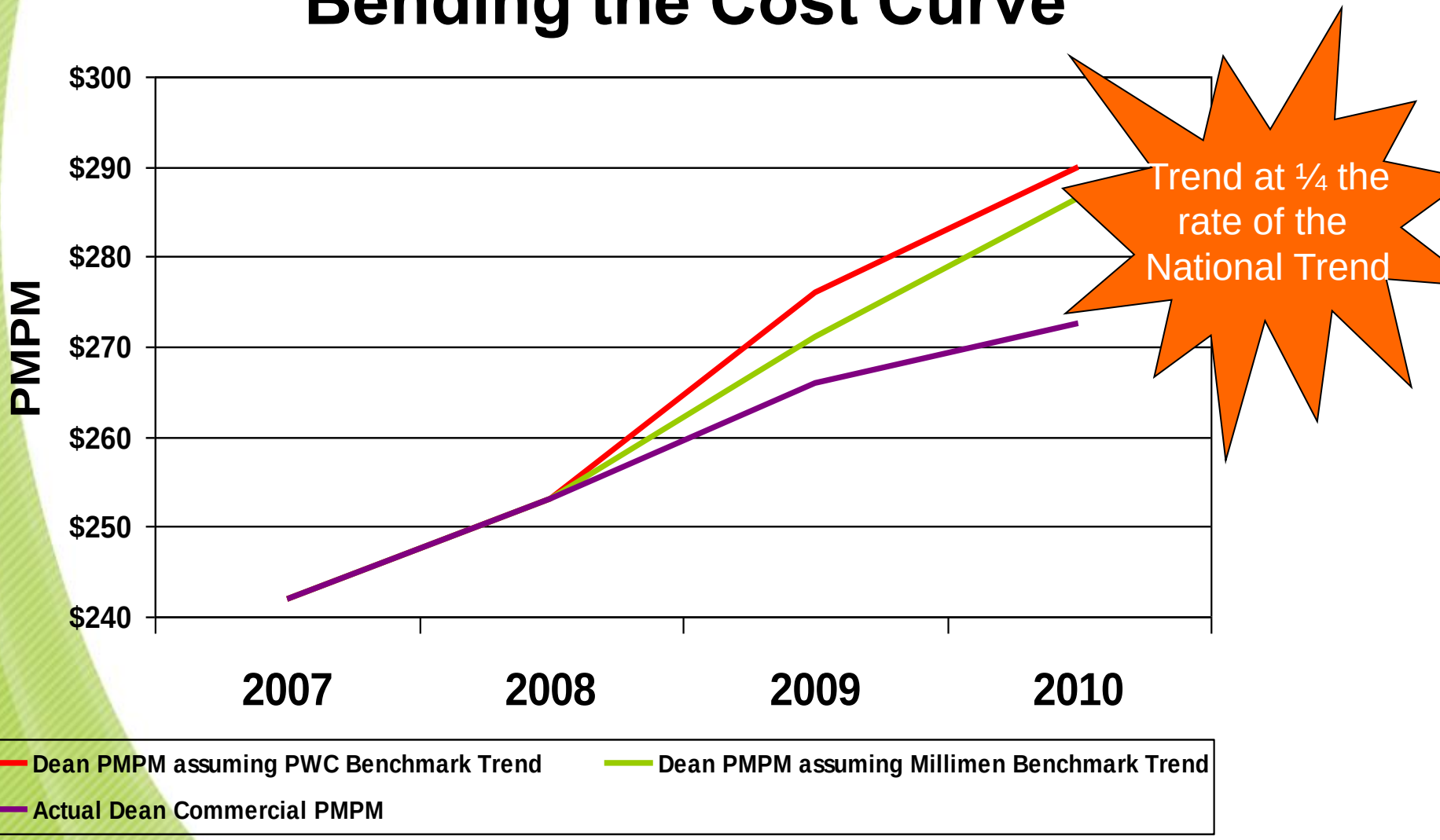
Delivering Value through Quality:

PCMH vs. Non-PCMH Performance in Clinical Effectiveness, Clinical Efficiency and Service Metrics (Dec 2009 vs. Jan 2011)

Measure	PCMH Sites (Pre- vs. Post)			Non-PCMH FM & IM Sites (Pre- vs. Post)			Current Performance Differential (PCMH vs. Non-PCMH)		
Clinical Effectiveness	**Dec-09**	**Jan-11**	**Change**	**Dec-09**	**Jan-11**	**Change**	**PCMH**	**Non-PCMH**	**Diff**
CV LDL Control	69.7%	72.0%	**2.3%**	63.6%	64.7%	**1.1%**	72.0%	64.7%	**7.3%**
CV LDL Testing	88.4%	91.0%	**2.6%**	84.3%	85.7%	**1.4%**	91.0%	85.7%	**5.2%**
Diabetes BP Control	49.1%	48.5%	**-0.6%**	46.5%	48.2%	**1.7%**	48.5%	48.2%	**0.3%**
Diabetes HbA1c Control*	52.6%	62.5%	**9.9%**	52.3%	61.9%	**9.6%**	62.5%	61.9%	**0.6%**
Diabetes HbA1c Testing	71.6%	74.4%	**2.8%**	68.5%	66.5%	**-2.0%**	74.4%	66.5%	**7.9%**
Diabetes LDL Control	60.5%	60.6%	**0.1%**	53.2%	51.7%	**-1.5%**	60.6%	51.7%	**8.9%**
Diabetes LDL Testing	87.4%	88.7%	**1.3%**	86.3%	84.8%	**-1.5%**	88.7%	84.8%	**3.9%**
Diabetes Nephropathy Screen	79.3%	85.3%	**6.1%**	79.0%	79.8%	**0.8%**	85.3%	79.8%	**5.5%**
HTN BP Control	73.7%	74.5%	**0.8%**	70.6%	72.1%	**1.5%**	74.5%	72.1%	**2.4%**
Breast Cancer Screening	76.2%	78.5%	**2.3%**	66.2%	65.5%	**-0.7%**	78.5%	65.5%	**13.0%**
Cervical Cancer Screening	84.9%	84.9%	**0.1%**	83.1%	81.9%	**-1.2%**	84.9%	81.9%	**3.0%**
Colorectal Cancer Screening	75.8%	77.1%	**1.4%**	72.1%	72.8%	**0.7%**	77.1%	72.8%	**4.4%**
Osteoporosis Screening	74.7%	75.0%	**0.4%**	61.6%	62.2%	**0.5%**	75.0%	62.2%	**12.9%**
Tobacco Screening	98.8%	98.5%	**-0.3%**	97.3%	98.0%	**0.7%**	98.5%	98.0%	**0.5%**
Adult Pneumo Vaccination	82.1%	85.1%	**3.0%**	76.0%	79.2%	**3.2%**	85.1%	79.2%	**5.9%**
Clinical Efficiency	**Dec-09**	**Jan-11**	**Change**	**Dec-09**	**Jan-11**	**Change**	**PCMH**	**Non-PCMH**	**Diff**
90-Day Rx Refill	13.3%	40.0%	**26.7%**	14.1%	35.8%	**21.7%**	40.0%	35.8%	**4.2%**
Generic Utilization	79.2%	81.7%	**2.5%**	79.9%	82.5%	**2.6%**	81.7%	82.5%	**-0.8%**
My Chart Enrollment	22.8%	33.2%	**10.4%**	21.3%	27.7%	**6.4%**	33.2%	27.7%	**5.5%**
Service	**Dec-09**	**Dec-10**	**Change**	**Dec-09**	**Dec-10**	**Change**	**PCMH**	**Non-PCMH**	**Diff**
Overall Rating of Provider	76.4%	79.8%	**3.3%**	77.5%	77.2%	**-0.3%**	79.8%	77.2%	**2.6%**
Routine Access	60.2%	63.3%	**3.1%**	65.4%	67.0%	**1.6%**	63.3%	67.0%	**-3.7%**

Delivering Value by "Bending the Cost Curve"



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The Dilemma

Attempting to deliver value when incentives regard volume

The Dilemma: A Clinical Case

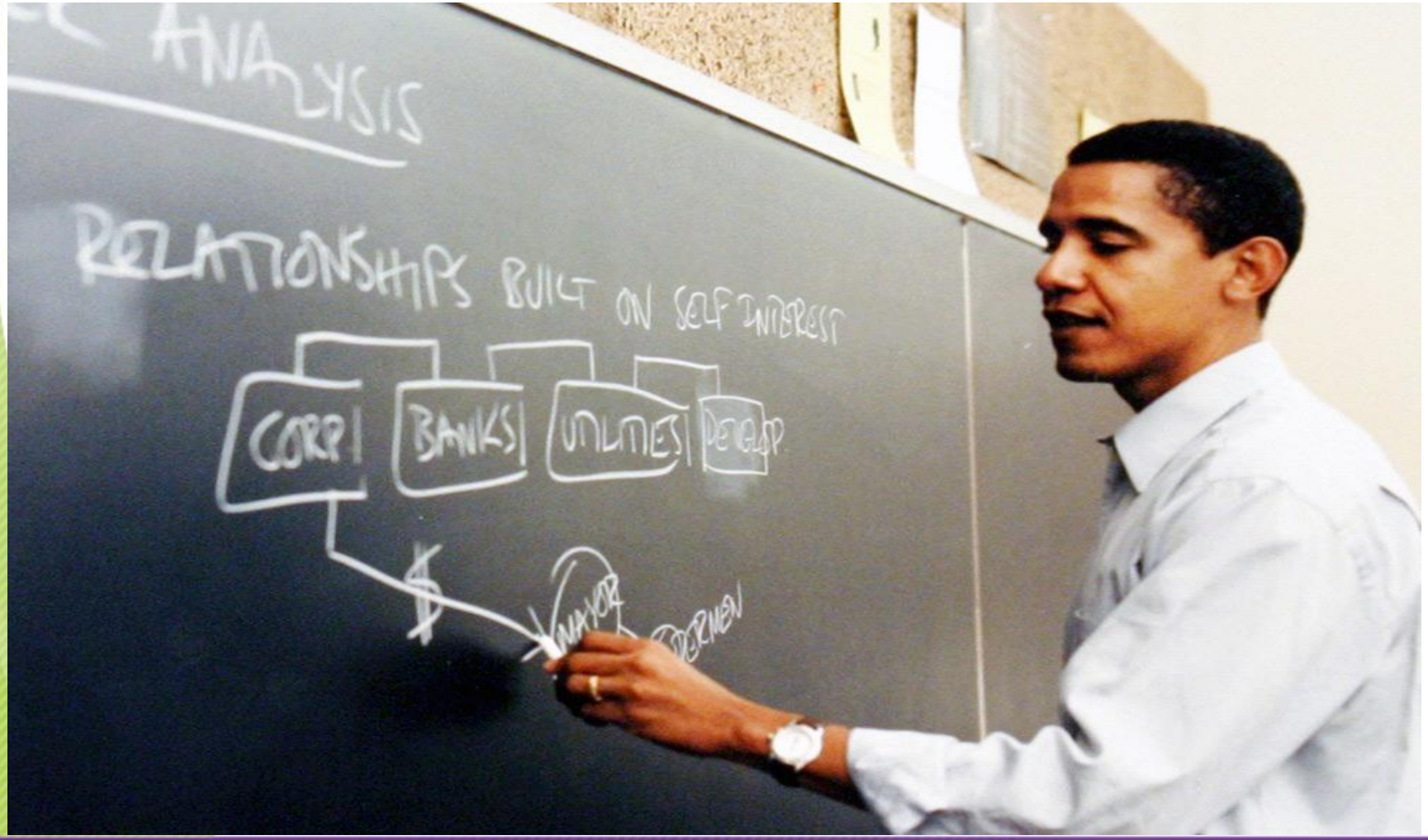
- "A 50 year-old patient presents to their PCP for a routine physical and to refill medicines, and comments that they have had hip pain since playing 36 holes of golf last week. A close friend recently had the same problem and got a "new hip" as a result. This patient wants one of those too." What happened next?
  - PCP prescribed 30 days with 11 refills of all the patients' branded meds
  - The patient is referred directly to Orthopedics
  - Orthopedics conducts hip-replacement procedure per the patient's wishes.
  - Orthopedist chooses implantable device of his preference
  - Patient lives alone and doesn't want to impose on friends or family to support him. Requests transfer to Skilled Nursing Facility at discharge
  - Patient slated to go SNF on a Friday, but is not transferred until Monday because SNF doesn't do admissions on weekends.
  - Discharge determination at the SNF is made by PT and by the patient
  - After discharge, the patient is scheduled to see the MD in follow-up

Where are the Opportunities Here?

(and were we able to convince providers to change?)

★	1. Generic Drug Prescribing
★	2. 90 Day Prescribing
⊘	3. Patient Education/Shared Decision Making
⊘	4. Retaining work in the Medical Home
⊘⊘	5. Joint Replacement Frequency/1000
★★	6. Implantable Device Standardization
★★	7. Hospital Length of Stay (LOS)
★	8. SNF Utilization
★	9. SNF LOS
⊘	10. Optimal use of MDs versus other Providers

We've Learned Four Key Lessons



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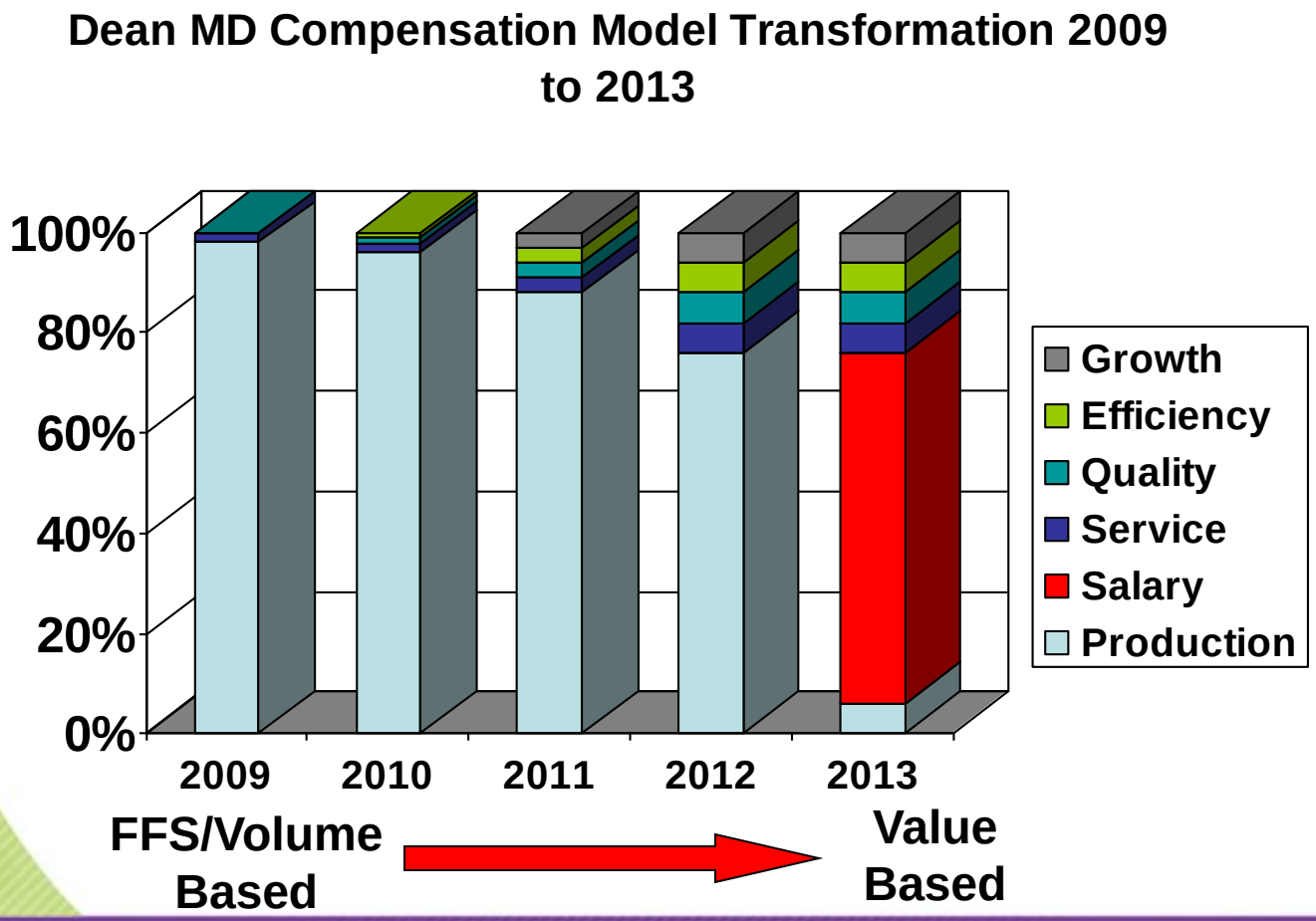
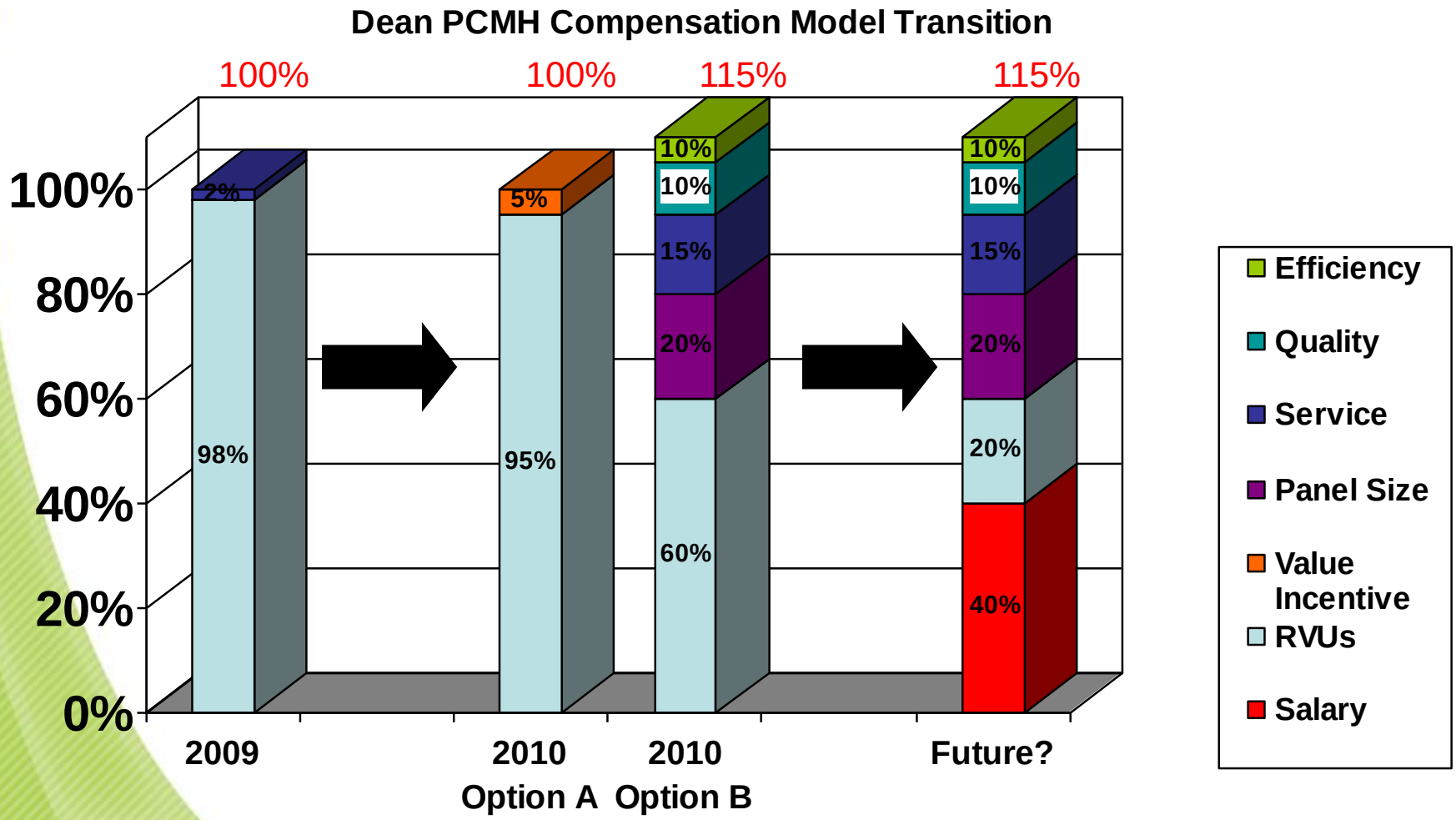
Dean's Lesson #1

"We learned that paying for volume in a value based system simply created a world of privatized gains and socialized losses"

So, we began (once again) the journey toward creating a variable comp plan



In our Medical Home, the urgency for re-alignment was even greater



Dean's Lesson #2

"We learned that nothing makes physicians more angry than changing their staff, changing their office, or changing their pay"

Lessons Learned along the Way

- "Involve and Persuade"
  - While it takes more time, and its fraught with many headaches, we encouraged the Dean Board and a committee of physicians to lead the comp re-design process. When all that your culture knows is "pay for volume", it takes time and effort to convince physicians how they'll do in a value-based world.
- "Comp Re-Design Doesn't Solve Everything"
  - The flaw of most compensation model re-designs is that they try to do too much. Remember that vision, data, peer-pressure, values, compacts, or guilt can sometimes be more effective than pay.
- "Create a Balanced Scorecard"
  - If you want to reward value, the incentive plan (or other persuasion techniques) need to have balanced measures to encourage service, quality, cost, growth and production.
- "Reward Corporate, Department and Individual Performance"

Lessons Learned along the Way (continued)

- "Measure First"
  - It is most ideal to measure and report first, and link to comp second.
- "Options made the transition palatable"
  - Given the fear and anxiety associated with comp change, we created a menu of options so that there were multiple chances to receive the incentive.
- "Incentive size made the transition palatable"
  - We initially set the incentive at very small percentages, e.g. 1-2% each.
- "Low thresholds made the transition palatable"
  - We initially made the goals as achievable as possible by assuring that we supplementally rewarded very high performers
- "We changed the metrics, decreased the options, increased the weights, and raised the thresholds over time"
  - Once comfort with the new model set in, we raised the bar.

Dean Physician Incentive Model 2012

Access/Growth
- New patient growth (or)
- Improved appt availability (or)
- Scheduling standardization

Patient Satisfaction
- CG-CAHPS Overall Rating of Doctor at the individual level (or)
- CG-CAHPS Overall Rating of Doctor at the department level

Quality
- Attainment of target performance on division level quality metric(s)

2010 Goals
- Dictation Rate
- MyChart Enrollment
- 90 Day and Generic Rx
- Open Encounters

Cost
- Achieve meaningful use targets

Dean's Lesson #3

"We learned that, at the system level, receiving bundled payments is not hard….it's unbundling them that's hard."

Dean Clinic and SSM-WI Service Agreement

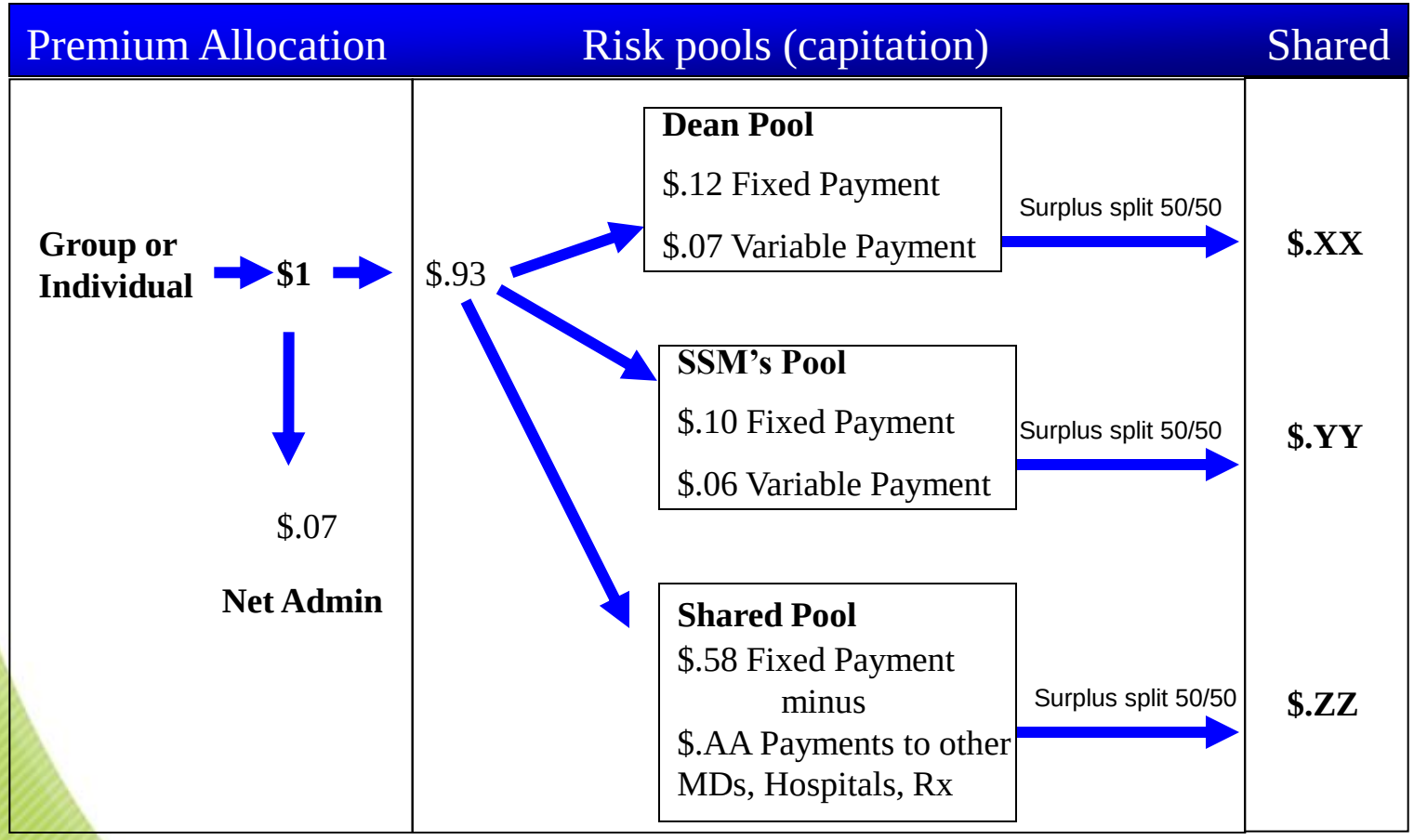
- 15 Year Agreement
- Fairness benchmarking conducted every 5 years
- Commitment by both Dean Clinic and SSM-WI to evaluate and develop programs to improve member value (quality, service, efficiency)
- Creation of a Three-Pool Structure
  - Dean Pool (Pool #1) – services performed and billed by Dean Clinic
  - SSM's Pool (Pool #2) – services performed and billed by SSM's Primary Hospital
  - Shared Pool (Pool #3) – all other services, e.g. Rx, Other MD, Other Hospital

Commercial Pool Summary continued

- The funding for SSM's Pool and Dean Pool are split into Flex and Fixed payments
  - Flex Payment at 30%
  - Fixed Payment a 70%

- Surpluses or deficits in each of the three pools are shared equally by Dean and SSM-WI

Dean and St. Mary's "Unbundling" Allocation



Total Proceeds to Dean **= (.XX+.YY+.ZZ) * 0.5**

In Summary, the Service Agreement

- Compensates both parties fairly
- Rewards both parties for cost efficient high value care
- Aligns incentives in the short and long-term for Dean, SSM and Health Plan members
  - Both parties incentivized to control utilization
  - Touch points keep agreement aligned into the future
- Built in flexibility to keep the relationship adaptable
- Establishes predictability in funds flow to provide stability
- Provides reimbursement consistent and equitable with the market

The Future

The “new normal”…..
Payment Reform

YouTube in search of an ACO Search Bro

In Search of an Accountable Care Organization (ACO)

CenturaHealth 86 videos Subscribe

Like | Add to | Share | Embed

62,485

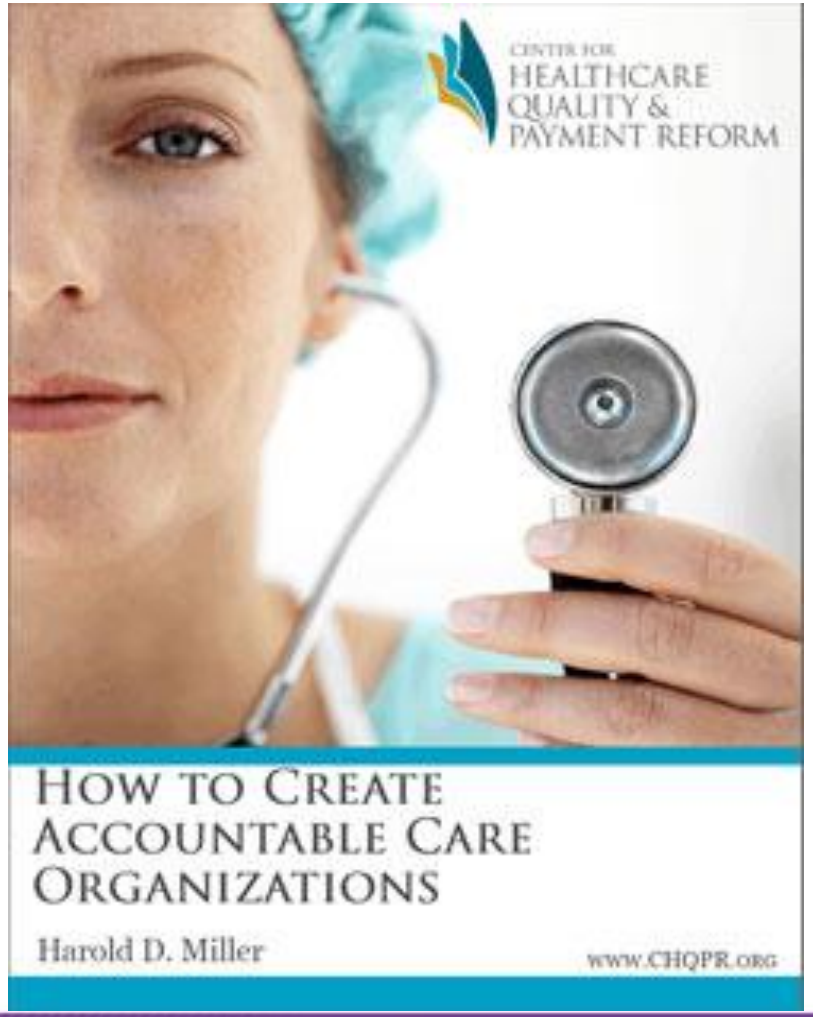
CenturaHealth | August 13, 2010 | 44 likes, 0 dislikes

Clueless health care executive tries to learn about accountable care organiza...

CMS at the Leading Edge of Transition to Value-Based Payment Reform

"In addition to establishing a shared savings model for rewarding quality and financial performance, the program also holds ACOs accountable for excess expenditures by establishing, as an option, a two-sided risk model which requires repayment of losses to us. This represents a new approach for the Medicare FFS program, under which providers have traditionally had little or no financial incentive to coordinate the care for their patients or to be accountable for the total costs and quality of the care provided."

Medicare Shared Savings Program: ACO Draft Rule 03/31/11



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But is CMS really first?

Blue Cross Blue Shield of Massachusetts

EON Enhanced Online News

Beth Israel Deaconess Physician Organization, LLC

Blue Cross Blue Shield of Massachusetts and Beth Israel DeaconessPhysician Organization Sign Alternative Quality Contract

Dean HEALTH PLAN

Anthem

SHARP

CareFirst BlueCross BlueShield

Advocate Health Care

BlueCross BlueShield of Illinois

"With nearly 500 primary care physicians and 1,300 specialists, aligned across the entire spectrum of care, we are

CARILION CLINIC PATIENT TRANSPORTATION

Aetna™

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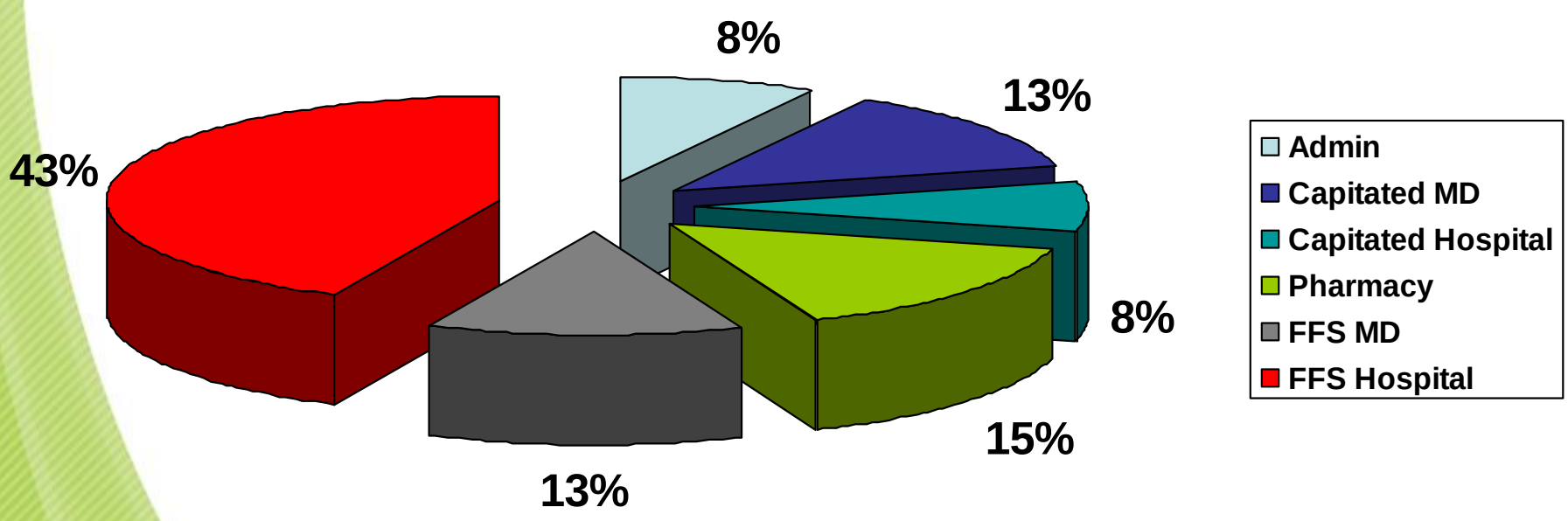
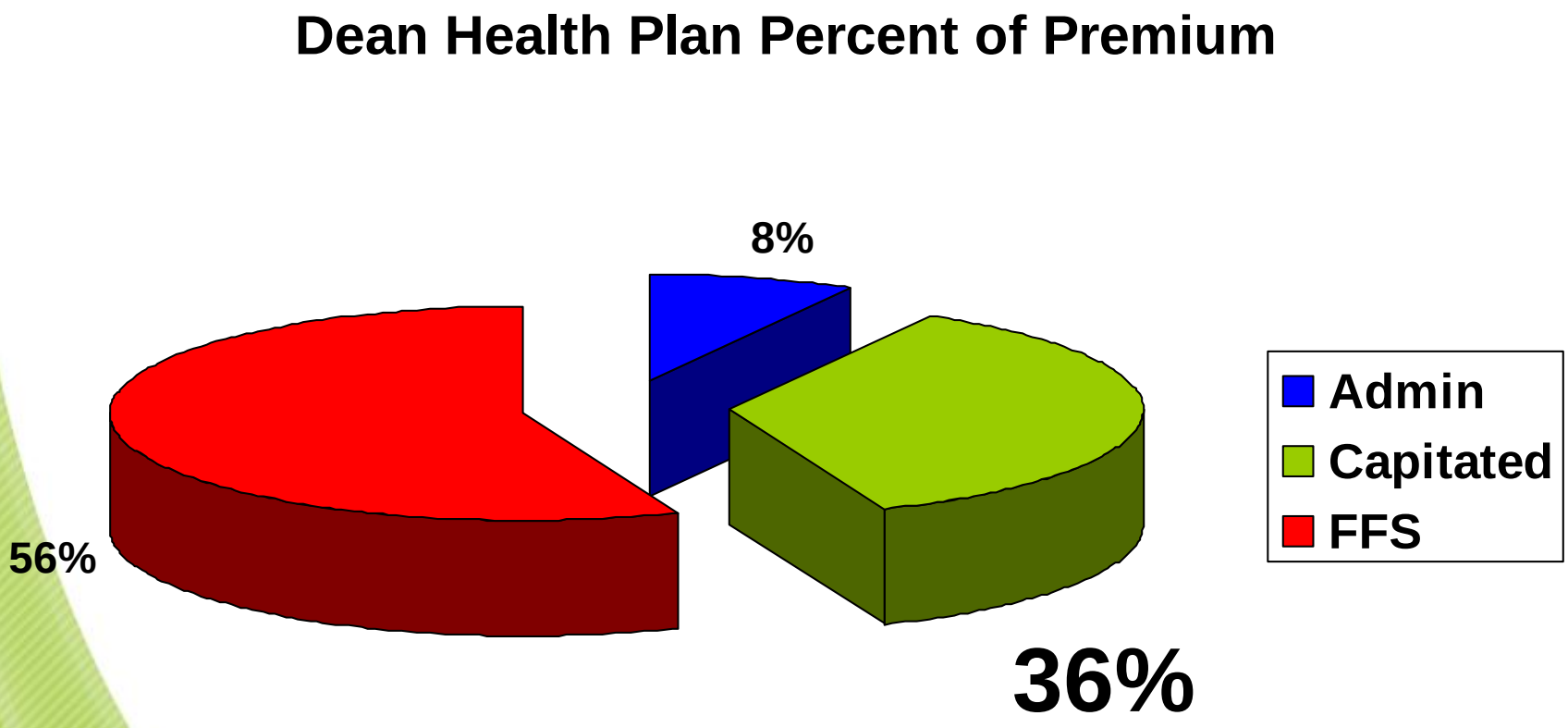
Dean's Lesson #4

"While we've achieved alignment without our integrated system, how do we drive value through our entire contracted network? We're not that dissimilar from CMS in that regard"

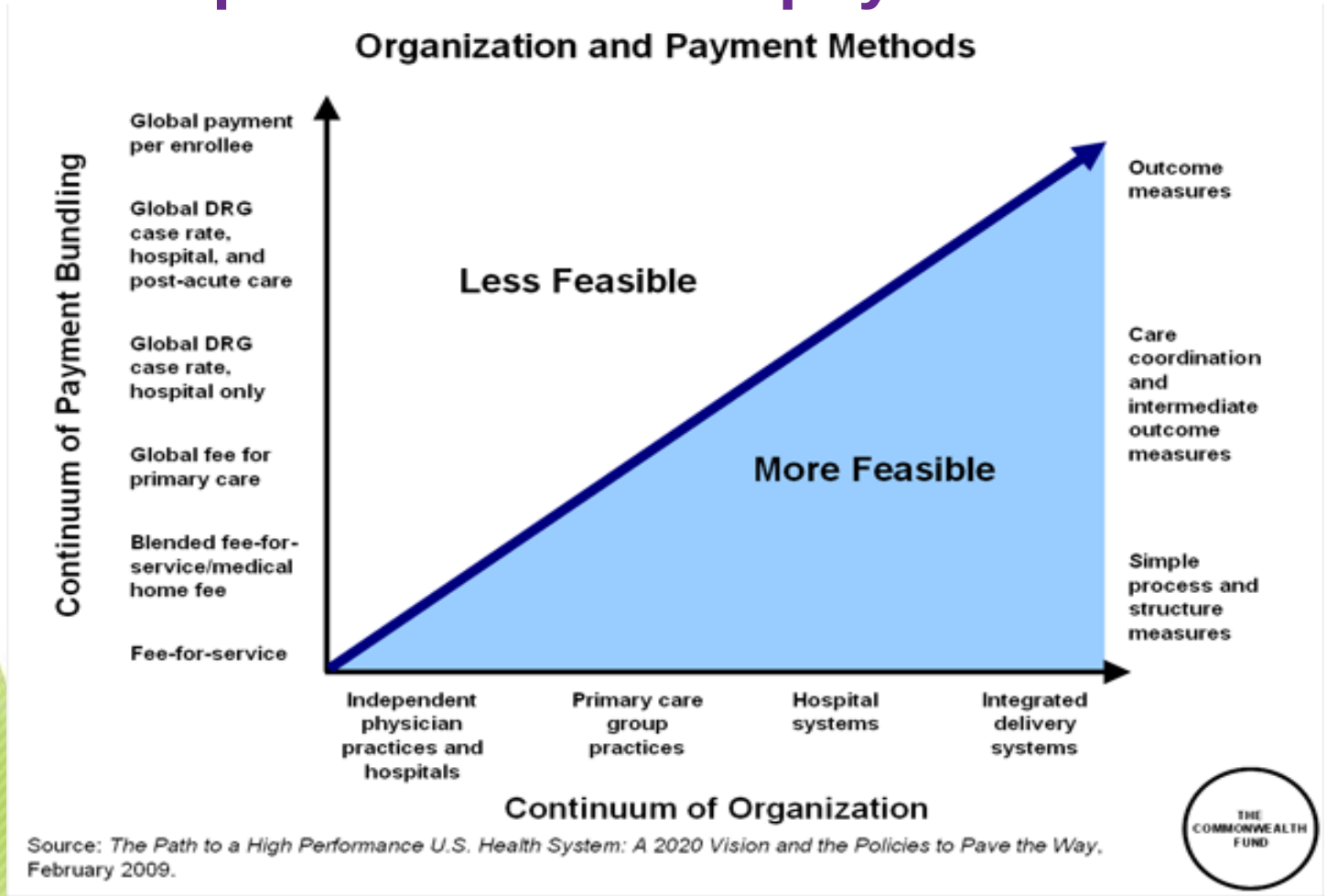
Dean Health Plan Percent of Premium



Despite our high-level of integration, we're only aligned toward value 36% of the time



So we've needed to find alternative ways to incent different providers differently, as we expect CMS and all payors will do.



Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

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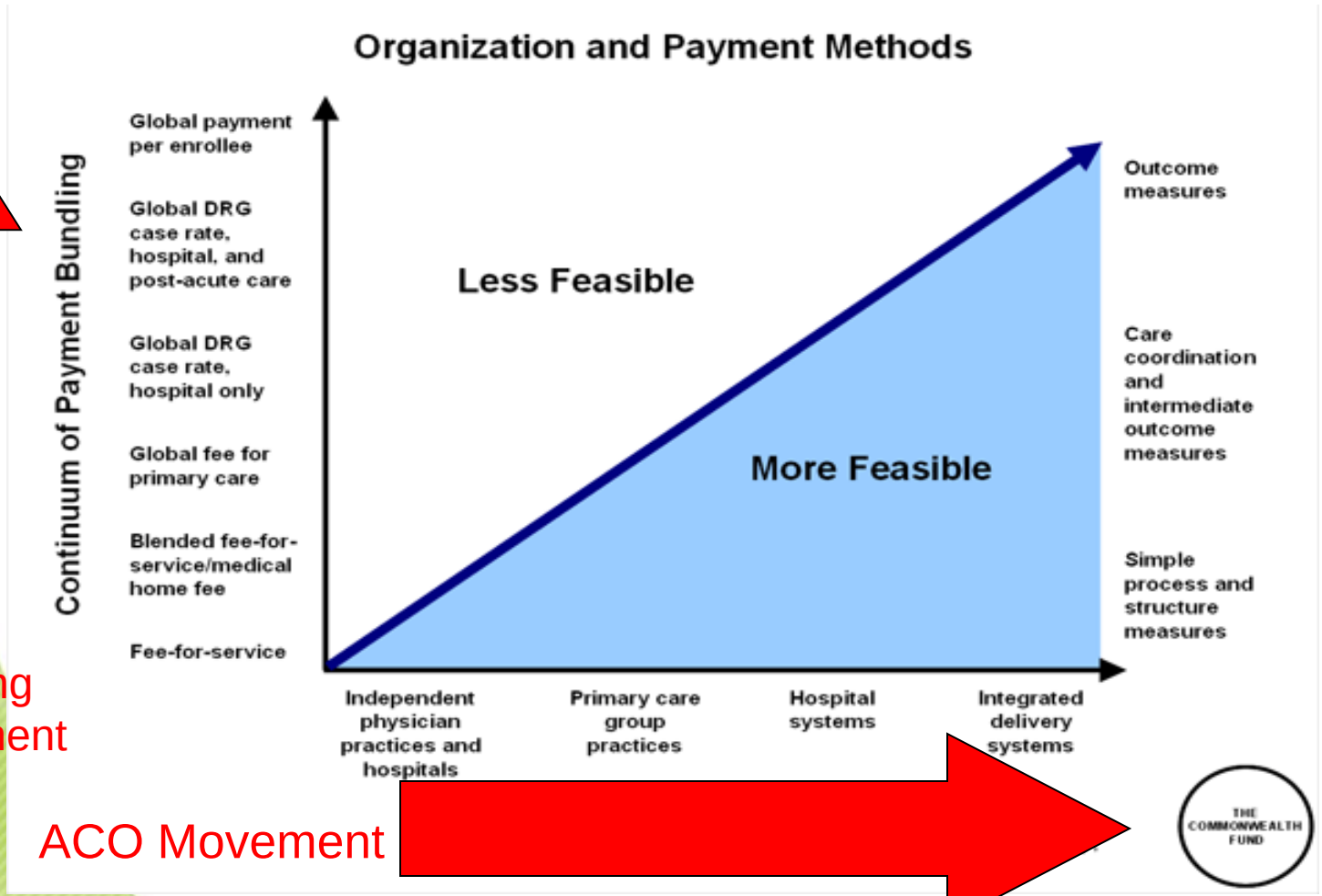
So we're incenting different providers differently, based on size and integration



Thank You

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