Aligning Incentives in Health Care

Physician Practice and Health System Partnership

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Abstract

Background The key to successfully aligning hospitals and physicians is financial integration and joint incentives for academic, quality, and clinical productivity. Many physician practices and health systems are moving toward closer integration, but mainly through consolidation and employment strategies.

Questions/purposes We describe a fully integrated physician and hospital relationship including an overview of an aligned funds flow process that affords the department support for clinical services and teaching, research, and administrative activity. We also describe a physician compensation model that provides incentive not only for increased clinical performance, but also quality and academic objectives.

Methods The content of this article was acquired through our own experience in managing the Department of Orthopaedic Surgery at the University of Pennsylvania Health System including the health system's funds flow process. Based on input from both health system leaders and the faculty, the department's compensation plan was totally redesigned to create a line-of-sight plan that credits clinical performance and academic productivity.

Results Our model is multifactorial and provides sustainable support for the department and a compensation plan that is competitive within the local market and nationally. The health system's funds flow process has enhanced alignment of the faculty and hospitals by providing compensation for nonclinical time and assists the department's growth strategies by providing funding for new faculty and gain-sharing of improved hospital margin. The implementation of the compensation plan increased productivity by 8% in its first year with no additional resources. Academic productivity in that same year was arguably at or above any other year in the department's history in terms of accepted publications, national presentations, and research grants awarded.

Conclusions A model of complete integration between an academic department and a health system is achievable through a systematic process of mission-based support.

Introduction

As health care moves into an age of reform, accountable care, and bundling, it is even more important to align physicians with the goals and priorities of the hospital. At the same time, to manage a successful academic department at a major medical center, you need a structure to support faculty both clinically and academically. Penn Funds Flow, initiated in 2004, restructured the distribution of institutional funds across all the missions of the clinical departments so as to provide clearly defined support for teaching, research, and administrative duties as well as rationally based clinical support and incentives for strategic clinical and research growth [3]. The department also redeveloped the compensation model from a profit/loss model to a collections model with an academic and quality

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component. This successfully increased both clinical productivity and academic productivity in its first year after inception.

Methods

This is mainly an article based on our experience participating in the funds flow process and redeveloping a compensation plan to promote alignment with hospital priorities. The two major supporting articles were those written on this topic and the organizational structure of the health system and include an article Kennedy et al. entitled “Aligning academic and clinical missions through an integrated funds-flow allocation process” [3] and another by Phillips et al. entitled “The changing relationships between academic health centers and their universities: a look at the University of Pennsylvania” [4]. For additional background content, we performed a literature search on academic alignment models through Medline and we were able to obtain a few other articles on physician alignment strategies and experiences as referenced.

Background

Penn Medicine is a totally integrated academic medical center that reports to a single board of trustees and is comprised of the Perelman School of Medicine at the University of Pennsylvania and the University of Pennsylvania Health System (UPHS), which includes the physician practice plan (the Clinical Practices of the University of Pennsylvania). UPHS owns three hospitals: the Hospital of the University of Pennsylvania, Pennsylvania Hospital, and Penn Presbyterian Medical Center [4] (Fig. 1). As a result of the nature of this structure, the physician practice plan is aligned with the hospitals, the health system, and the School of Medicine, allowing for the achievement of common goals across all missions. This structure also allows the flexibility of providing shared financial incentives, aligning the organization in ways not possible under a private practice model or a less integrated academic medical center structure. This alignment will become increasingly important as American healthcare policies place pressure on traditional cost structures and move toward bundled payment methodologies and population-based health outcomes reimbursement strategies.

Methods

The Department participated in the Penn funds flow process, a systematic approach to integrated support between the hospitals and academic departments.

Funds Flow

As an integrated health system, Penn’s School of Medicine and Health System established a funds flow process in 2004 based on the founding principles that the methodology be transparent, fair, and rational; matching revenue with expenses; and providing appropriate incentives to encourage departments to achieve or exceed system growth objectives. Funds flow was created to align incentives for growth and improved profitability and to provide support to the clinical departments for all three missions under a rules-based methodology that ensured equity in the distribution of funds across entities and reduced the random negotiation between departments and hospitals. A fundamental principle of funds flow is that every department within the practice plan should have the opportunity to break even on its clinical mission so long as it meets provider productivity and overhead expense management expectations. A second principle is that those departments that are in the position of helping the hospitals achieve improved technical margins (ie, hospital contribution margin) should have the opportunity to share in that incremental contribution margin growth [3].

This process results in a model of true integration and support by the health system of the clinical departments. Furthermore, it facilitates the alignment of priorities on an ongoing basis because funds flow for each department is rebased every 3 years.

Funds flow provides support for all missions. Teaching support compensates the department for faculty time that is spent teaching residents and medical students and provides direct salary support for program directors. Research support consists of three categories: (1) support for underfunded research administration costs using a formula based on 16.5% of a department’s indirect (health system funds that do not constitute a redirection of indirect cost recovery dollars from either the University or the School); (2) support for a portion of faculty protected time for research; and (3) over-the-cap salary support or salary support for research effort of the National Institutes of Health-established salary cap.

Clinical support is the most complex [3] and is divided into five categories (Table 1): (1) new hire support; (2) purchased services; (3) programmatic support; (4) incentive payment; and (5) pass-through support.

New Hire Support is health system support of new physician recruits is an important example of alignment between the hospital and the departments. This is simply the support for the cost of the start-up of a new practice. The chairman and the hospital mutually agree on a new recruit. This can be based on a clinical need of the hospital and/or department, an academic need of the department, or a combination of the two. Once a candidate is selected, an

Fig. 1 The Penn Medicine Organizational Structure is a fully integrated model comprised of the School of Medicine, Hospitals, and the Clinical Practices [4].

estimate is created by the department of the cost of the new recruit and presented to the hospital. The new practice is underwritten by the health system on the basis of a profit-and-loss projection for the 3-year start-up phase; this support is fixed for the duration of this period. The funding is provided to the department based on this estimate ensuring there is shared risk. Specifically, the risk to the department is in realizing the revenue projections regardless of the circumstances that develop over the course of the practice development. The risk for the hospital is the practice fails to deliver on projected volumes and realizes less margin growth. Templates were developed for new hire support and they include defined time periods for clinical practice ramp-up measured against University Health Consortium (UHC) productivity benchmarks.

Purchased services are funding provided by the health system for defined tasks based on a specific need. Support is provided for faculty that includes a defined percentage of the chair's effort and faculty time for directorships, administrative

duties, or regulatory positions. This support includes actual salary, benefits, and malpractice expense support. Purchased services are an important component of funds flow because they pay for nonclinical time. This allows for physicians and clinical leaders within the department to allocate a portion of their time on important, nonrevenue-generating activities. Specific examples of purchased services include the physician's weekly participation in the Unit Based Clinical Leadership teams. These are teams of physicians, nurses, and quality improvement experts that meet weekly to focus on improvement hospital nursing units. Areas of focus include: patient satisfaction/Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), medication reconciliation, discharge planning, and overall improving the patient experience on a hospital unit.

Programmatic support provides direct support for new clinical programs or losses incurred by practices. A clinical program example of this is the vascularized composite allotransplantation program. The support of this program

Table 1. Categories for the clinical component of funds flow along with their definitions and methodology

New hire support	Support for new clinical faculty Time-limited seed funding	Profit and loss completed up front and agreed-on support underwritten by hospital for defined period of time Support limited to clinical effort
Purchased services	Support provided for administrative time from clinical faculty May also pertain to clinical time for hospital needed/requested services	Salary, benefits, and malpractice expense provided for a defined portion of faculty effort
Programmatic support	Hospital support for clinical programs that lose money as a result of uncontrollable inefficiencies	Hospital provides support for a defined period of time based on projections set at beginning of funds flow cycle Department must be operating below benchmarked expense ratio
Incentive payment	Gain-sharing for improved clinical performance	Percentage of hospital contribution margin shared with department for incremental profit year over year
Pass through	Provider-based clinic revenue passed from hospital to department	Based on terms of third-party contracts

was born completely by the health system for a patient who underwent bilateral forearm and hand transplantations, a procedure not currently reimbursed by insurers. The concept of alignment is best demonstrated by this investment, underscoring the importance of the dialogue between departments and the health system leadership for innovative clinical programs based on scientific discovery. Clinical programmatic support is targeted according to the overall importance of clinical programs, which, even when performing at the expected clinical productivity levels (65% UHC) and with mutually agreed-on overhead/infrastructure rates, were not expected to break even. Appropriate mutually agreed-on expectations are established between the hospitals and practices and these arrangements are reviewed in relation to market conditions on a regular basis [3]. Therefore, programmatic support also underwrites the cost of the unfunded practice expenses such as advanced practice professional support (nurse practitioners and physician assistants) or staffing support related to new satellite program development. This is contingent on the department realizing clinical productivity above the 65th percentile of UHC benchmarks and overhead below a health system-established benchmark applicable to all departments. These productivity benchmarks are applied based on a mission-based profit-and-loss statement. This allows for the department to allocate the effort of faculty to the missions of clinical care, teaching, and education. In turn, the benchmarks are prorated to the faculty member's clinical effort and not their time in total. This support is also fixed for a 3-year period assuming there are no major changes in market factors. In the state of Pennsylvania, malpractice costs are extremely expensive and without the support from the health system, this expense would be untenable for our practitioners. The mass exodus of health professionals from the state of Pennsylvania during the tort reform crisis several years ago changed the playing field of the health labor force dramatically, forcing many physicians out of practice and into adjacent states or other locations in the country. This is currently not a risk for Penn Orthopaedics because of the generosity of funds flow and the recognition that the funds flow process helps to offset high malpractice costs.

Incentive payment (otherwise known as gain-sharing) occurs when there is an incremental increase in hospital contribution margin. A percentage of the incremental margin realized by the hospital is shared with the department (not the individual physician). Of note, not all departments may be eligible for clinical incentives; these are developed individually with those departments that are in a position to substantially increase the hospital margins. That margin growth is then what supports funds flow to all departments. These incentives provide a discretionary fund for the department to support items such as unfunded research protocols or medical missionary work for the

residents and faculty. Focusing on growth of contribution margin facilitates collaboration between the hospital and the department to both increase revenue and/or decrease expenses for the hospital. An example of this would be mutual agreement on equipment purchases such as joint implants and trauma products. Controlling costs is an advantage to the health system, thereby optimizing the contribution margin of each procedure and making the department more profitable. An aligned orthopaedics program allows the physicians to reduce the number of implant brands that they use and the health system to negotiate a standard price for these implant selections. This maintains relative flexibility in implant choice for surgeons but does not result in exorbitant prices of one implant compared with another. Maintaining diversity of implants prevents companies from developing a monopoly as a supplier, which can result in sudden price increases, adversely affecting hospital budgets. Other expense reduction activities include length of stay management, improved efficiency of operative time, and due diligence in the use of hospital resources. In approaching the new age of healthcare reimbursement, management to Medicare margins is becoming increasingly important for hospitals to succeed in the future. Gain-sharing provides an incentive for the physicians to be more accountable for cost-effective care. This will allow Penn to be well positioned in eventual ACO models and other bundled approaches to healthcare reform.

Pass-through support provides revenue realized by the health system for global fees to the department. This is negotiated based on particular contracts and includes the sharing of revenue for hospital-based practices [3]. More specifically, many departments have practices that are hospital-based or provider-based clinics (PBCs). The government pays higher rates to PBCs because it is more expensive to operate than a freestanding physician clinic. Clinics of this type have more intense regulatory requirements. Reimbursement in a PBC is 40% more than a freestanding clinic. This reimbursement goes back to the hospital, which in turn, through this type of clinical funds flow, is passed to the department.

Results

Redeveloping the Department's Compensation Plan

The Department of Orthopaedic Surgery physician compensation plan changed dramatically in fiscal year 2012. Historically, the department used a profit-and-loss (P&L) compensation plan compensating physicians based on revenue and expense allocation within the department. As a result of market factors including provider reimbursement rates, high malpractice expense, and limited sources of

ancillary revenue, physicians were held to an individual P&L statement that often minimized the impact of their actual productivity year over year. This is primarily because the physician's incentive was dependent on the department's successful management of expenses to budget. If there are unforeseen circumstances that increased the overhead for the department, the physician's incentive would be minimized as a result of increased expenses not directly attributable to that faculty member. For example, a physician could have high productivity in terms of clinical receipts, yet not be compensated as well as a result of a potential unbudgeted expense such as increased practice overhead allocation with a unplanned departure of a faculty member. It became increasingly evident that the faculty was not aligned with the health system in this model because there was not a line of site connection between increased caseload and incentive payment. There was no clear connection for the faculty between clinical productivity and compensation because uncontrollable increased departmental expenses reduced their end-of-year incentive.

This compensation plan was ultimately transformed into a work relative value unit (WRVU) and collections-based incentive system that disassociates physician compensation from departmental expenses (Fig. 2). An advantage of this plan is that physicians, based on the formula, know exactly how they will be compensated in terms of their salary, which is based on collections and WRVUs. A disadvantage of the plan is that if the department does not manage expenses appropriately and to budget, there is a budget loss for the department at the end of the year.

The compensation plan has four components: clinical activity, academic productivity, quality initiatives, and citizenship. The clinical activity from the prior year (charges, collections, WRVUs) provides each surgeon with a dollar/WRVU amount for each fiscal year (Fig. 2). This amount is multiplied by baseline WRVUs from a prior calendar period

to determine the total productivity compensation for the physician. Eighty percent of this amount is the base salary, which is fixed for the fiscal year and paid monthly. The 20% incentive is divided into two components. The first is clinical productivity, which is 75% of the 20% incentive (or 15% of total productivity compensation). The clinical productivity incentive is paid quarterly as 75% of every productivity dollar (actual WRVUs multiplied by the \$/WRVU) over the base salary.

Take the example provided in Figure 3. The sample physician generated \$2.2 million in charges, \$792,000 in collections with a 19% unfavorable payer mix, and 10,123 WRVUs in the prior year period. The compensation plan provides an adjustment for the payment differential (\$13/WRVU is a difference in payment between Medicaid plans and all other payers) up to the first 20%. This amount is added to the physician's collections to provide the physician with credit for seeing uninsured or underinsured patients. Therefore, the baseline \$/WRVU amount is determined by taking the physician's collections plus the payer mix adjustment divided by the WRVUs. This physician has a baseline \$/WRVU of \$83.61. This then creates the \$/WRVU benchmarks for the next year. Based on preset collection goals (left of benchmark chart), which are consistent for all physicians, the collection goal is divided by the \$/WRVU specific to the physician to determine WRVU levels needed to achieve the retention percent (ranges from 45%–70%) of their \$/WRVU. So in this example, this physician's adjusted collections (collections plus payer mix adjustment) put him in level III, which allows him to retain 65% of his \$/WRVU or \$54.34 per WRVU. To get to level IV (70% retention), the physician will need to perform a minimum of 11,961 WRVUs in the next year. If this is achieved, each WRVU back to the first will be paid out at a higher rate. To determine the base salary, the 10,123 WRVUs from the prior year are

Fig. 2 The Penn Orthopaedics compensation plan description.

multiplied by the level III \$54.34/WRVU for a total productivity compensation of \$550,121. The base salary is 80% of this and paid monthly in addition to the other income (such as call pay or administrative stipends). The remaining 20% is determined in the actual fiscal year based on actual WRVUs performed. The calculation for payment is WRVUs multiplied by \$/WRVU less base salary. Therefore, if the physician performed 10,500 WRVUs, he would be paid $(10,500 \times \$54.34 - \$440,097)$ \$130,473 in incentive. Seventy-five percent of this is the clinical incentive paid quarterly. Twenty-five percent is withheld until the end of the fiscal year as the pool for the academic, quality, and citizenship incentives (Fig. 3).

The second component is academic/quality, which represents 25% of the 20% incentive (or 5% of the total productivity compensation). This component has three parts: academics, quality, and citizenship. The academic incentive is a mutually agreed-on individual goal determined by the faculty member and the chair each fiscal year, which is set in the beginning of the year and evaluated at fiscal year end. This could include credit for papers accepted, national podium presentations, or research activity such as grants being funded. The quality incentive is based on departmental performance on key initiatives that are aligned with health system priorities, for example improving HCAHPS scores or Surgical Care Improvement Project (SCIP) measures. A specific example is the quality metrics set in fiscal year 2013. The quality metric set for this year had two components. First was all faculty to participate in the patient experience training that the staff completed. This aligns the faculty with the staff in an effort to improve patient satisfaction scores. The second component of the quality metrics was section-specific (ie, joints, hand, sports, etc) metrics set by each section and approved by the hospital Chief Medical Officer. A metric example that was set was improving performance on several SCIP measures to 100% compliance. The citizenship incentive is a series of department-wide goals that include billing compliance, grand rounds, and faculty

meeting attendance and development activities. Using billing compliance as an example, the criterion to achieve this initiative was to turn in surgical charges (the charges with the highest charges and greatest impact to the department's bottom line) within 5 days. Each day over 5 had a lower incentive payment attributed to it and no incentive was paid over 7 days. The days are based on the average submitted days for the entire fiscal year. This improved the overall timeliness of submitting charges for most faculty within the department.

The key to the affordability and ability to implement this compensation model was the funding provided by the health system. Physicians are compensated at a high percentage of collections, leaving insufficient funds to cover practice overhead (such as what would occur in a P&L model). Without support of the health system in underwriting this plan, the current model would not have been possible. Philadelphia is a highly competitive market. Physician flight risk from our academic medical center into private practice has been a consistent problem as a result of a compensation plan that was not competitive in the marketplace. A compensation plan that leveled the playing field was required to provide stability to the faculty workforce within the department. As a result of health system support, recruitment and retention of outstanding surgeons and educators is now possible, resulting in departmental growth. Such departmental growth is an advantage to the health system because of increased clinical activity and long-term return on investment in faculty. Recruitment of outstanding faculty also benefits the missions of education and research.

This plan aligns the physicians with the Penn Health System through increased clinical and academic productivity and improved patient care, compliance, and safety. This new plan has resulted in a 5.5% increase in surgical case volume and a 4.8% increase in WRVUs. This was a direct result of this new compensation system, which is a line of sight program directly rewarding physicians for increased in productivity across all missions.

Prior Year Data*								
Charges	\$	2,200,000						
Collections	\$	792,000						
Unfavorable %		19.00%						
Payer Mix Adj	\$	54,340						
WRVU		10,123						
Baseline \$/RVU	\$	83.61						

* Prior Year: March 11 - Feb 12

\$/WRVU Benchmarks - Preset at the beginning of each year					
Productivity Level	Collection Goal	% of \$/WRVU	WRVU Threshold	WRVU Limit	\$/WRVU
Level I:	0 - 600k	45%	0	7177	37.62
Level II:	601 - 750k	55%	7177	8971	45.98
Level III:	751 - 999k	65%	8971	11961	54.34
Level IV:	1 Mil +	70%	11961	+	58.52

Goals & % are standard department wide

	WRVU	\$/RVU Earned	Target Productivity Comp	80% Base Salary (fixed)	20% Incentive		Other Income	Total Comp
					WRVU Incentive (75%)	Academic & Quality Incentive (25%)		
Productivity Income	10,123	54.34	550,121	440,097	82,518	27,506	40,000	590,121

Fig. 3 The Penn Orthopaedics compensation plan example.

Integrated Management Structure

In addition to the financial alignment, the Department of Orthopaedic Surgery is also integrated with the health system through its administrative structure. Traditionally, the organizational structure appointed a separate chief operating officer for the department and an Orthopaedic Administrator for the hospitals and health system. In January 2012, the health system changed this role, creating a chief administrative officer for musculoskeletal services. The individual in this position has responsibility for department administration functions, hospital product line management, and health system strategic development. This allows the orthopaedic product to be managed as a service line or a multidisciplinary approach to managing orthopaedic care. This includes the management of the practice, the hospital departments, all strategic planning, and the coordination of care to related services such as radiology, physical therapy, and rheumatology. This allows for the health system to be more nimble in its approach in an evolving and extremely competitive environment. The administrator reports to the chair of the department, the executive director of the practice plan, and the senior vice-president for business development of the health system.

This role is increasingly important as the health system is working to formalize the musculoskeletal service line. This system-wide alignment of musculoskeletal care delivery includes orthopaedic surgery, physical medicine and rehabilitation, rheumatology, physical therapy, anesthesia (pain management), and radiology. The ability of the musculoskeletal service line to be successful is facilitated by the close collaborative working relationship and mutual support of the department chairs within the Penn System. Opportunities now exist based on the creation of a formal, multidisciplinary service line with shared incentives from key initiatives spanning multiple departments. This facilitates ongoing dialogue among chairs on how to create win-win situations resulting in improved patient care and improved revenue for multiple departments based on symbiotic and proactive relationships. These initiatives would not be possible unless the system was an integrated organization of fully employed physician practices. This structure will be critical as the health system is constructing a facility for the Penn Musculoskeletal Institute involving all of the aforementioned entities in a shared space with shared resources.

Other Examples of Alignment

The department participates in an annual risk reduction initiative, which allows the physicians to focus on quality and diminish the risk of medical legal issues that often

result in large payouts as a result of medical error. The department develops a mutually agreed-on initiative each year with the health system and on successful completion of this initiative, malpractice savings earned in that fiscal year are passed back to the department. The initiative in fiscal year 2012 was the development of a risk stratification tool for high-risk patients undergoing hip and knee arthroplasty with multiple comorbidities to accurately plan postoperative placement in the hospital (ie, medical/surgical unit versus surgical intensive care unit). A recent article in the *Journal of Arthroplasty* has recognized a Penn risk reduction effort resulting in the reduction of unplanned intensive care unit admissions after THA [2]. Another example of an initiative developed in the risk reduction collaboration is the production of a DVD for patients providing education about their total joint arthroplasty. This was in response to relative low rates of patient participation in joint classes and an increased need for flexibility of educational choices for these patients. In addition to the DVD, content can be found on the Penn web site at www.pennmedicine.org/orthopaedics.

The health system also provides a series of centralized support services, including human resources, information technology, marketing and public relations, legal and risk management, and strategic planning, among others, which is a major benefit of departmental integration. The marketing support provides dedicated resources to the department to increase market share for the department and the health system. The marketing division is provided by the health system and not by the department. The department chair and orthopaedic division chief's council have direct influence on the content of marketing, working in conjunction with the chief operating officer to enhance patient flow and revenue.

Discussion

The key to a successful alignment strategy between hospitals and physicians is financial integration and joint incentives for academic, quality, and clinical productivity. Many physician practices and health systems are moving toward closer integration, but mainly through consolidation and employment strategies [1]. The model in place at the UPHS for the Department of Orthopaedic Surgery is multifactorial and allows for complete integration between the hospital and physicians. This model incentivizes the department for productivity beyond clinical performance. It recognizes and supports academic time, aligns parties to focus on quality initiatives, and promotes research activity. This has proved useful for the realization of health system priorities and overall growth and stability of the Department of Orthopaedic Surgery. The purpose of our article is

to provide a detailed description of a fully integrated physician and hospital relationship. This includes an overview of an aligned funds flow process, which provides academic department support for clinical services and teaching, research, and administrative activity. Another important component of this publication is the overview of a physician compensation model that provides a line-of-sight incentive for not only increased clinical performance, but also realizing quality and academic objectives. This article also highlights other examples of alignment evident at Penn Medicine and a discussion on any potential downside risks of alignment.

A potential disadvantage of an integrated department-health system structure includes the centralized negotiation of managed care contracts and negotiations with health insurers. Because the orthopaedic department is one of many departments that are negotiated for, procedural reimbursement may be less than optimal to benefit the health system at large. The alternative of this is that such an arrangement can also advantage the department with access to a better rate structure overall compared with private practice rates. Another relative disadvantage for absolute alignment with an academic health system is the potential restriction of entrepreneurship. Unlike private practice, the department cannot purchase its own imaging machines, build outpatient surgery centers, or organize physical therapy programs that result in remuneration to partners. This is not unique to Penn Medicine.

Penn Medicine is a system with true alignment across all missions. This alignment creates a consistent strategic

direction among all entities resulting in leverage when managing any market condition or change in healthcare policy. The Department of Orthopaedic Surgery continues to be greatly advantaged by this structure with direct influence in patient management throughout the continuum of care. As we approach potentially dramatic changes in health care such as bundling or the development of Accountable Care Organizations, our system greatly benefits the faculty in an employment model that fosters collaboration and input. The Department of Orthopaedic Surgery has been fortunate to be in a health system with a great market position and one with a national and international reputation for excellence. The advancement of the departmental objectives is a priority of the health system and is evidenced by strong financial support and inclusion in the decision-making process for musculoskeletal care delivery.

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