Introductions & Agenda

Daniel Parker, CPA

- ✓ ***Insight from operational and financial perspective***
- ✓ Director, Value-Based Strategy, Beacon Health System, South Bend, IN

COVERING: Types of P4P contracts resulting in operational and financial impacts to health systems

Gerard I. Duprat, MD

- ✓ ***Insight from successful ACO leader & implementer***
- ✓ Medical Director Beacon ACO

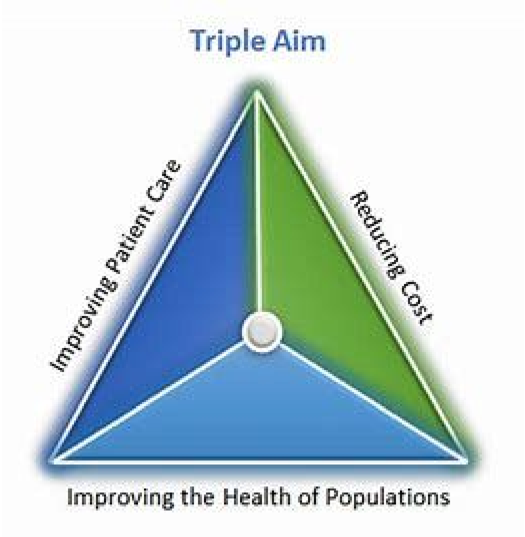
COVERING: Process to successfully establish and implement P4P programs with physicians

Jen Johnson, CFA

- ✓ ***Insight from Third Party Valuation Firm***
- ✓ Managing director at VMG health overseeing compensation division

COVERING: Tips to ensure payments to physicians for P4P programs are compliant and consistent with FMV

Increased Focus on P4P



Transitions in reimbursement based on quality and cost savings is happening now

Local and national hospital ratings are based on quality scores

Hospitals need physician participation / alignment in order to improve quality and cost efficiency

FFS and P4P Co-Exist During Transition

Presenters will Address:

1 - How to develop P4P programs in FFS world

2 – How to think through if P4P physician payments are appropriate

P4P Evolution & Regulatory Guidance

- ✓ **QUALITY**: Primarily quality payment focus during 2003-2010 (sharing savings was a slippery slope)
  - Hospital Quality Incentive Demonstration (HQID) for over 250 hospitals: 2003-2009
  - Physician Group Practice Demonstration for ten physician groups: 2005-2010
  - Third-party payors and health systems start incentivizing for quality
- ✓ **SAVINGS**: Numerous favorable OIG gainsharing opinions early 2000s and new shared savings opinion from December 2017 shows consistent guidance
- ✓ Multiple models and arrangements exist today beyond commercial and Medicare ACOs
  - Medicare Shared Savings Program
  - Bundled Payments for Care Improvement
  - Commercial payor P4P programs growing exponentially
  - Government launching of numerous APMs – ahead of schedule!
- ✓ **TRENDS** in evolving models: Physician -> Service Line -> Population Health

**Understand regulatory guidelines and payor models in the market before developing program and establishing payments – this will help proper alignment of strategy*

Insight from Operational and Financial Perspective

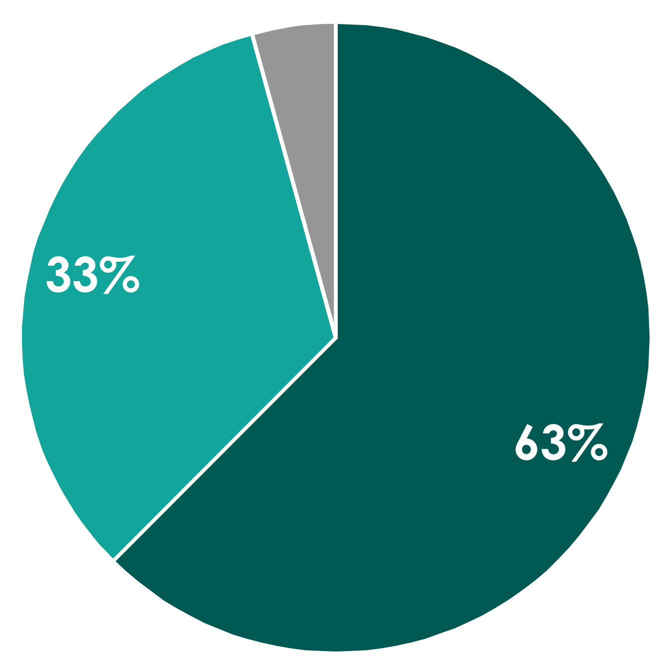
Beacon Health System

Value-Based Reimbursement Participation

Pay for Performance

ACO / Shared Savings / Capitation

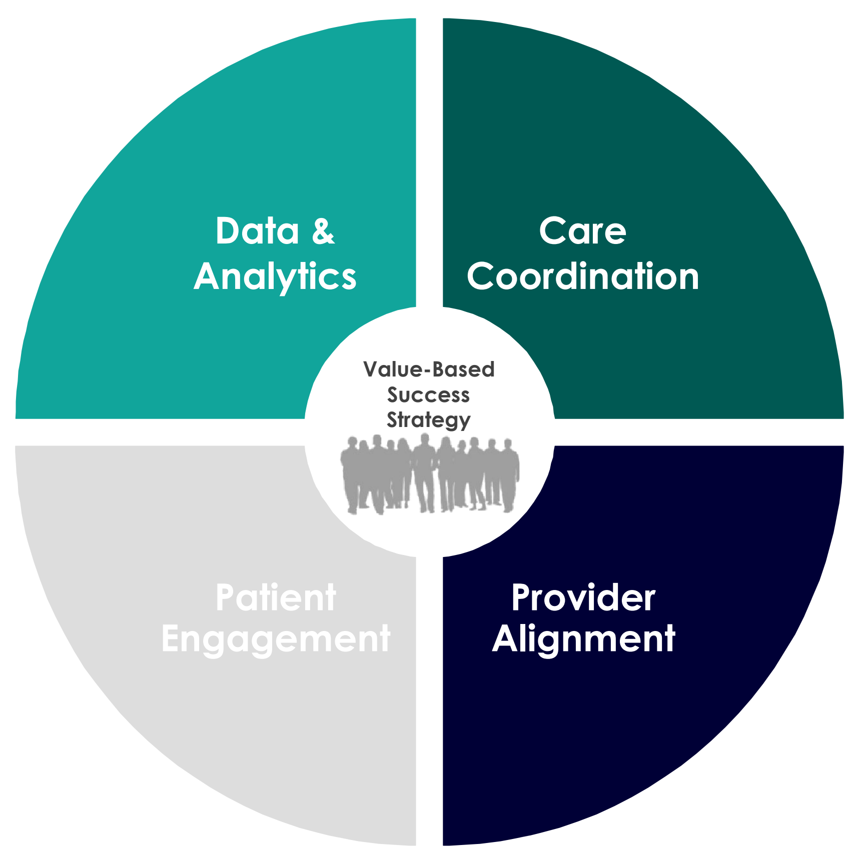
Business From Value-Based Reimbursement



21% of operating income direct result of value-based bonuses, shared savings payments, etc.

■ Value-Based ■ Fee For Service ■ Self Pay

Value-Based Strategy



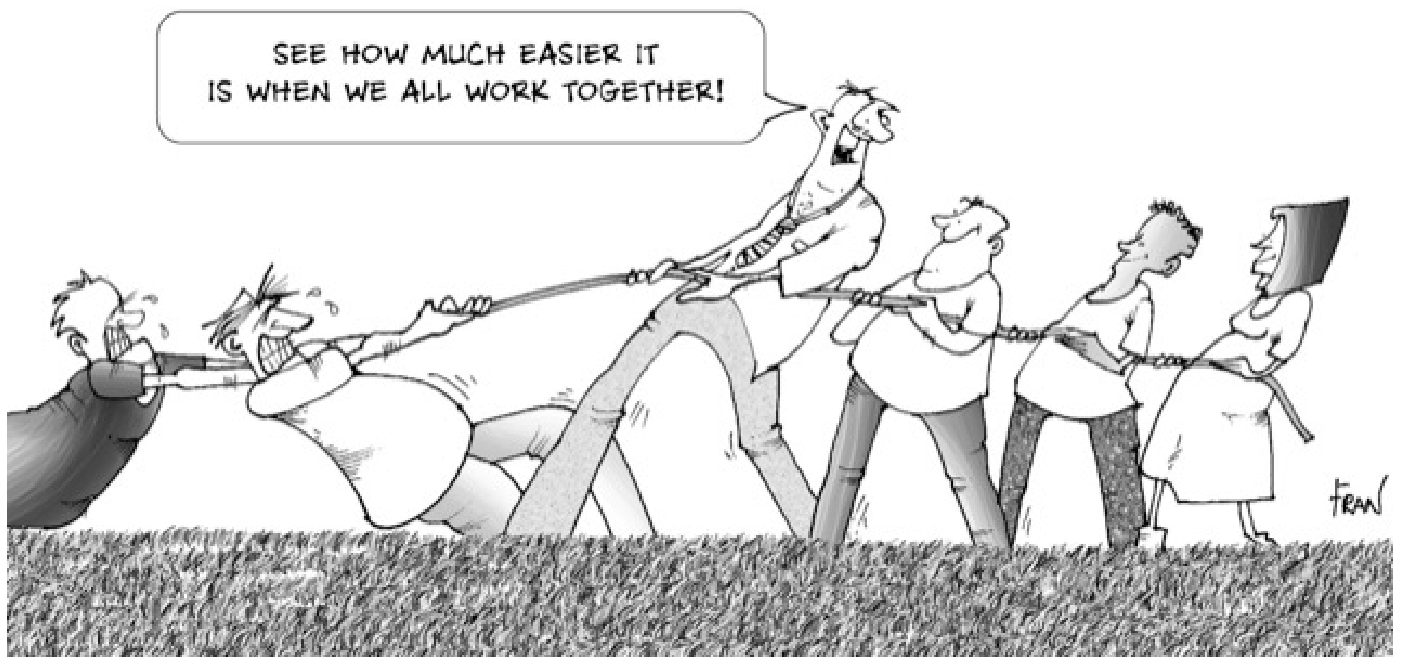
Insight from Successful ACO Leader & Implementer

Case Study: Heart, Vascular, Stroke Care

- ✓ Beacon Health System: 2 Hospitals (Memorial Hospital, South Bend. Elkhart General, Elkhart).
- ✓ In 2013: Traditional Cardio Vascular clinical services, basic referral/ triage. Conventional Medical staff, department focused, typical peer review.
- ✓ Many physicians on staff at both hospitals.

Memorial Hospital: 2013

Endo Vascular Credentialing



- ✓ Credentialing: multiple departments
- ✓ Uneven Quality. No standardized peer review
- ✓ Sense of urgency → Opportunity recognized by Administration/ physicians
- ✓ "Steering Committee" created

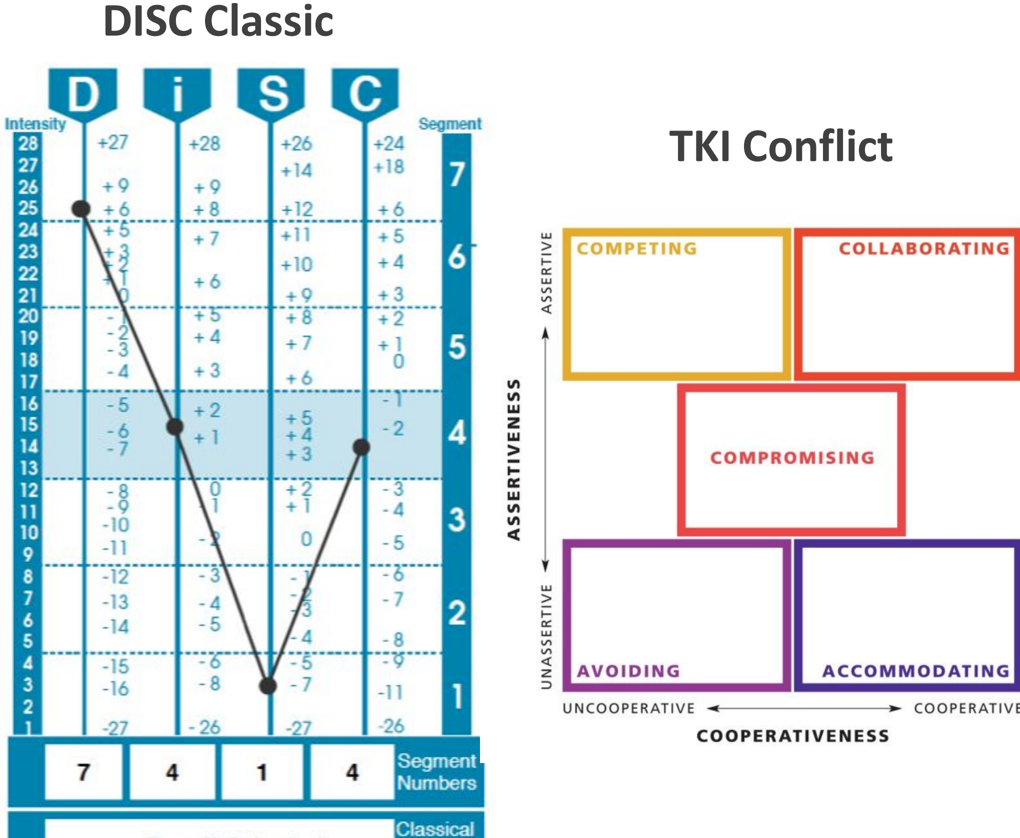
Memorial Heart, Vascular, Stroke Network: Foundations

- ✓ Supported by Administration and Med staff; delegated credentialing and peer review
- ✓ Program Consultants
- ✓ Leadership Consultant

- ✓ Physician led Governing Council. Co-Chairs: Physician and Hospital President
- ✓ Intentional physician selection
  - Best in respective fields
  - Reputation, honesty, integrity, caring
  - Leader of leaders: emotional intelligence. Ability to learn fundamentals of leadership

Heart, Vascular, Stroke Network: Leadership

- ✓ Leadership consultant: 2013-2015
- ✓ Sophisticated assessment tools: Disc classic, Lifo Strength management, Firo-B Profile, Thomas Kilmann Conflict mode instrument (TKI)
- ✓ Individual Coaching for MD Co-Chair, Administrative Co-Chair (bimonthly 1 hour meetings, quarterly day meeting) and Governing Council Members.



Physician Leadership Development Goal: High Performing Team

Focus on Results

Hold One Another Accountable

Commit to Decisions & Plans of Action

Engage in unfiltered conflict around ideas

Trust One Another

Patrick Lencioni

Heart, Vascular, Stroke Network: Vision

Stage 4 Institute	Comprehensive set of services (advanced and supporting services) spanning continuum of care Multiple disease specific accreditations Hub & spoke hospital network	~~Advanced research with academic components~~ Publications Quarterary level of care Full clinical integration
Stage 3 Specialty Center/ Center of Excellence	Defined mission and vision Distinct program identity Advanced certification/accreditation for disease specific care with above average outcomes (AMI, HF, VAD, etc) Critical volume Advanced/comprehensive outcome analysis	Board certified physicians Integrated facilities and staff Market offerings (bundled payments, etc.) Governance structure with focus on strategy, finance, quality & operations Basic research Comprehensive diagnostics and treatment Full implementation of EBG and clinical protocols
Stage 2 Service Line	Broad collection of related services Multidisciplinary peer review Formalized integrated care approach Basic certifications (i.e. Primary Stroke) Care transition Advanced diagnostics	Basic data Integration (chart abstraction) Service Line leadership (Admin & Medical director) Registry participation Shared resources (Staff and Equipment) Basic multidisciplinary protocol development
Stage 1 Traditional Clinical Service	Basic diagnostics/triage/referral Basic Med/Surg services Department/division focused Traditional medical staff peer review	Home grown quality tracking program Led by steering committee

Content Source: Healthcare Advisory Board

Governance Structure

Physician Led

- ✓ Oversee strategy, standards, and resource allocations
- ✓ Gain sharing model: not individual, Group
- ✓ Redesign systems to improve care, cost, patient experience
- ✓ Evidence based performance benchmark and targets
- ✓ <u>Collectively Accountable</u>

Heart, Vascular and Stroke Network

30 physicians signed Co-Management agreement

Governance Council

Program Exec. Director

Quality and Peer Review: Heart, Vascular, and Stroke

Credentials: Heart, Vascular, and Stroke

Care Redesign: Accountable Performance

Cardiac Services

Cerebral Vascular Sub-Committee

Procurement Sub-Committee

CHF Sub-Committee

Heart, Vascular, Stroke Network

2016 Scorecard

- 44 Quality Metrics (cardiac, vascular, stroke, patient/staff experience) monitored. 12 of used for incentive compensation
- 14 Budget efficiency Metrics (DRG's) monitored. 4 used for incentive compensation
- Total payout to Physicians was: $288,242

NTL avg - red/green   Top Decile - blue

	Data source	Ntl avg	Top Decile	2015 HX	2016 YTD
(isolated)CAB with >= 4 units of RBC's(post op only)	STS	5.2%	3%	19.1%	11%
Smoking cessation referral given for PCI	QM-Manual	goal 90%	>99%	n/a	100%
Pre procedure ABI documented prior to PV intervention	QM Manual	96%	100%	93.2%	97.2%
Smoking cessation **referral given** across all VQI modules	QM-Manual	goal 90%	>99%	n/a	83.7%
Statin, ASA or Coumadin or Plavix (or other appropriate antiplatelet therapy) on discharge/ document contraindications for PVI	QM-Manual	goal 90%	>90%	86.7%	98.3%
Vascular surg with post op Sepsis	NSQIP	<1%	0.3%	1.2%	0.58%
Smoking cessation referral given for Carotid Endarterectomy	QM-Manual	goal >90%	>99%	n/a	83.3%
% statins at discharge for carotid endarterectomy	QM-Manual	goal >80%	>99%	n/a	98%
% statins at discharge for fem-pop bypass	QM-Manual	goal >80%	>99%	n/a	100%
Percentage of Stroke patients receiving IV tPA within 45 minutes of presentation to the ED	Stroke Nav	goal >40%	>70%	36%	15%
Physician compliance for Ischemic Stroke Order Set usage	Stroke Nav	goal >80%	>90%	53%	72%
Stroke patient with inpatient rehab referral will have consult completed within 24 hours of order	IP Rehab	goal >80%	>99%	na	99%

Accomplishments

Revenue/ Cost Reduction

- ✓ Net Technical Revenue Contribution over $76 Million annually
- ✓ Cost reduction recognized through Cardiovascular Procurement Committee over $1.1 million (2015-2016)
- ✓ Care Re-design committee focus DRG initiatives recognized over $1.5 million savings through supply vendor negotiation and decrease ALOS (2015-2016)
- ✓ Stroke Bundle Payment from Medicare $116,538

Accomplishments

Quality

- ✓ Addition of registries to track and benchmark quality metrics (VQI, NVQI, AHA-stroke and HF)
- ✓ Positive Trending in Key Quality Initiatives: 80 quality metrics monitored
- ✓ Lipid/Statin Protocol Implementation for cardiovascular patients
- ✓ Cardiac, Endovascular and Vascular Surgery Credentialing
- ✓ Multi-disciplinary Peer Review process

Accomplishments

Program Development

- ✓ Implementation of Care Coordinators
- ✓ Post-Acute Care Transition for at Risk Patients
- ✓ Auto Accept Protocol: Ischemic Stroke
- ✓ Expanding Beacon TAVR program
- ✓ Intracranial Embolectomy

Accolades

- ✓ Primary Stroke Center Certification
- ✓ CHF certification
- ✓ Echo Lab Certification (ICAEL)
- ✓ Anthem Blue Distinction Award in Cardiology
- ✓ VQI registry awards
- ✓ Watson Health 50 Top Cardiovascular Hospital (based on 2016 improvements)

Watson Health 50 Top Cardiovascular Hospitals

AMI and HF patients:
2016 Performance and Five-Year Rate of Improvement Matrix

Elkhart

2012 - 2016 Rate of Improvement

2016 Performance

PROFILED HOSPITAL compared to:

2016 Community hospitals: n = 475

2012 - 2016 Community hospitals: n = 440

Memorial

2012 - 2016 Rate of Improvement

2016 Performance

PROFILED HOSPITAL compared to:

2016 Teaching hospitals: n = 307

2012 - 2016 Teaching hospitals: n = 295

DATA POINT KEY

1	OVERALL*
A2	AMI IP Mortality
A3	AMI 30-Day Mort
A4	AMI 30-Day Readmit
A5	AMI Avg LOS
A6	AMI Cost per Case
H7	HF IP Mortality
H8	HF 30-Day Mort
H9	HF 30-Day Readmit
H10	HF Avg LOS
H11	HF Cost per Case

QUINTILES

- 80 TO 100
- 60 TO 80
- 40 TO 60
- 20 TO 40
- 0 TO 20

Watson Health 50 Top Cardiovascular Hospitals

CABG and PCI patients:

2016 Performance and Five-Year Rate of Improvement Matrix

Elkhart

2012 - 2016 Rate of Improvement (y-axis: 20, 40, 60, 80, 100)

2016 Performance (x-axis: 20, 40, 60, 80, 100)

Data points: P10, P9, C3, 1, C6, P8, C4, C5, C2, P7

PROFILED HOSPITAL compared to:

2016 Community hospitals: n = 475

2012 - 2016 Community hospitals: n = 440

DATA POINT KEY

1	OVERALL*
C2	CABG IP Mortality
C3	CABG Complications
C4	CABG w IMA
C5	CABG Avg LOS
C6	CABG Cost per Case
P7	PCI IP Mortality
P8	PCI Complications
P9	PCI Avg LOS
P10	PCI Cost per Case

QUINTILES

- 80 TO 100
- 60 TO 80
- 40 TO 60
- 20 TO 40
- 0 TO 20

Memorial

2012 - 2016 Rate of Improvement (y-axis: 20, 40, 60, 80, 100)

2016 Performance (x-axis: 20, 40, 60, 80, 100)

Data points: C6, P8, 1, P7, C5, P10, C3, P9, C2, C4

PROFILED HOSPITAL compared to:

2016 Teaching hospitals: n = 307

2012 - 2016 Teaching hospitals: n = 295

Heart, Vascular Stroke Network

Lessons Learned

- ✓ One Health system 2 Hospitals. Hospital with physician led, integrated Cardiovascular/ Stroke care delivered superior results from both quality and financial perspective.
- ✓ What's ongoing/ next:
  - System wide Heart, Vascular, Stroke network
  - Virtual bundles (PCI, CABG, AMI, Stroke)
  - Ortho network for total joints

ACO

Foundations

- Use Heart, Vascular, Stroke network model and create physician led, integrated lines of services in areas such as:
  - ✓ Ortho joints
  - ✓ Oncology
  - ✓ In-patient medicine
  - ✓ Mother/ Baby
  - ✓ Primary care
- Align Incentives within hospitals, medical groups, Health System, and ACO
- Takes time. Invest. Start now.

Insight from Compliance Perspective
VMG HEALTH
WE VALUE HEALTHCARE
BEACON
HEALTH SYSTEM

Process When Determining Compensation Under a P4P Model

1. Define program goal – individual (employed, medical director, bundled payment), service line (co-management), or population (ACO, CIN, HEP)
2. Define services and metrics - quality, cost savings, combination
3. Define risk and responsibility of physician participants
4. Define compensation structure - dollar, percentage of compensation, percentage of shared savings, splits between primary care and specialists, distribution methodology
5. Determine FMV of compensation to physician participants

Value Drivers That Impact P4P Compensation

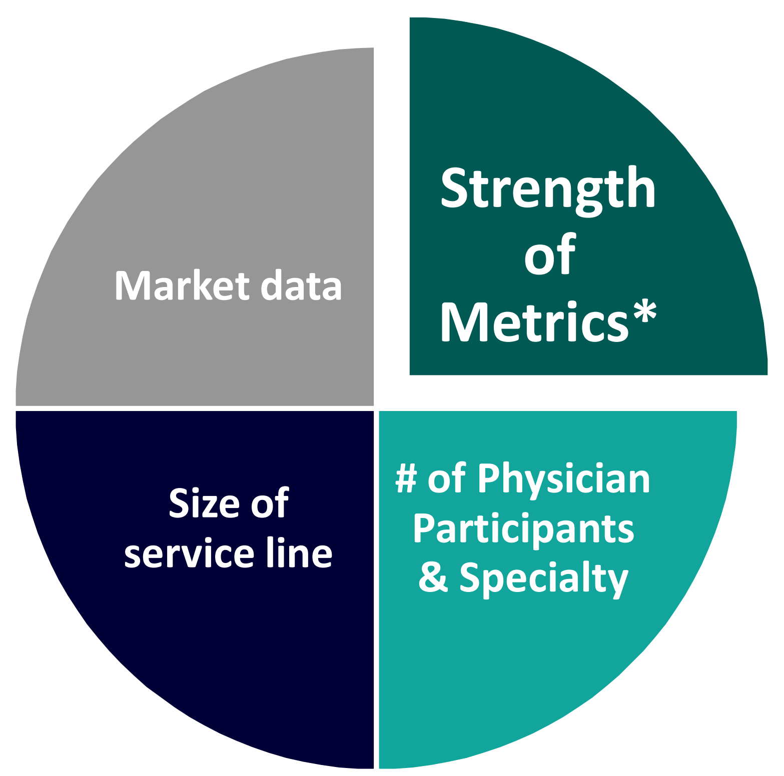
Source of Program Funding

Level of Responsibility of Parties/Participants

Degree of Risk &/or Expense of Parties/Participants

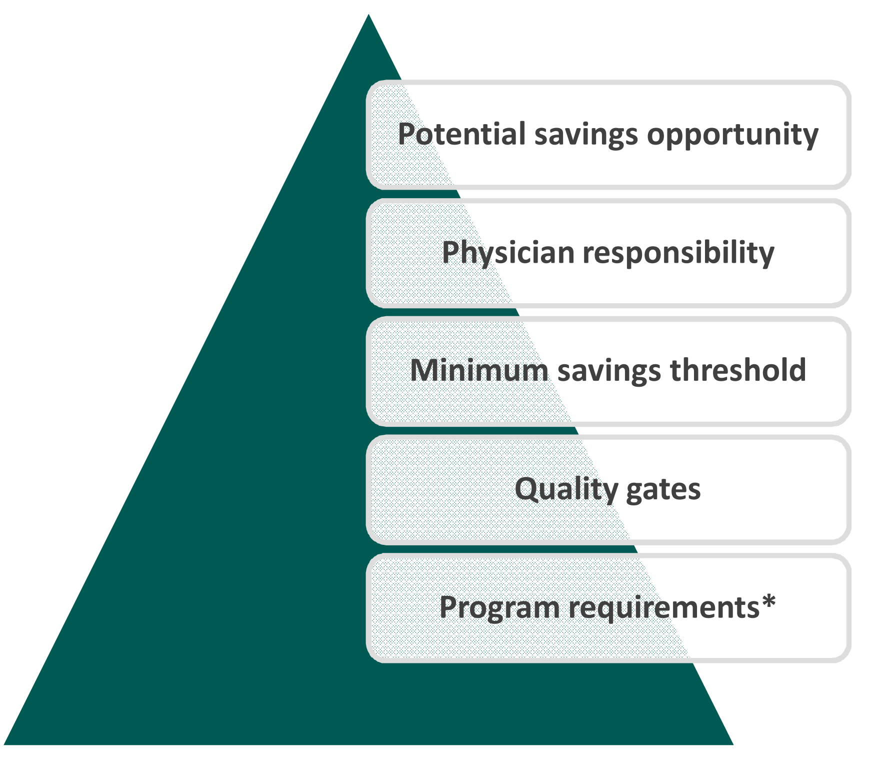
Specific FMV Considerations Related to Arrangement Type

Key Value Drivers - Quality



*Quality Metric Considerations
Selection and Number of Meaningful Metrics
Aggregate Physician Responsibility
Metric Type
Metric Source
Benchmark Source
Likelihood of Achieving Maximum Payout

KEY VALUE DRIVERS – COST SAVINGS



*Program Requirements
Focus to reduce waste and increase efficiency
Physicians required to work with hospital(s) to evaluate and conduct clinical reviews of various processes
Clearly defined participation criteria
Processes include standardization measures and best practices
No savings paid unless quality criteria thresholds are met or exceeded
Certain safeguards are in place to ensure patient safety and quality are not negatively affected
Objective and credible support for cost reductions are considered, as well as, historical performance related to the subject cost reduction benchmarks
Metrics/benchmarks/initiatives will be reassessed and/or rebased annually

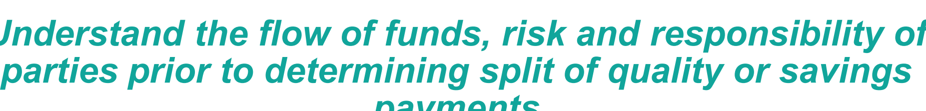
Compliance Checklist – P4P Arrangements

QUALITY PAYMENTS

- ✓ Metrics outlined
- ✓ Primarily outcomes metrics (versus process or reporting)
- ✓ Be careful with low hanging fruit metrics
- ✓ Benchmark performance against medical credible evidence
- ✓ Ensure physician(s) will have demonstrable impact on quality
- ✓ **Check for overlap of payments from co-management, bundled payments, etc…**

COST SAVINGS

- ✓ No cherry picking or lemon dropping
- ✓ Identify separate identifiable cost savings opportunities in advance
- ✓ Ensure physician(s) will have demonstrable impact on cost savings



Compliance Questionnaire

Does your P4P program meet these criteria?

Has an agreement been drafted that details the services and responsibilities of each party, fee structure/flow of funds (if applicable), and quality metrics/gates (if applicable)?

Have all eligible physicians been asked to participate?

Have safeguards been put into place to ensure patient safety and to prevent reduction in patient care?

Has there been a review of various P4P programs to ensure there is no overlap of services or payments?

Have the subject quality metrics and/or cost savings opportunities been determined in advance?

Do the selected performance metrics align directly with the patient population, service line, and/or the hospital's mission and values?

Has performance been benchmarked against historical and national data in order to identify areas of opportunity and superior outcomes?

Has physician participant risk and/or responsibility for performance under the P4P model been considered?

Has an infrastructure been put into place to track and monitor performance and expenses incurred?

Have the parties ensured that the payments to the physician participants in the P4P program are Commercially Reasonable and consistent with fair market value?

THANK YOU!

Gerard I. Duprat, MD
Medical Director, Beacon Health System

Daniel Parker, CPA
Director, Beacon Health System

Jen Johnson, CFA
Managing Director, VMG Health