POPULATION BASED PAYMENT®
A "Buy Right Strategy"

IHA Conference
March 23-25, 2011
San Francisco, CA

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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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Compensation Arrangements Under Consideration – 2011

- Capitation
- Fee for Service
- Salary
- Case Rates - with and without guarantees
- Bundled Payments
- P4P
- Risk
- Shared Savings
- Medical Homes
- ACO's - with and without risk

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Accountable Care Organizations*

- **Identify hospitals as the “natural organization” within which to improve care**
- **Local health delivery systems are the driver for change**
- Advocate the value of shared physician accountability
- Establish spending benchmarks for ACOs
- Performance measures are established to promote accountability
- Shared savings bonuses are distributed only if an ACO’s performance is below its benchmark

***Fisher, Elliott, et. al. Fostering Accountable Healthcare. Health Affairs. January 2009**

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“So, which one of us is the right silver bullet?”

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Population Based Payment®

A framework and ***process for compensating health care practitioners*** for providing an agreed upon set of services for a specified population of covered beneficiaries for a specific period of time.

It is Not -

CAPITATION

RISK

It is -

- A PHYSICIAN CENTRIC SHARED SAVINGS MODEL

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Why the Time is Right for Population Based Payment®

- Market Forces
  - Section 3022 of ACA – Shared Savings Model
  - Movement to Accountable Care Organizations
  - American Recovery and Reinvestment Bill –HITECH ACT
  - Clear FTC Advisory Opinions – TriState Health Partners April 23, 2009
- Current Compensation Models are being challenged
- The Process Steps are logical
  - Traditional Financial Modeling Principles can be used
  - Framework supports principles of Evidenced Based Medicine and Clinical Protocols

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POPULATION BASED PAYMENT® PROGRAM FEATURES

- Enables payors and providers to:
  - Continue to submit claims and receive payment using standard industry billing and reimbursement arrangements
  - Use providers' claim history to establish financial benchmarks
  - Mutually benefit from improvements in medical claim expense

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POPULATION BASED PAYMENT® PROGRAM FEATURES Continued

- Utilize HEDIS and other population based metrics to monitor and improve outcomes
- Incentivize high cost providers to participate
- Move unorganized providers into FTC compliant clinically integrated joint ventures
- Benefit from the use of available HiTech Act funding for EHR adoption efforts

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Characteristics of Population Based Payment® Arrangements:

- Clinically integrated provider panels
- Historical medical claim cost experience is actuarially determined
- Clinical guidelines are in place
- Performance targets are established for :
  - Quality/Outcomes
  - Efficiency
- Established mechanisms are in place for routine and ad hoc reporting

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INCENTIVE MODEL COMPARISON

		INCENTIVE MODEL TYPES		
	INCENTIVE MODEL FEATURES	POPULATION BASED PAYMENT	ACO	GLOBAL PAYMENT
1	No change in claim submission process	●	ϴ	O
2	Physician centric	●	O	ϴ
3	Hospital or health system centric	O	●	ϴ
4	Historical PMPM is used to document cost trends and establish financial benchmarks	●	O	o
5	HEDIS and other 3rd party measures are used to establish, monitor and reward outcomes	●	●	●
6	Providers are rewarded via a gain-share arrangement (50/50) after reaching cost benchmarks	●	●	O
7	High cost providers are incentivized to join clinically integrated provider panels	●	O	O
8	Supports all lines of business and all product types	●	ϴ	ϴ
9	Counties with at least 10,000 covered lives	●	●	ϴ

Good - ●
Fair - ϴ
Poor - O

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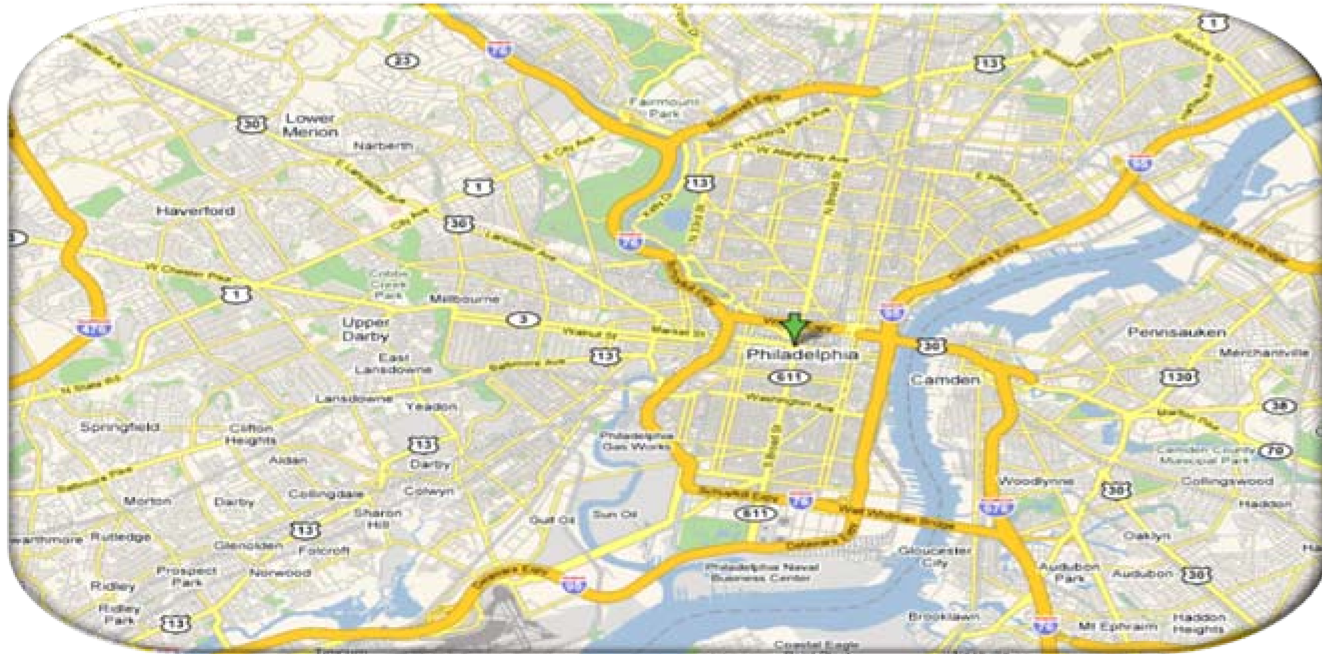
Population Based Payment®



Historical Claim Cost and Target PMPM:

Premium	$291.28	Target	Savings
Member Cost	$236.62	$230.70	$5.92
Total Members	10,656	10,656	$63,083

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Compensation is based upon historical medical claim cost (PMPM) of a defined population

$236.62
PMPM

Chronic
disease
management

RX
Spend

Admissions
per 1/K

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These 3 hospitals share common primary and secondary service areas

Abington Memorial Hospital

- DRG 195 - $6,916
- DRG 293 - $7,307
- DRG 310 - $5,510
- DRG 392 - $5,077
- DRG 470 - $14,007

Grand View Hospital

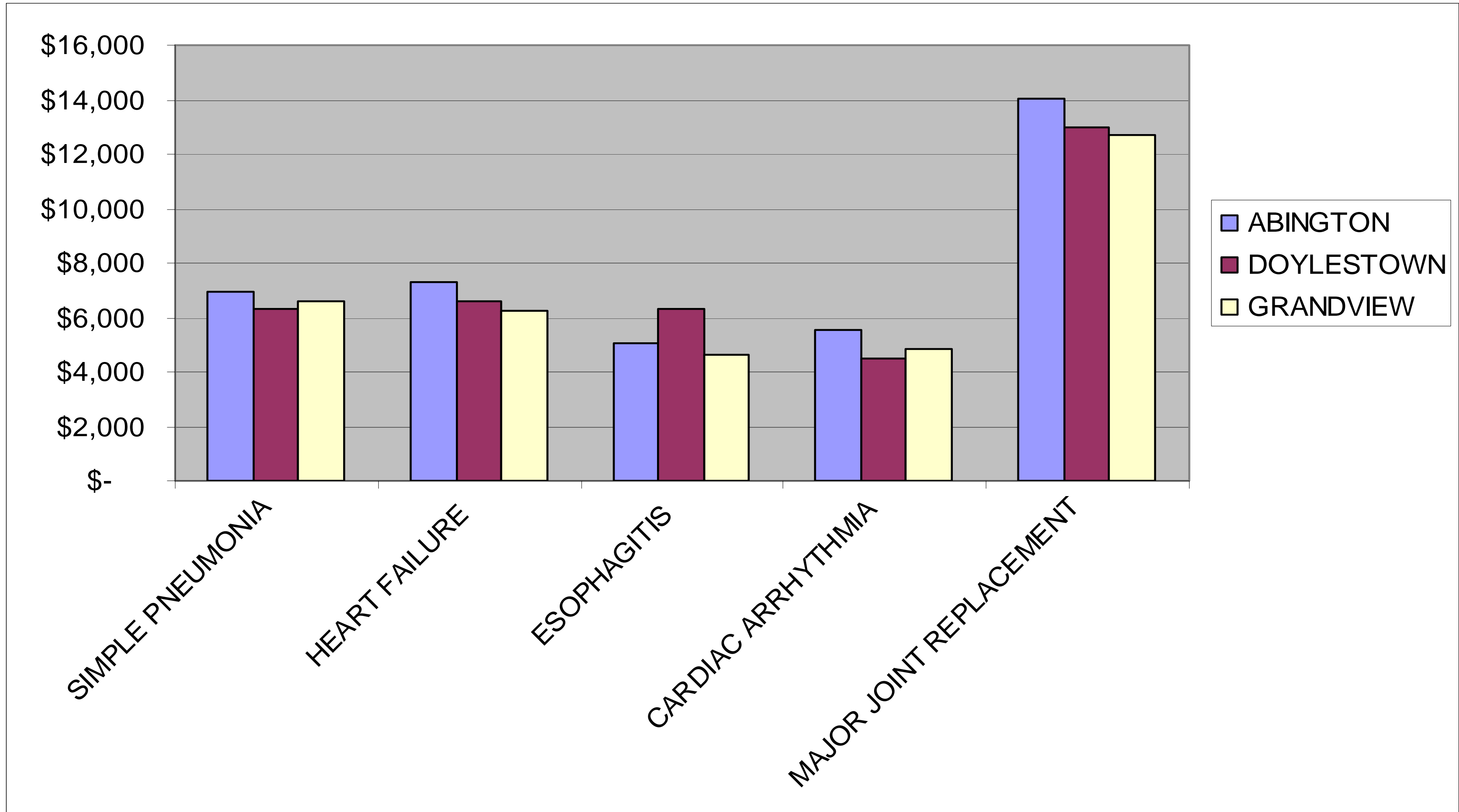
- DRG 195 - $6,667
- DRG 293 - $6,267
- DRG 310 - $4,858
- DRG 392 - $4,664
- DRG 470 - $12,699

Doylestown Hospital

- DRG 195 - $6,312
- DRG 293 - $6,568
- DRG 310 - $4,478
- DRG 392 - $6,312
- DRG 470 - $12,973

DRG - 195 Simple pneumonia
DRG – 293 Heart failure
DRG – 310 Cardiac arrhythmia
DRG – 392 Esophagitis
DRG – 470 Major joint replacement

Facility Cost Comparisons



Source – American Hospital Directory
Based on Medicare IPPS claim data (2009)

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Savings Opportunity
Facility Spend
Generic Drug Dispensing Rate

Hosp Spend = 31% of Tot Spend	PMPM	Reduction 11.0%	Annualized 100% of move	RX Spend @$0.75 PMPM per/1% Change	75%
2011	$91	$10	$1,199,693	1%	$90,000
2011	$98	$11	$1,289,676	2%	$180,000
2013	$105	$12	$1,386,411	3%	$270,000
2014	$113	$12	$1,490,347	4%	$360,000
2015	$121	$13	$1,602,141	5%	$450,000
2016	$130	$14	$1,722,323	6%	$540,000
2017	$140	$15	$1,851,466	7%	$630,000
				8%	$720,000
				9%	$810,000
				10%	$900,000

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Delivering Quality, Convenience and Value
in prescription fulfillment at the point-of-care.

QuiqMeds improves prescription compliance and patients love the convenience!

As Many as
20% of Prescriptions
Never Get Filled

33% of Refills
Never Leave the Pharmacy

Replay

QUALITY, CONVENIENCE and VALUE

The QuiqMeds system increases the quality of care and enhances the trusted relationship between the physician and patient by providing patients with the most often prescribed medications at the time of their office visit.

The practice of prescribing and fulfilling prescriptions by physicians in their offices is supported by numerous national organizations including the American Medical Association, the American Academy of Pediatrics and the Federal Trade Commission, which claims that it "increases service and price competition among practitioners and between practitioners and pharmacists, to

The QuiqMedsï¿½ System

On the leading edge of in-office pharmaceutical fulfillment, QuiqMeds offers an easy to use, intuitive delivery system to physicians and office staff. User friendly software, accessible through any local computer, is linked directly to the QuiqMeds Inventory Control Cabinet (ICC) which contains up to 700 units of controlled-access inventory. Using a computer touch screen, the doctors order prescription medications, which will be delivered by the office staff at check out. Patients pay for and receive their medication along with the appropriate consumer drug information. This is a one step financial transaction. This savings realized by eliminating layers of administrations is passed on to the physician and the patient. Learn More.

QuiqMeds Demo Video

The QuiqMeds System is intuitive, easy to use and benefits the physician and the patient.ï¿½
Click here for a brief demo.

Population Based Payment® - Financial Model

Practice	PMPM	Members	Monthly Cost	Distribution
Practice 1	$203.66	2,801	$570,460	$39,766
Practice 2	$224.61	3,695	$829,919	$52,458
Practice 3	$261.54	679	$177,585	$9,639
Practice 4	$291.92	1,146	$252,024	$16,269
Practice 5	$429.38	617	$264,924	$8,759
Practice 6	$255.31	558	$142,461	$7,921
Practice 7	$244.85	1,160	$284,025	$16,468
Total	**$236.62**	**10,656**	**$2,521,401**	**$151,284**

Target Savings of $5.92 *(10,656*12) = $757,002

Provider Gain-share after first 2.5% = 50/50

1% reduction = $2.37*.5 = $1.18 *(10,656*12) = $151,284

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What the skeptics say!

- What is the value of the model after initial savings are achieved?
- Providers have to assume some risk in order for the model to work. PBP is an up-side only model.
- Why would a plan support efforts to foster provider collaboration; namely, giving up market leverage?

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Value of the Model after Year 1

	PMPM TREND	PMPM @	Annualized Savings/MM		Annualized Savings/MM		Annualized Savings/MM		Annualized Savings/MM		Annualized Savings/MM
YEAR	107.5%	105.0%	120000	104.0%	120000	103.0%	120000	102.0%	120000	101.0%	120000
2008	$236.00										
2009	$253.70	$247.80	$708,000	$245.44							
2010	$272.73	$266.39	$761,400	$263.85							
2011	$293.18	$286.37	$817,620	$283.64	$1,144,896	$280.91	$1,472,172	$278.18	$1,799,448	$275.46	$2,126,724
2012	$315.17	$307.84	$879,720	$304.91	$1,231,536	$301.98	$1,583,352	$299.04	$1,935,168		
2013	$338.81	$330.93	$945,780	$327.78	$1,323,984	$324.63	$1,702,188	$321.47	$2,080,392		
2014	$364.21	$355.75	$1,015,140	$352.36	$1,421,712	$348.97	$1,828,284	$345.59	$2,234,856		
2015	$391.53	$382.42	$1,093,140	$378.78	$1,530,192	$375.14	$1,967,244	$371.49	$2,404,296		
2016	$420.90	$411.11	$1,175,220	$407.19	$1,645,056	$403.28	$2,114,892	$399.36	$2,584,728		
2017	$452.46	$441.95	$1,261,800	$437.74	$1,766,880	$433.53	$2,271,960	$429.32	$2,777,040		
			$7,188,420		$10,064,256		$12,940,092		$15,815,928		
		Available Distribution $			2,875,836		$5,751,672		$8,627,508		$1,309,104
		Practice size of 250/10000			$ 71,896		$143,792		$215,688		$32,728

Net Savings = $1,309,104
Savings opportunity for Avg. FP = $235,638

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The Fall Of The House Of AHERF: The Allegheny Bankruptcy

A chronicle of the hows and whys of the nation's largest nonprofit health care failure.

by Lawton R. Burns, John Cacciamani, James Clement, and Welman Aquino

PROLOGUE: The drama of the collapse of the Allegheny Health, Education, and Research Foundation (AHERF) has captured the attention of industry observers from Wall Street to the ivory towers of academe. All are eager to know who ultimately held responsibility—legal, financial, and managerial—for AHERF's decline. Part of the intrigue of the story certainly stems from the fact that so many actors, both inside and outside the company, appear to have played a part. Indeed, the diffusion of responsibility itself may have contributed to the snowballing catastrophe, for as Polish poet Stanslaw Jerzy Lec observed, "No snowflake in an avalanche ever feels responsible." There are many stories still to be told about why no one was able to stop the "avalanche," and many of them will be told only as they are revealed in the courts. Meanwhile, the health policy community waits to see whether AHERF's fall has implications for other struggling academic health centers.

Robert Burns is James Joo-Jin Kim Professor of Health Care Systems and Management at the Wharton School of the University of Pennsylvania in Philadelphia. He has studied integrated delivery systems for more than fifteen years. John Cacciamani is a geriatrics fellow at the University of Pennsylvania School of Medicine in Philadelphia. James Clement is a consultant at Andersen Consulting Strategic Services in Boston. He and Cacciamani are currently completing master's degrees in business administration at Wharton. Welman Aquino is a nurse manager at New York Presbyterian Hospital and Columbia-Presbyterian Medical Center in New York City.

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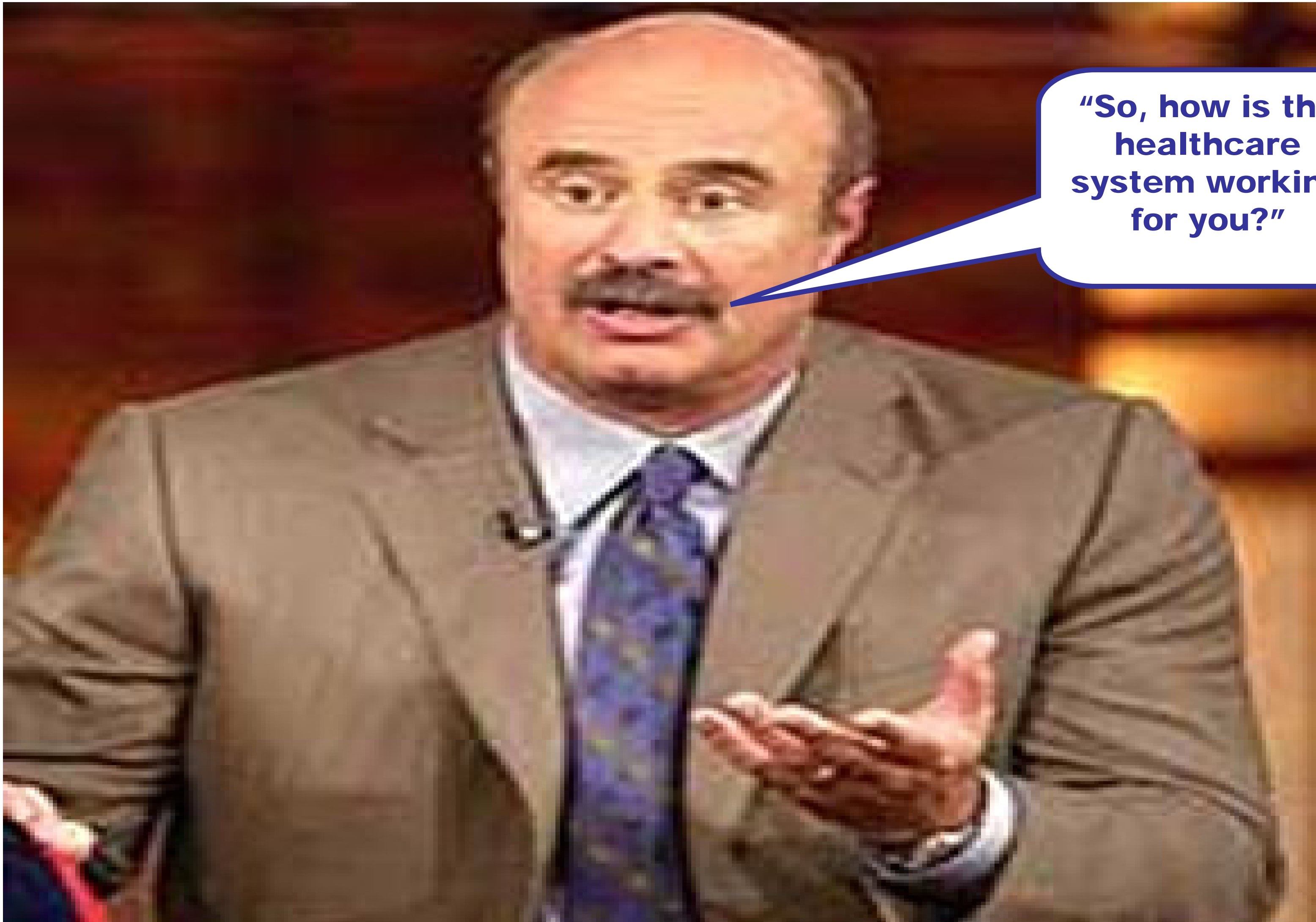

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Support for – Population Based Payment

- Commonwealth of Pennsylvania – Office of Healthcare reform
- Pittsburgh Regional Health Initiative

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POPULATION BASED PAYMENT®

Presented to:
The Commonwealth of Pennsylvania's
Other Critical Reforms Sub-Committee of the Health Care Reform Implementation Advisory Committee

November 17, 2010

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The Commonwealth of Pennsylvania Health Care Reform Implementation Advisory Committee Final Report January 2011

Major Recommendations included:

- ***Exploring the development of a pilot using Department of Health and Pennsylvania Health Care Cost Containment Council data and Population Based Payment® in designated counties.***

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Pittsburgh Regional Health Initiative

“ What an excellent presentation of an inspired concept. This will certainly attract an audience, as I'm sure you've found. It is also useful to see ideas customized for the purchaser. And I really like the idea of practice twinning to help the efficient practices help the ones with more challenges.”

Keith K. Kanel, MD, Chief Medical Officer, PRHI. December 2010

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Population Based Payment – A Healthcare Trifecta

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