Transitioning Reimbursement from Volume to Value: Performance Based Contracting Using a Shared Savings Model

Michael J. Tronolone, M.D., M.M.M
Chief Medical Officer
The Polyclinic
Seattle, WA


CONFLICT
INTEREST
RETURN
STUDY
RESULT
ADVERTISER
CAMPAIGN
AUTHORITY
CONTRIBUTIONS
ELECT
MAJOR
PROFIT
RECESSION
NONGOVERNMENTAL
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RELATED
BREACH
CONSUMER
ROLE
MISCONDUCT
PRIVATE
PERSONAL
CONSTITUENTS
PRESIDING
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DEFUSED
AUDIENCE
LEGISLATIVE
EVALUATION
SECONDARY
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OBJECTIONABLE
ADVERTISING
COMMINGLING
POTENTIAL
GOVERNMENT
INTEREST
IMPROPER
COMMERCIAL
DECISION
RULE
RELATIVE
AVERAGE
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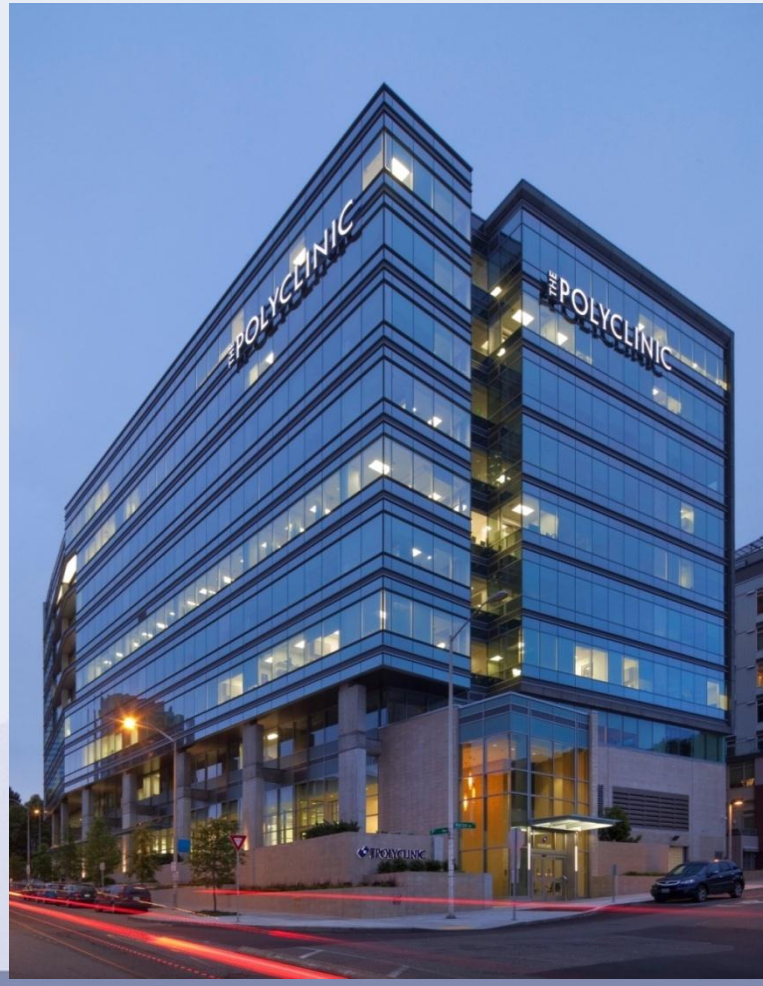
MEDIA
ACTS
CORPORATE
SECTOR
FINANCIAL
POLITICAL
RECUSE
BLOTTER
AUDITOR
EMPLOYMENT
INSURANCE
GOVERNMENTAL
CONSOLIDATION
BEHAVIOR
ECONOMISTS
INDIVIDUAL
CIRCUMSTANCE
ETHICAL
PRIMARY
WRONGDOING
DISBARRED
DUTY

Polyclinic Profile

- Independent MD-owned MSGP (1917), Seattle, WA
- 200+ providers, 175 MDs, 30 specialties, ancillaries
- 425,000 visits (2012)
- 180,000 patients
- 25% Medicare
- CMS ACO
- 10 locations



The Polyclinic Madison Center

Mission, Vision, Values

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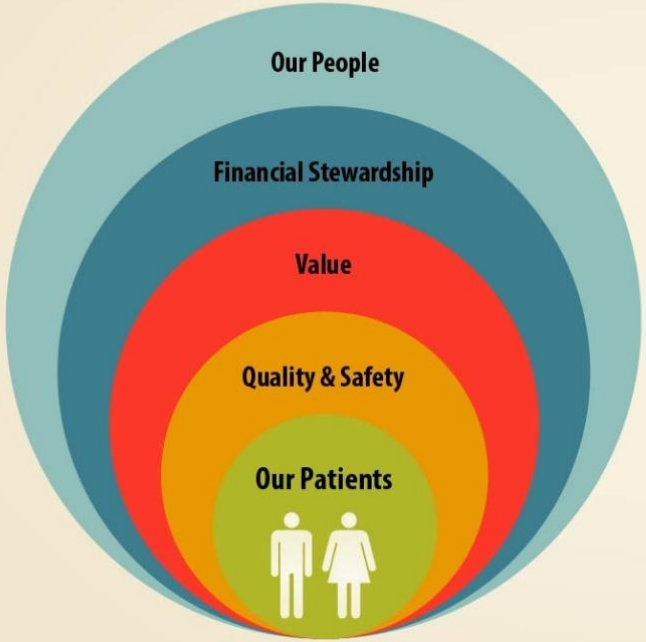
"To promote the health of our patients by providing high quality, comprehensive, personalized health are."

"We are the best place in the Northwest to receive and provide health care."

Pursuing Perfection



Our Patients:
Every patient is completely satisfied with every interaction

Quality & Safety:
All patients receive complete, appropriate care with no preventable adverse outcomes

Value:
No waste

Financial Stewardship:
Able to finance our mission

Our People:
100% of our people are trained, engaged, empowered and performing

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Summary

- In 2010, The Polyclinic and Premera Blue Cross implemented a 3 year performance based contract that allows both parties to share in savings if The Polyclinic can reduce the overall total cost of care for its attributed Premera Blue Cross members.
- Results: In 2010, the parties shared $0.6M and in 2011, $2.1M. 2012 results are pending.

You can’t start until you start…..

Our Starting Point (2009)

- Mutual commitment to a performance based contract
- Simple principle: save money/share it
- Symmetrical uncertainty: Neither party was initially sure of exactly how to accomplish our mutual goal
- Process: We did agree that we would learn and refine as we go

Immediate Questions

- How do we measure performance?
- How are savings calculated?
- How are savings shared?
- Are there more questions that we should be asking?

Issues List

- Methodology (metrics, measurement period, savings calculations, risk adjustment, comparison group)
- Costs included/excluded (outliers, other adjustments)
- Member Attribution
- Hospital costs
- Data sharing
- Other Considerations (quality benchmarks)

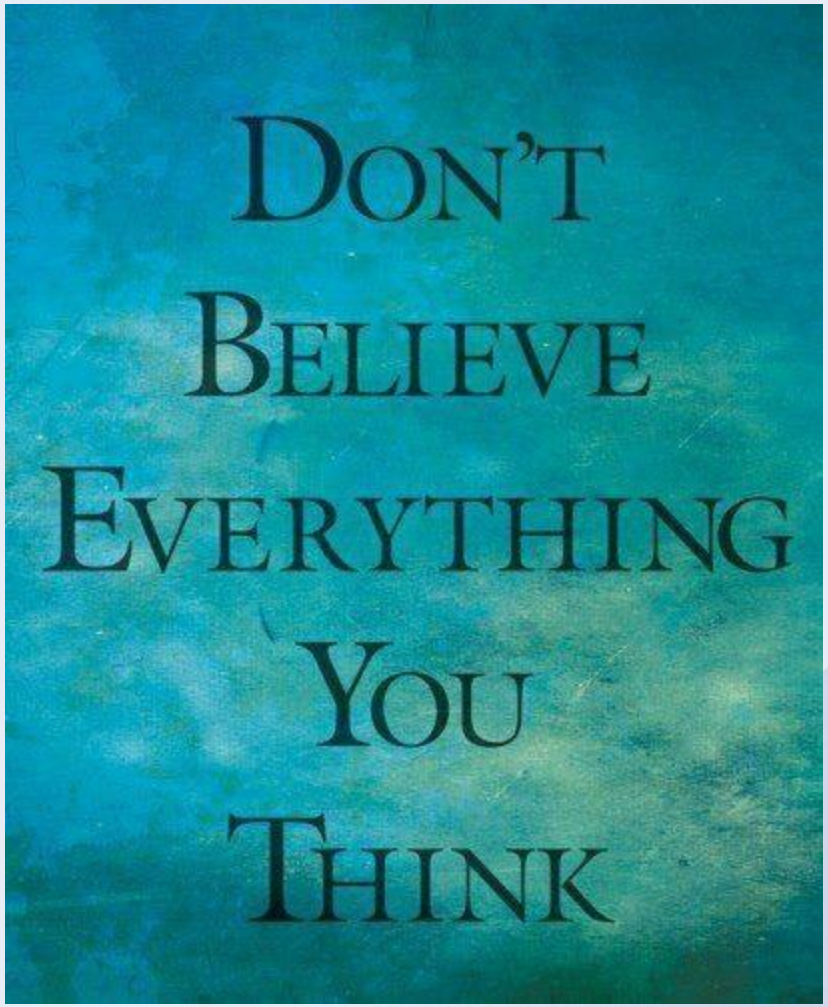
Straw Man Proposal

use Episode Treatment Groups (ETGs) as the basis to measure savings

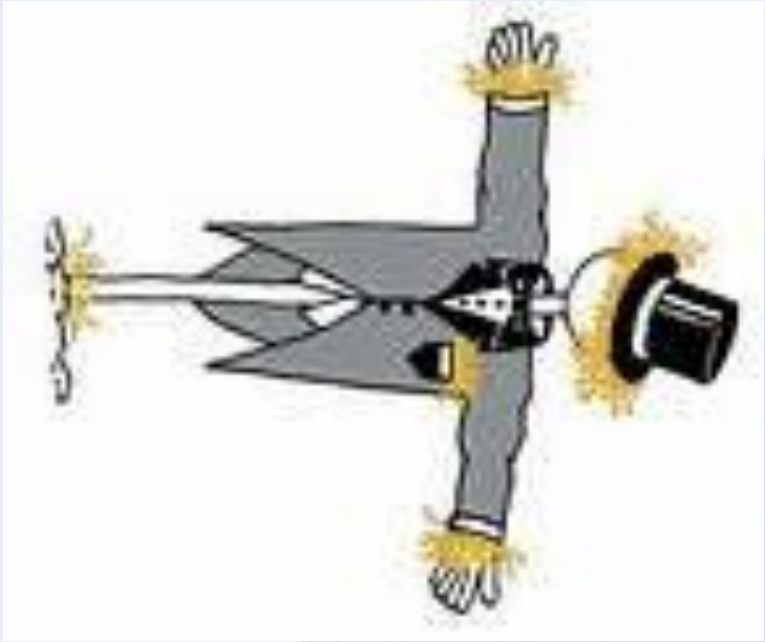
Why ETGs?

- Familiarity methodology
- Years of credible comparative data
- Thought to be the best alternative at the time despite some known issues

We agreed that we would look at ETGs as a “sample” of overall Polyclinic performance and make the assumption that this “sample” was indicative of overall Polyclinic performance and overlay that performance level across all Polyclinic business.


DON'T
BELIEVE
EVERYTHING
YOU
THINK

There was little basis for the assumption that ETGs could serve as a representative sample of overall cost performance



Measure the total cost of care of a member over a period of time rather than the total cost of a care episode

Attribution Issue

All our business with Premera is based on a PPO model, where Premera members are free to get services from any Premera contracted provider, which are virtually all providers in our service area. We needed to agree on a method of attributing patients to The Polyclinic.

Attribution Solution

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Primary Care Attribution Model

- Familiarity
- Previous proof of concept

Modification: added selected specialties where specialist directed chronic care management substituted for traditional for primary care (Endo, Rheum, Card, Neph)

Transition to a New Metric

Total Cost of Care

= the total of the allowed charges from all providers for an attributed member paid during the measurement period (in this case a calendar year).

How to calculate savings?

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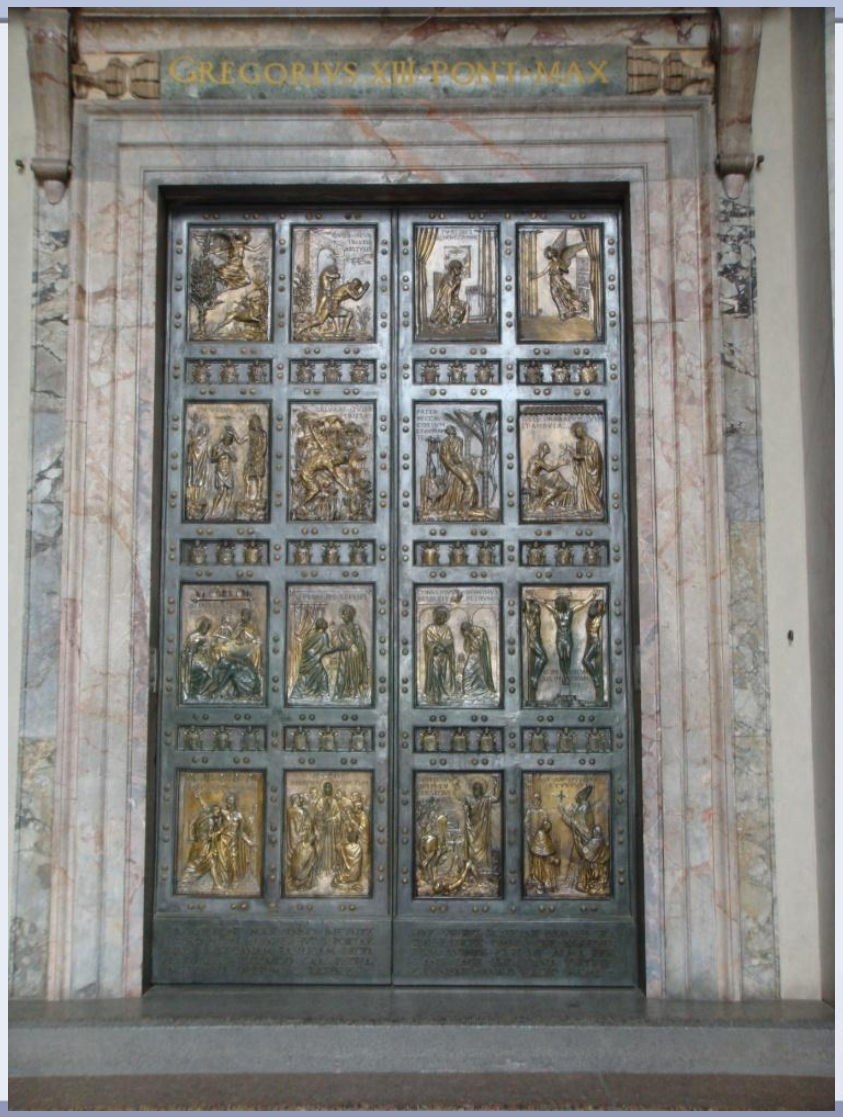

Year Over Year Cost Trend

Agreed was to use a comparison of year over year cost trend rather than absolute dollar cost as the method to calculate the “shared savings”.
If the risk adjusted cost of caring for The Polyclinic attributed patient population grew more slowly than the risk-adjusted Control Group patient population, there would be savings to be shared.

Control Group

- The Control Group needed to be large, representative of our patient population, and appropriately risk-adjusted.
- With the ETG methodology, we initially agreed that the Control Group would be all other providers in our major service area, Seattle metro area.
- Later, when we moved to a “Total Cost of Care” methodology, the Control Group was chosen to match The Polyclinic attributed patient population by matching the percentage of patients by the zip code of their residences.

Total Cost of Care (TCC) Metric
How it works

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- TCC looks at at all patients that are attributed to Polyclinic and all their allowable charges paid during the year and comes up with a per member per month (PMPM) cost.
- The same is done for a Control Group.
- Outliers are excluded from both groups.
- Then a risk adjustment is applied using an industry standard method (DxCG Solutions by Verisk Health).
- This is done for the baseline year (the year immediately preceding each measurement year) and the measurement year.
- The year over year trends are compared.
- Savings are realized when the trend vs. the Control Group is favorable.
- The PMPM savings is then used to calculate the annual savings available to be shared.

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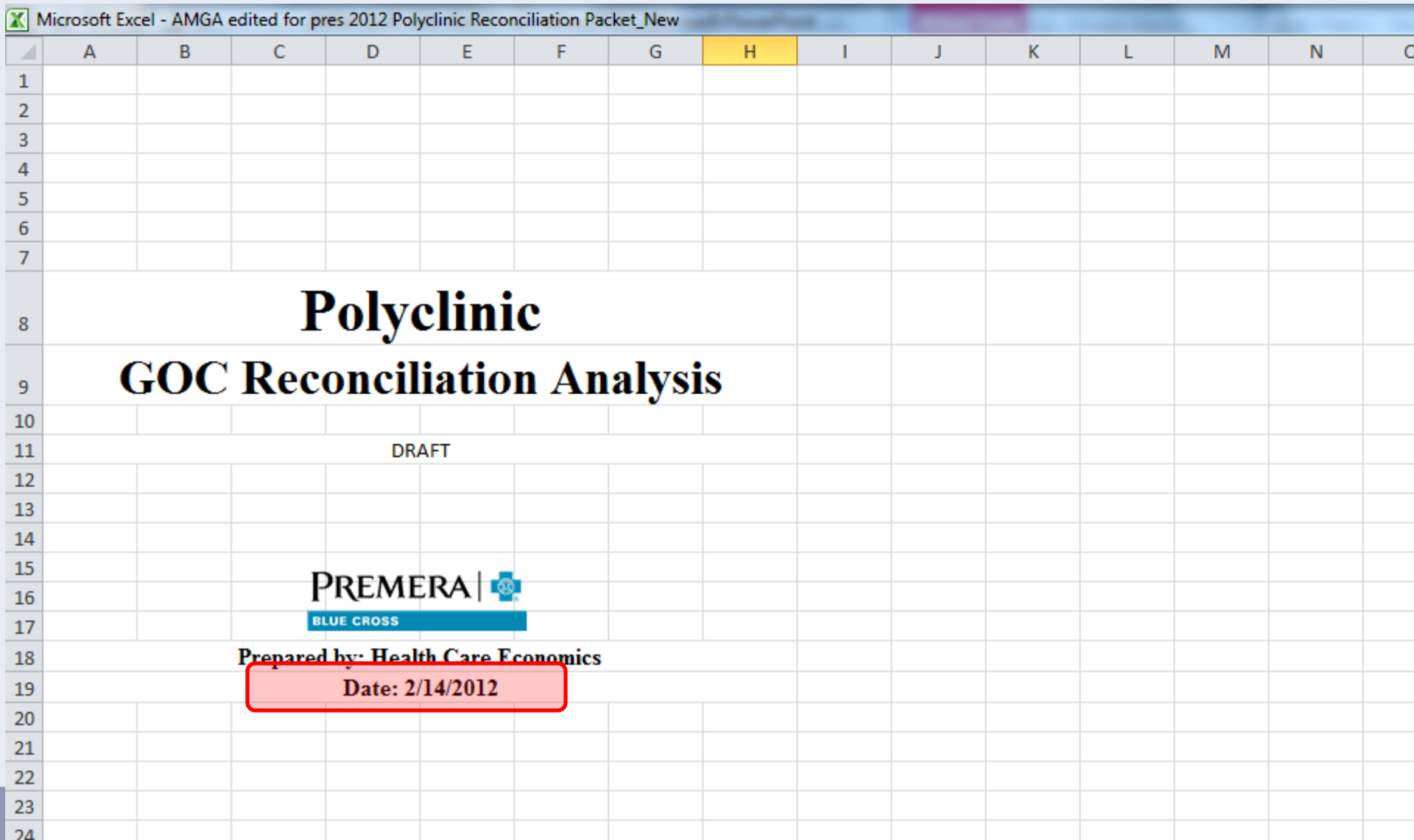

Proprietary data slides for display but not distribution

Results

- In 2010, both parties shared $600,000 in savings on approximately $35M in total costs and in 2011 both parties shared about $2.1M on about $60M in total costs
- In 2010 Polyclinic's Risk Adjusted PMPM trend was 1.8% lower than the Control Group (0.9% vs. 2.8%).
- In 2011 Polyclinic's Risk Adjusted PMPM trend was 3.7% lower than the Control Group (-1.7% vs. 2.0%).
- Results for 2012 will be available in early 2013.

What's next?

short term

- We need way to get the value of saving other than through future fee increases
- While our comfort and ability to share data has increased dramatically, there are still a few crucial areas where lag time is impeding performance improvement.
- Continuous process improvement activities

longer term

- First mover advantage eventually disappears
- This is a transitional state for reimbursement
- Fundamental pricing problem in health care remains
- Sustaining Innovation vs. Disruptive Innovation

Questions & Discussion

Additional Materials

While the primary focus of this presentation is about crafting a shared savings agreement, I will be ready to discuss the high level strategies and tactics that we employed to produce those shared savings if there is audience interest.

Accountable Care

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Objectives:

- Better care outcomes
- Lower cost

Methods:

- Aligned incentives
- Information sharing

Participants:

- Public sector (Medicare ACO)
- Private sector (Premera GOC)

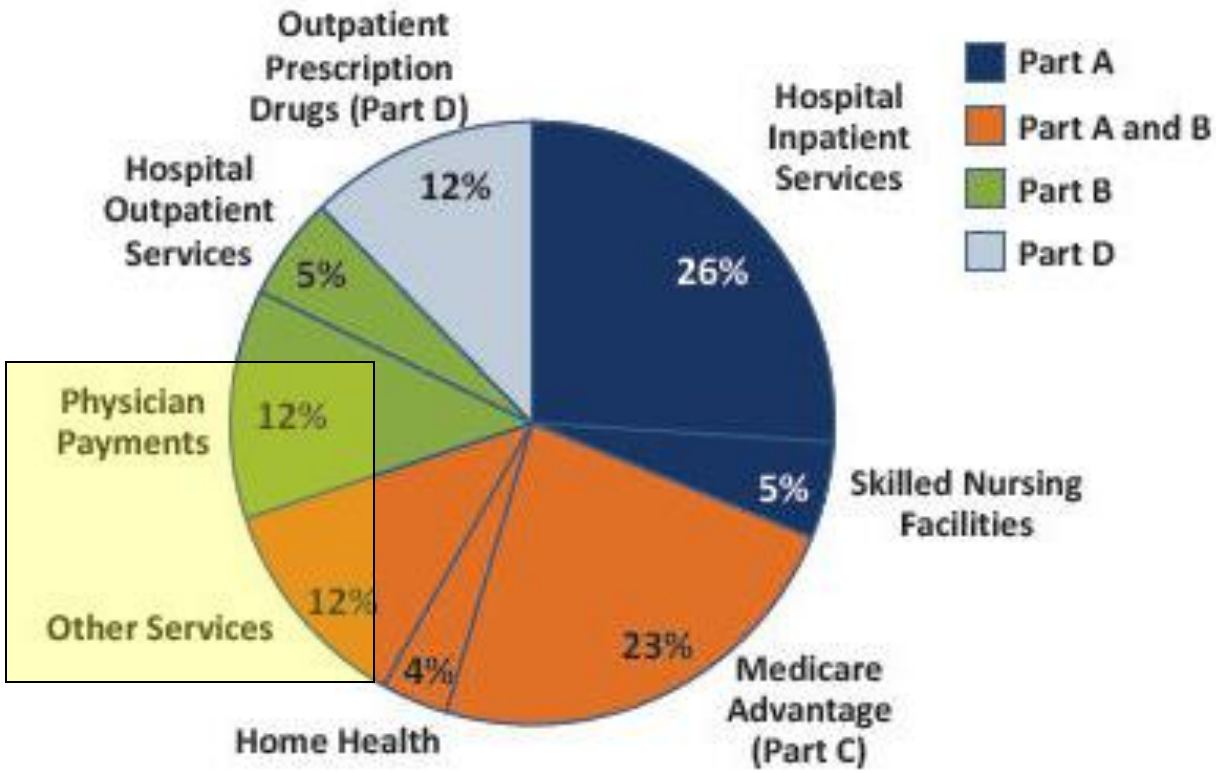
Critical Success Factors

- Strategy
- Infrastructure
- Culture

Strategy

- Is there a specific “ACO” strategy?
- Is it different from your organization’s overall business strategy?
- Are they aligned?.....Can they be aligned?

Medicare Benefit Payments By Type of Service, 2011



Total Benefit Payments = $551 billion

NOTE: Numbers do not sum to 100% due to rounding. Total does not include administrative expenses and is net of recoveries.
SOURCE: CBO Medicare Baseline, March 2011.

Strategies to reduce the overall cost of care

- **Reduce unnecessary ER visits***
  - Standardized message and triage by on call MDs
  - After-hours care centers as ER alternative * *
  - Follow-up of ER visits to prevent bounce back
  - Patient education

- **Reduce hospitalizations ***
  - Re-admissions
  - Follow-up of discharges
  - 1 day stays
  - Avoidable admissions
  - Alternative sites of service * *

- **Reduce pharmacy expense ***
  - Generic prescribing
  - Standardized approach to biologic modifiers
  - Standardized approach to HIV treatment

***OPM**

****Revenue opportunity**

Strategies to reduce the overall cost of care (cont'd.)

- **Reduce unnecessary advanced imaging**
  - Prior authorization
  - Radiologist consultation
  - Best practices for cardiac imaging
  - Best practices for interval surveillance imaging in oncology
- **Risk assessment**
  - Care management of high utilizers
- **Reduce futile care**
  - Advanced directives
  - Acceptable alternatives (Palliative care, Hospice)
- **Alternative care delivery**
  - E-consults
  - Primary Care / Specialty service agreements

Infrastructure

It is really about information and the ability to use information to create market value and internal value

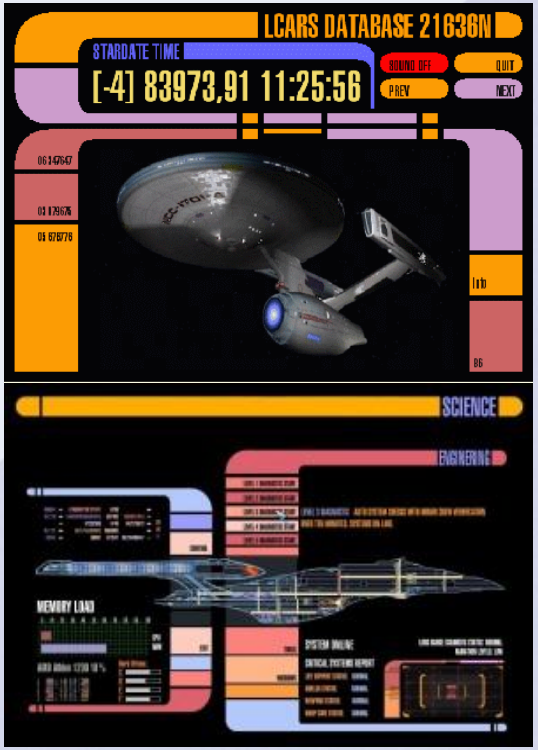
All Relevant Data
Multiple Sources
Internal/External

Timely
Actionable
Clinical
Information

Process
Control

Insight
Knowledge

Fully integrated
BI/CI platform



Culture

Accountable Care is a Team Sport

Approach

- Have clear objectives
- Communicate the objectives and build support with all stakeholders
- Use data wisely
- Be timely and directionally correct
- Use continuous process improvement
- Stay true to your values

Learning

- **Talk is cheaper than infrastructure**: don't underestimate the effectiveness of the bully pulpit
- **Unexpected alignment**: many patients now have "skin in the game" and behave as such
- **Seeing around corners is sometimes possible**: Measuring outcomes of processes that are proxies for reducing the total cost of care is a way to monitor your performance in real time

Learning

- **Don’t let the perfect be the enemy of the good**: directionally correct and timeliness are often more important that precision in pursuing goals
- **Clinical integration and care coordination can be organic processes**: nurture, don’t hinder them