POPULATION BASED PAYMENT™

A mechanism for returning responsibility for patient outcomes, medical management, and equitable compensation to local physicians

World Research Group

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Presentation Overview

- Current Environment
  - Quality
  - Cost
  - Market Forces
- Current Compensation Models
- Why the Timing is Right for Population Based Payment™ (PBP)
  - PBP vs. Risk
  - FTC Compliance Requirements
  - 5 Process Steps
  - Financial Model
  - Clinical Protocols
- Questions & Answers

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CURRENT ENVIRONMENT

- Inefficient system with mediocre quality
- Cost of care continues to outpace workers' earnings and overall inflation
- The present system is "unsound in that it continues to reward providers for cost-raising behavior, independent of health results"
- Outcomes and Patient Safety are becoming more important

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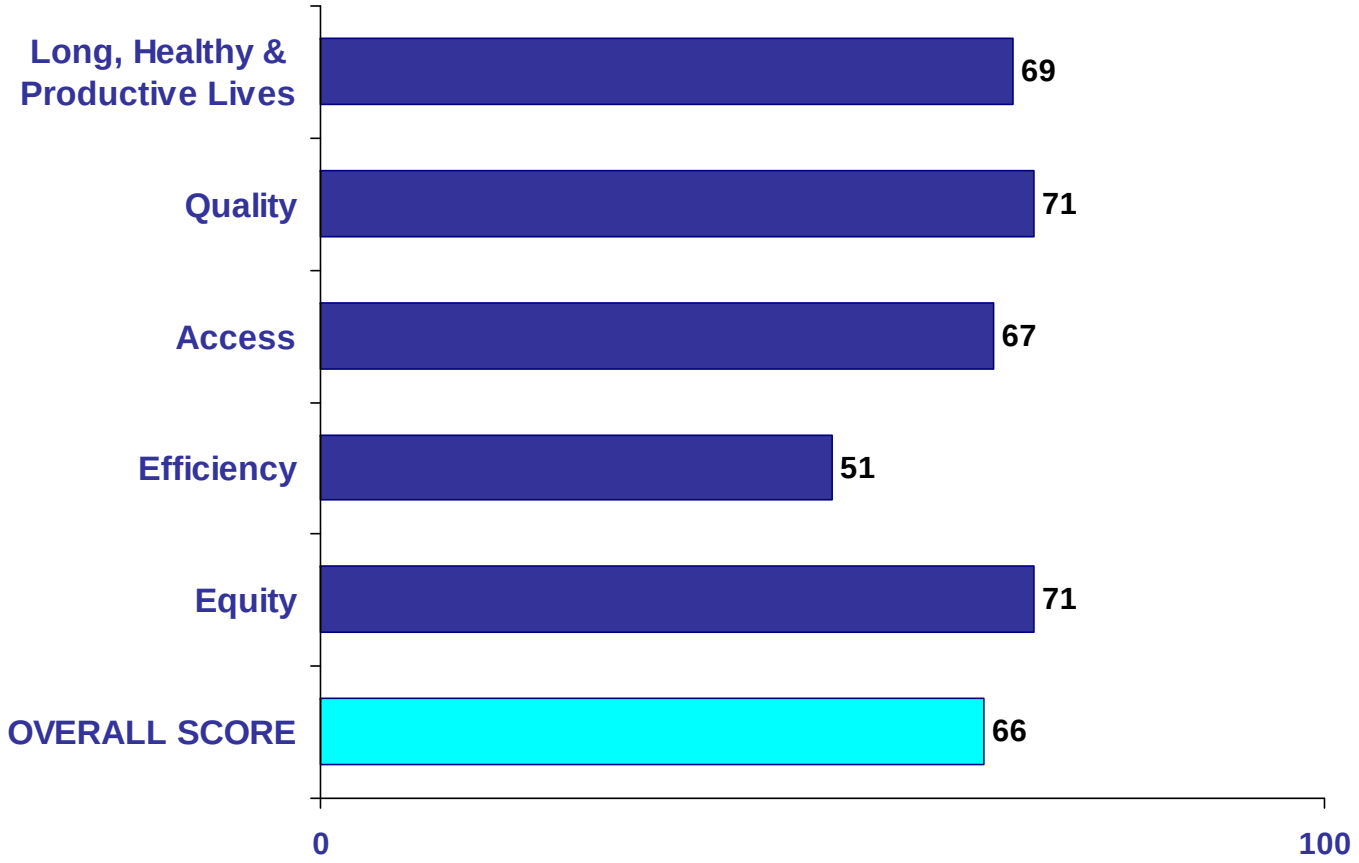
Criteria of a High Performance Health System



Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006

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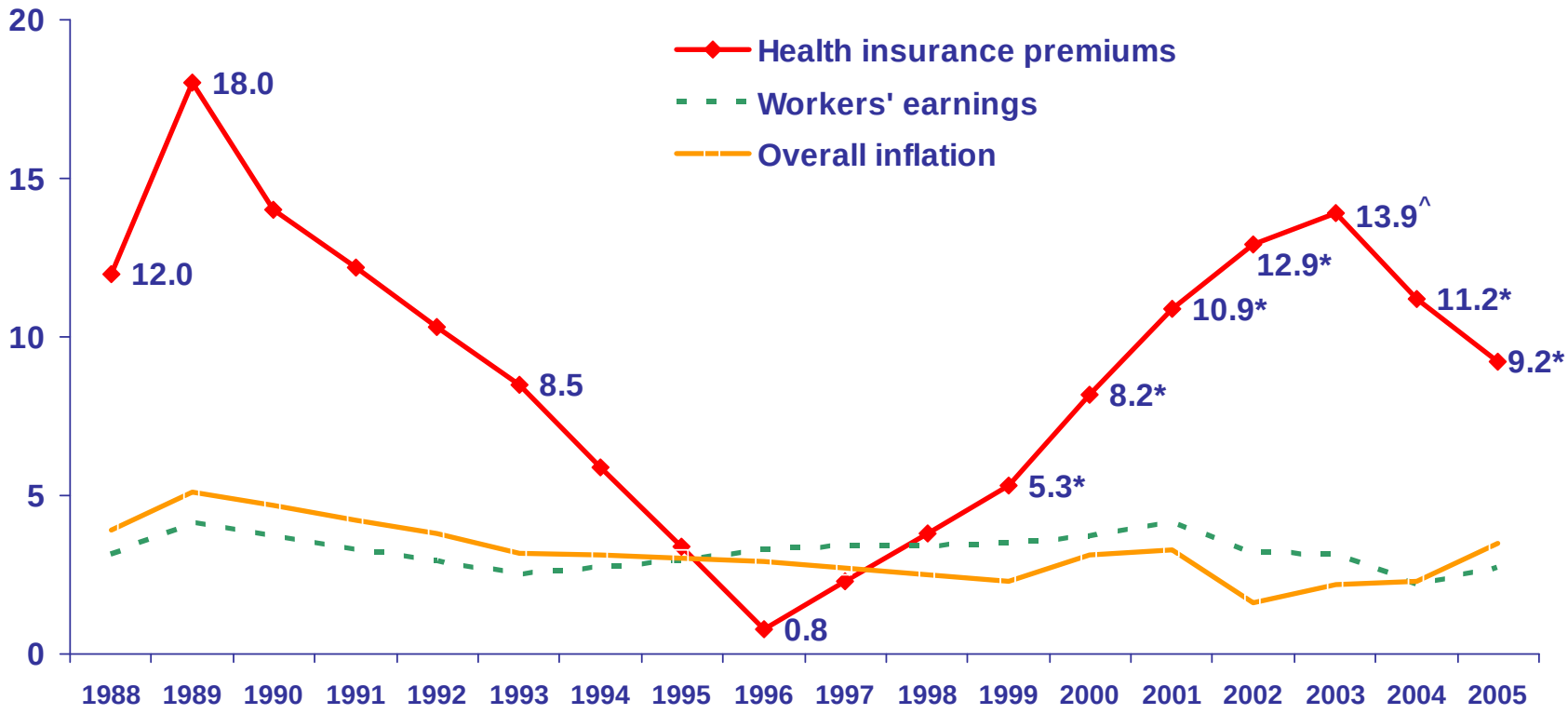
Increases in Health Insurance Premiums Compared with Other Indicators, 1988–2005



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Current Physician Compensation Models

- There are many mechanisms for paying physicians; some are good and some are bad. The three worst are fee-for service, capitation, and salary.

James Robinson, Milbank Quarterly. 2001

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Adam Smith's Sound Market Theory

- The most powerful device for productivity improvement ever invented by mankind is Adam Smith's sound market. Even the Soviets know that Karl was wrong and Adam was right. Competition in sound markets is the most powerful device ever invented to make producers serve consumer interests. The present unsound health care market stringently rewards providers for cost-raising behavior, independent of health results. However, **if you** change the way you buy **– start buying right** – then **providers will be compelled to perform well**.

Walter McClure, Chairman, Center for Policy Studies.
October 20, 1990

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Performance Based Compensation Models

- The systematic and deliberate use of payment incentives that recognize and reward high levels of quality improvement can serve as a powerful stimulus to drive institutional and provider behavior toward better quality.

Institute of Medicine- National Academy of Sciences – Rewarding Provider Performance - 2006

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Why Population Based Payment™ ?

Population Based Payment™

- All involved parties win:
  - Provider
  - Plan
  - Member
- Full disclosure of information
- Focus on Efficiency + Outcomes
- Motivates providers to recruit and improve the productivity of under-performing practices
- FTC Advisory Opinions and CMS Civil Monetary Penalty Opinions Support:
  - Clinical Integration
  - Physician – Gain Sharing

Risk Deals

- Framework creates a “winner” and a “loser”
- “Deal” not “Partnership”
- Guarded information exchange between Payor and Provider
- Focus is on Efficiency/Cost Reduction not Outcomes
- When quality and productivity do not improve organizations are forced into bankruptcy:
  - AHERF
  - MedPartners
  - Phycor-NAMM

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Population Based Payment™ Arrangements

- Clinically integrated physician practice arrangements consistent with:
  - 1993 DOJ and FTC Statements on Enforcement Policy
  - Recent Advisory Opinions allowing joint contracting for networks which have financial risk sharing and or clinical integration
    - Med South – 2002
    - Greater Rochester IPA - 2007

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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

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Population Based Payment™
A 5 Step Process

Step 1: Identify potential participating practices including one leadership office

Step 2: Create clinically integrated physician panels

Step 3: Calculate panel's historical performance and determine medical cost targets

Step 4: Establish clinical initiatives and clinically based quality indicators for tracking outcomes and progress against expectations

Step 5: Identify mechanism to support panel with routine and ad hoc reports and data

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Financial Model

	» Commercial		Medicare	
	» MCR	Members	MCR	Members
• Leadership Site	69.92	2,801	101.17	1,007
• Site 2	77.11	3,695	93.29	1,231
• Site 3	89.79	679	107.59	342
• Site 4	75.50	1,146	107.66	401
• Site 5	147.41	617	94.75	206
• Site 6	87.65	558	88.84	194
• Site 7	84.06	1,160	77.08	576
Total		**10,656**		**3,957**
Weighted MCR	**81.23**		**95.49**	
Target	**79**		**93**	

- **Utilization measure are linked to quality standards. If quality standards are unmet, then no incentive is paid.**
- **As the panel matures, it can be expanded by additional area practices featuring high commercial or Medicare MCRs.**

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COMMERCIAL - PMPM EXAMPLE

Premium	$291.28	
MCR	81%	79%
Med. Cost	$235.94	$230.11
Members	10,656	10,656
Cost	$30,169,696	$29,424,765
Variance		$744,930
PMPM		$5.83

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SAMPLE COMMERCIAL DISTRIBUTION

Practice	Members	Distribution
Leadership Site	2,801	$48,952
Site 2	3,695	$64,577
Site 3	679	$11,867
Site 4	1,146	$20,028
Site 5	617	$10,783
Site 6	558	$9,752
Site 7	1,160	$20,273
Totals	**10,656**	**$186,233**

Distribution assumes 50/50 share weighted by membership for each 1% reduction in medical spend after threshold is met. Medical spend adjusted for burden of illness.

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MEDICARE- PMPM EXAMPLE

Premium	$1,081.03	
MCR	95%	93%
Med. Cost	$1,026.98	$1,005.36
Members	3,957	3,957
Cost	$48,765,116	$47,738,482
Variance		$1,026,634
PMPM		$21.62

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SAMPLE MEDICARE DISTRIBUTION

Practice	Members	Distribution
Leadership Site	1,007	$65,316
Site 2	1,231	$79,845
Site 3	342	$22,183
Site 4	401	$26,010
Site 5	206	$13,362
Site 6	194	$12,583
Site 7	576	$37,360
Totals	**3,957**	**$256,659**

Distribution assumes 50/50 share weighted by membership for each 1% reduction in medical spend after threshold is met. Medical spend adjusted for burden of illness.

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Performance Indicators and Practice Protocols

- Develop and implement practice protocols
  - Existing evidence based protocols modified for practice applicability (i.e. Asthma Management, CHF, COPD)
- Develop clinical initiatives and Care Management programs to assist quality improvement efforts
- Establish efficiency benchmarks
- Track outcomes and progress against expectations
  - Clinical
  - Practice Efficiency

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Conclusion

- 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

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