Dean
HEALTH PLAN

Pay for Performance Summit
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Pay for Performance Evolution: Dean Health Plan

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Presentation Outline

- Background of Dean Health Plan (DHP)
- Pay for Performance (P4P) as a Strategic Objective
- Evolution of P4P Programs
  - Hospital
  - Physician (PCP)
- DHP Network Physician Perspective

Dean Health Plan Overview

- Dean Health Plan (DHP) was founded in 1983 as provider-sponsored plan
- DHP is a subsidiary of Dean Health Insurance Inc. (a wholly-owned subsidiary of SSM Healthcare based in St. Louis, Missouri)
- DHP/DHI Revenue: $1.1 Billion (2013)
- DHP/DHI Net Worth: $103 Million (2013)
- DHP/DHI Membership: 404,000 (Largest HMO in Wisconsin)
  - Commercial Insured and ASO Plans
  - Medicaid HMO, Medicare Cost/Supplement Plans
- DHP/DHI insure more than 1,400+ Employer Groups
- A- Weiss Rating (Oct 2013)
- Provider Network: 10,000+ providers and 31 “plan” hospitals located throughout south-central and north-eastern Wisconsin
- DHP has held NCQA Excellent Accreditation since 2001
- JD Power Award Winner for Highest Member Satisfaction in the Wisconsin/Minnesota Region (5 of the last 6 years)
- WELCOA Platinum Award-designated employer
- Founded Navitus Health Solutions in 2003, a pharmacy benefit management company with nearly 3 million members nationwide

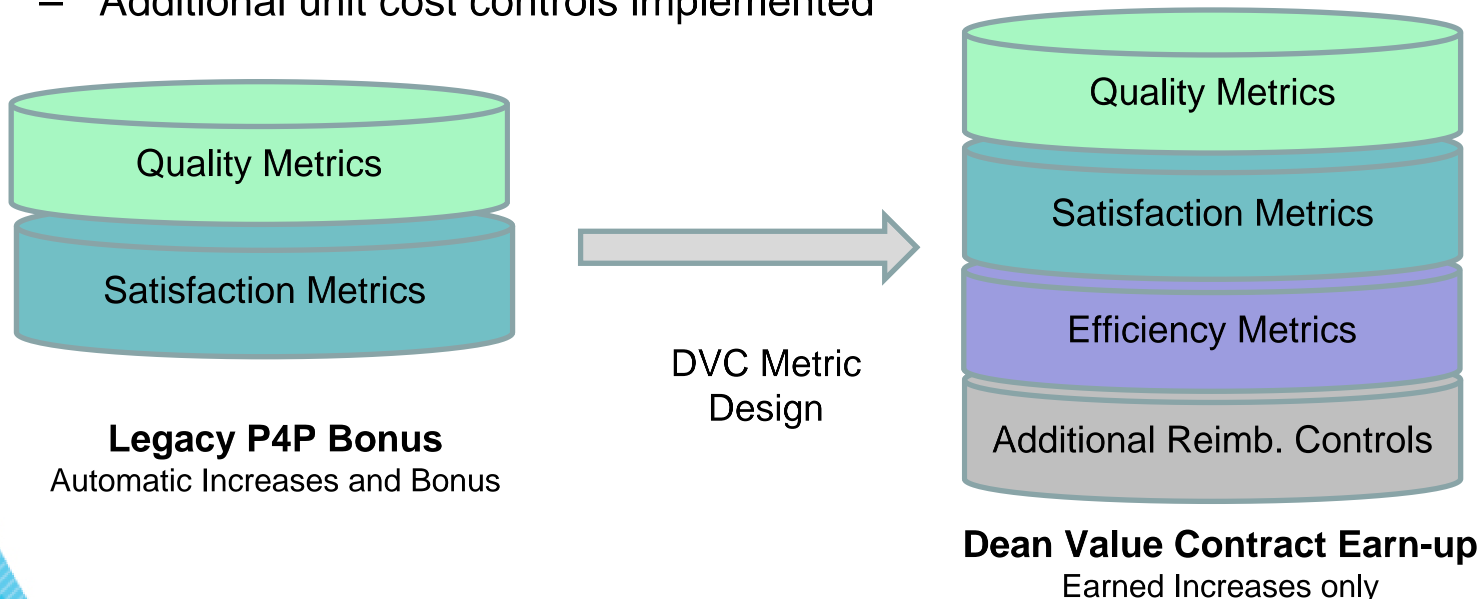
DHP P4P Background

- Dean Health Plan (DHP) has a strategic objective to transform reimbursement mechanisms
  - Transition from primarily volume-based to value-based approaches
  - Elevate provider engagement and align incentives toward improving value
- DHP has a long history with pay for performance (P4P) programs and pilots
  - Physicians (PCPs through “PIM,” and Emergency Medicine)
  - Chiropractors
  - Hospitals
  - Shared-Risk Arrangements
- P4P Programs largely focused on a “Triple Aim” approach and delivering value based on:
  - Patient Satisfaction
  - Quality
  - Efficiency

Today’s overview will focus on the core elements of DHP’s hospital and PCP-based P4P models and evolution of the programs

Hospital Reimbursement Redesign

- Dean Health Plan implemented value-based reimbursement redesign through its "*Dean Value Contract*" (DVC) initiative
  - Historically, hospitals received automatic annual rate escalators of 3-5%
  - Legacy Hospital P4P program based on a 2% bonus opportunity
- DVC-Hospital metrics focused on our Triple Aim
  - Metrics aligned with the Triple Aim now used to determine earned increases
  - Additional unit cost controls implemented



DVC-Hospital Metrics

- Two efficiency metrics provide incentives for trend deflection:
  - *30 Day Readmission Rate* and *1-Day Medical Stays* selected to assure appropriate acute inpatient usage
  - Demonstrated annual trend deflection of up to 2% of total hospital costs

- DVC is built for long-term, value-based reimbursement
  - Efforts are continuing through Hospital P4P Advisory Board to help promote and evolve metrics in support of continued transition from volume-based to value-based reimbursement
  - Hospital P4P Advisory Board includes participation from DHP medical directors, hospital executives, and the Wisconsin Hospital Association
  - Collaboration as well as transparency of metrics and the underlying data are critical for continued success

Physician (PCP) P4P

Provider Incentive Model ("PIM")

•Primary goal of the PIM program is to improve quality, patient satisfaction, and efficiency; HEDIS and CG-CAHPS measures used to assess quality and patient satisfaction

•PIM was established in the 1990's; 75 clinics currently participating in PIM

•PIM performance reports issued quarterly to network providers

•Performance in the selected measures determines the annual bonus payment (typically 2-4% of a clinic's total reimbursement)

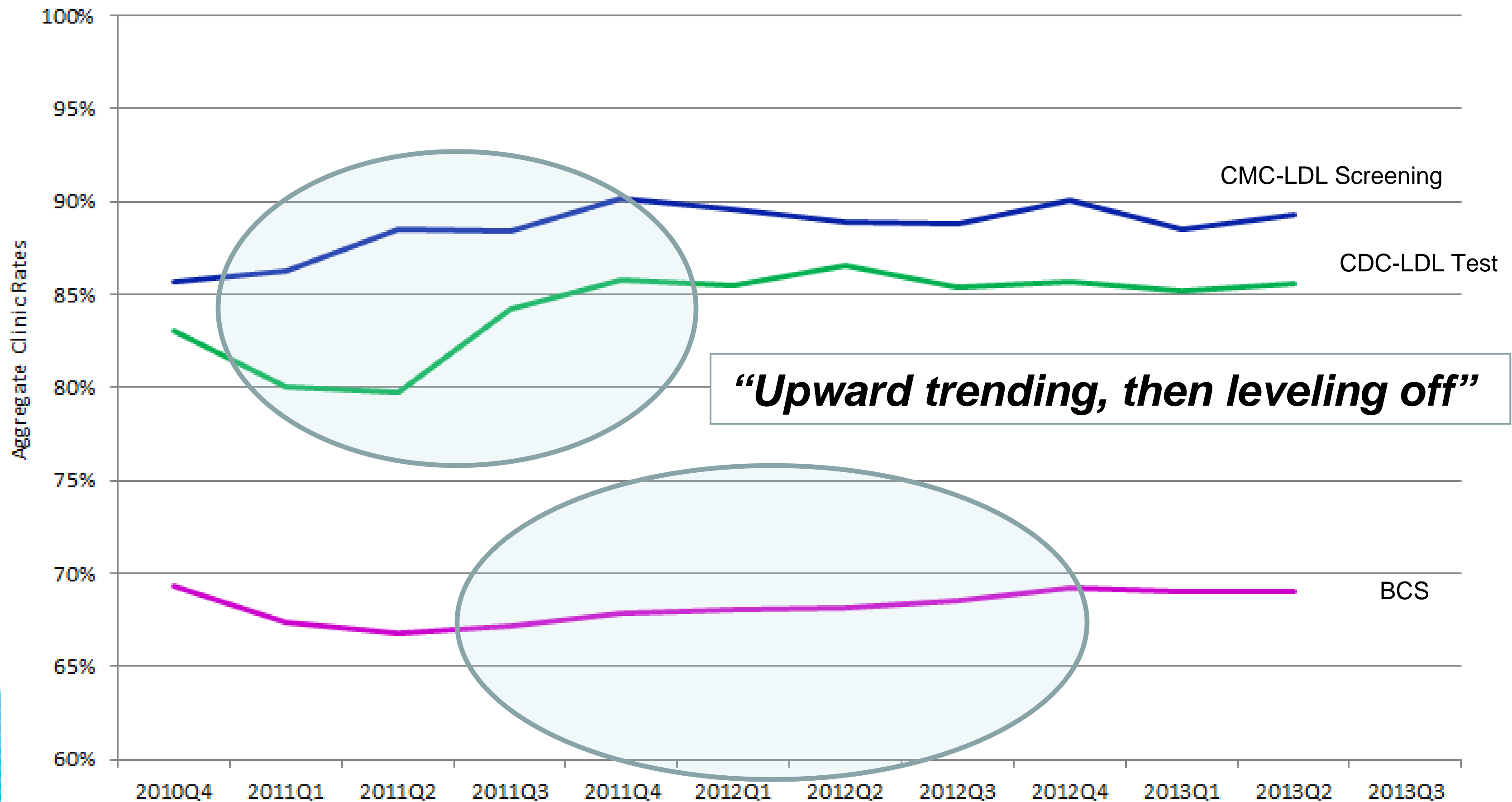
•In addition to the annual PIM bonus, automatic reimbursement increases are provided annually for network clinics

•2013 PIM measures presented below:

Quality Measures	*Satisfaction Measures*	*Efficiency Measures*
Diabetes – LDL Test	Patient obtained urgent appointment as soon as wanted	Emergency Dept. Utilization
Diabetes – A1c Test	Patient obtained check-up as soon as wanted	Generic Prescription Utilization
Cardiovascular Disease – LDL Test	Practitioner explanation was easy to understand	One Day Medical Admits per 1000
Childhood Immunizations	Practitioner listened carefully	
Breast Cancer Screening	Practitioner knew important issues in patient's medical history	

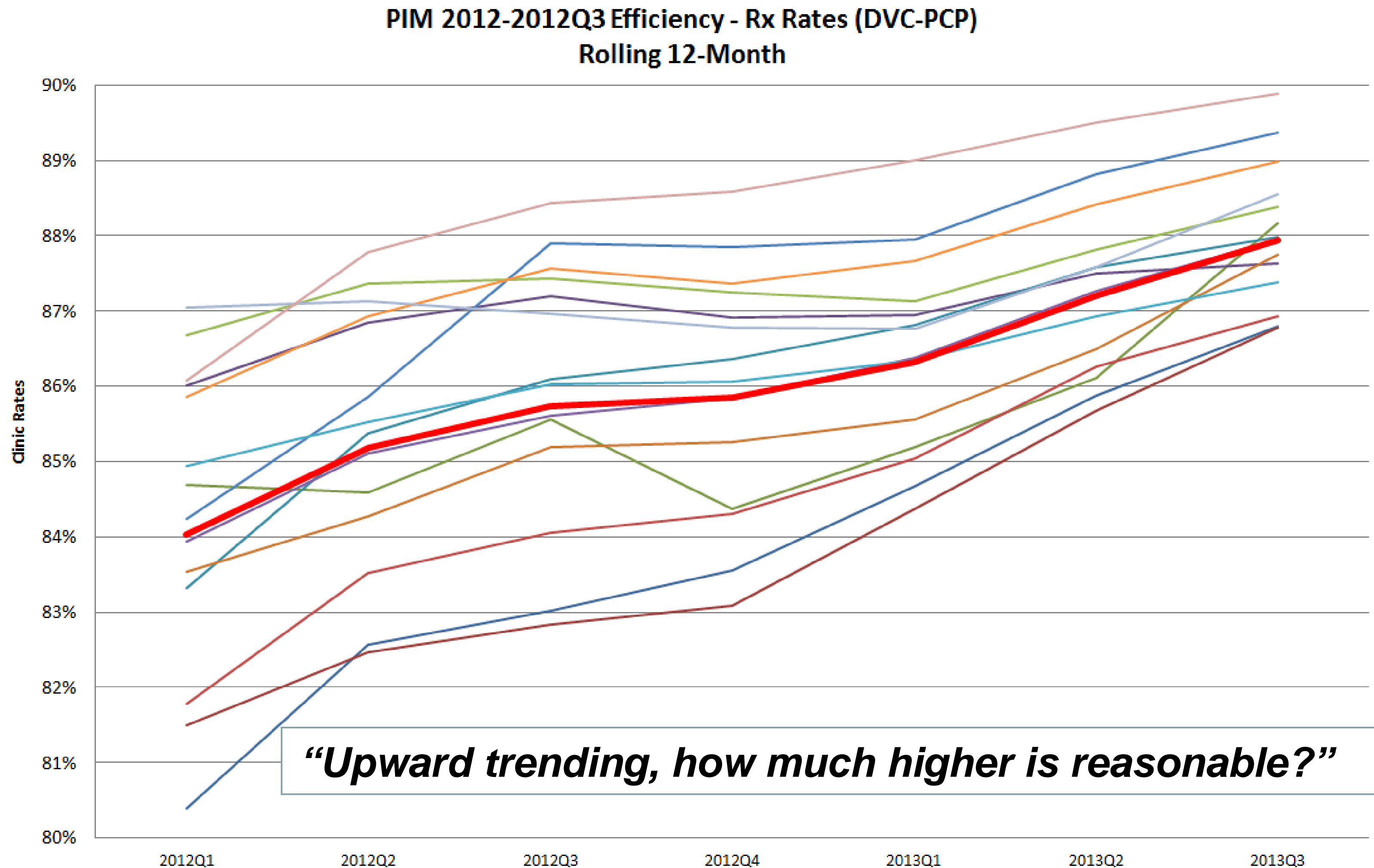
Physician (PCP) P4P

PIM Performance by DVC groups



Physician (PCP) P4P

PIM Performance by DVC groups



Dean Value Contract (DVC) for PCPs

DVC-PCP

•PIM and other P4P programs demonstrated improvements in provider performance over time, however they have limited upside for DHP network providers based on performance improvements already achieved, beginning to level off, and/or appropriateness of metrics

•Continued focus on transforming reimbursement mechanisms from primarily volume-based to value-based approaches that increase provider engagement and mutual benefit

•There are a number of value-based philosophies and incentive programs being advanced by government entities and commercial payors alike which provide a foundation for DHP to draw from in creating its own programs:

- Institute for Healthcare Improvement's Triple Aim
- CMS quality-based payments and gain-sharing
- HealthPartners (Minneapolis) – Triple Aim based contracting
- BCBS Massachusetts - Alternative Quality Contract

•Increased focus on provider engagement through enhanced support from DHP in the form of supplemental reporting, analytics, and quarterly discussions. Understanding and using the data provided with DVC is instrumental in driving improved performance.

•Like DVC for hospitals, DHP's objective is to improve the value of care for its members by effectively incentivizing network providers to deliver value based on DHP's Triple Aim

•Ongoing development and refinement of metrics occurred through the clinic rollout and vetting process

DVC-PCP – Program Components

- Higher potential earn ups
  - Automatic increase in first year of DVC-PCP
  - Potential to earn 8-10% annually in subsequent years
  - Modeling confirmed by experience shows "self-funding", retention, and premium moderation
- Eliminates automatic annual reimbursement increases and separate bonus opportunity in exchange for larger annual reimbursement earn up potential
- Rewards network PCPs for providing care that drives more efficient utilization (e.g. more preventive care and office visits, less ER and inpatient utilization) and ultimately decreases total cost of care while improving quality
- Uses Industry Benchmarks to Assess Performance
  - Continues using HEDIS and CG-CAHPS measures for Quality and Satisfaction
  - Introduces Milliman benchmarking tools to set goals for Efficiency
- Data used in measuring DVC-PCP requires a certain number of members in order to ensure the data are meaningful and actionable
  - Tier 1 and Tier 2 clinics targeted for DVC-PCP (minimum 2,000 members)
  - PIM program retained for remaining clinics
- Provide additional reporting and analysis that supports PCP sites with insight into patient utilization and potential improvement opportunities

DVC-PCP – Provider Engagement

- In addition to providing the quarterly DVC-PCP scorecards, detailed and actionable information is also provided to clinics in the DVC "Provider Toolkit" which includes:
  - Executive summaries
  - Gaps in Care (this is currently provided for PIM program)
  - Inpatient Admits
  - Generic Rx Rates
  - 90-Day Prescription Fill Rates
  - High Risk Member List
  - ED/UCF Visits
- Excel-based reports allow for analysis and trending to be performed in a variety of ways; focus on targeting specific areas that would "move the needle"
- Access to Shared Decision Making Programs (e.g., Emmi)
- Quarterly Visits
  - Includes representation from the network clinic and DHP
    - Leverage the point physician approach through the Network Clinic Medical Director Program
    - DHP attendees include: Senior Medical Director for Network, Quality Improvement, Informatics, Provider Services, and Reimbursement
  - Review data and trends; provide guidance on additional drill downs in the data
  - Discuss opportunities for improvement, ongoing initiatives and best practices

DVC-PCP – Program Metrics

DVC-PCP Metrics for 2014:

Quality	*Satisfaction*	*Efficiency*
Cancer Screening -Breast Cancer -Cervical Cancer -Colorectal Cancer	Patient obtained urgent appointment as soon as wanted	Admits per 1000
Childhood Immunizations	Patient obtained check-up as soon as wanted	ED-UCF Visits per 1000
Diabetes Care - A1c Testing -LDL Testing -Nephropathy -Blood Pressure	Practitioner Explanation was easy to understand	Outpatient Surgery per 1000
Cardiovascular Disease (LDL Test)	Practitioner listed carefully	Rx PMPM
Two specific HEDIS Metrics from the list below: CWP, URI, AAB, ADD, IMA, PPC, ASM, AWC, W15, W34, CHL	Practitioner knew important issues in patient's medical history	

- **"Quality Gate"**: Providers need to make improvements in at least 2 quality measures in order to be eligible for the increase
- Measures and other program elements undergo discussion and refinement as necessary to ensure DVC is mutually beneficial to network physicians and DHP

DHP Perspective - Conclusions

- P4P remains a strategic priority for DHP
- Increased focus on transitioning from volume-based to value-based approaches for both hospital- and physician-based incentive programs
- Continued focus on balancing the elements of Quality, Satisfaction, and Efficiency
- Increase provider engagement and optimize analytics and reporting
- Expanding P4P scope to other providers (e.g., specialists)
- Modify and enhance programs based on industry best practices, provider input and overall results
  - Replace efficiency measures with total cost of care performance
  - Transition reimbursement rate increase only feature - ranging from shared risk to full capitation

DHP Network Physician Perspective

Robert Cambray, MD

Medical Director

Wildwood Family Clinic, Madison, WI

- **Long-time DHP network physician and clinic group**
- **Collaboration with DHP**
  - P4P Programs and Development
    - P4P Advisory Board – periodic meetings with network physicians, DHP medical director, and PIM administrators to discuss metrics
  - Historical PIM Program experience
    - Clinic staff involvement in identifying DHP patients, documenting metrics
    - Challenges with outreach to patient population
    - Provider sense of control over metrics
    - Periodic meetings with DHP to discuss program goals and reports
    - Timely reporting

DHP Network Physician Perspective

- **Transitioning to DVC–PCP**
  - DVC metric selection and refinement
    - Metrics selection through direct discussions with clinic and DHP
    - Provider buy-in and sense of control (physician engagement, quarterly meetings)
    - Similar process internally for our clinic in terms of implementing change to procedures, metric directed behaviors
    - Outcome drives larger reimbursement potential, opportunities and incentives for new programs internally
      - Health counseling with PA's
      - Extended hours

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