ACO Accelerated Development Learning Session

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A Private Sector Perspective on ACOs and the Changing Payer-Provider Relationship

September 15, 2011
11:00 a.m.–12:00 noon

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Accountable Care:
A Private Sector Perspective

- Context: The private sector perspective on controlling costs
- Models: What we think will work
- Practical issues: Contracting, analytics, claims processing, and data transfers

Who Is HCSC?

13 million members

BlueCross BlueShield of Illinois
BlueCross BlueShield of New Mexico
BlueCross BlueShield of Oklahoma
BlueCross BlueShield of Texas

4th largest U.S. health insurer

Dearborn National
Strength. Independence. Solutions.

Dental Network of America

MEDecision

availity

PRIME THERAPEUTICS

TMG Health

realmed
your fastest path to payment

MedVantage
A Healthcare Informatics Company

GHS

MedConnect

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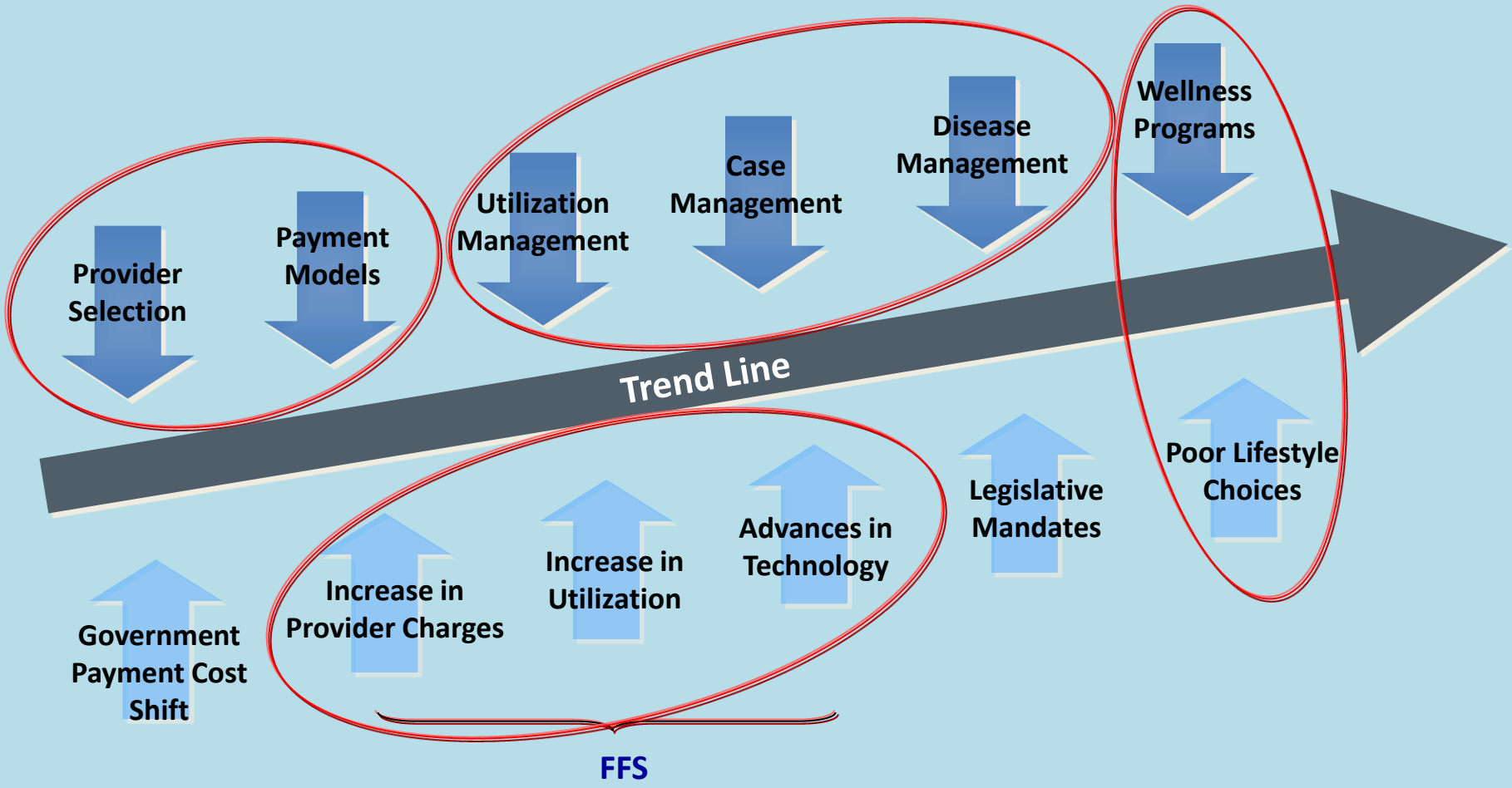
My Background and Perspective: I've Been Around the Block

- Provider side
  - Managed variety of risk arrangements including global cap for commercial, Medicare, Medicaid
  - Wide range of clinical programs: hospitalists, SNFists, home MDs, emergency room (ER) diversion, readmission prevention, disease, and Rx management programs
- Medicare Advantage (MA) Special Needs Plan (SNP) for institutionalized persons
  - End-of -life care, polypharmacy, acute illness management, OBS vs. inpatient
- Large commercial plan: Major focus on large national accounts (e.g., Boeing)
  - Full range of medical management and wellness programs
  - Full range of integration/delegation with/to providers
  - Evolving emphasis on
    - Individual market (Medicaid, exchanges)
    - Holistic management of persistently actionable high-cost patients
    - Integration of behavioral and medical

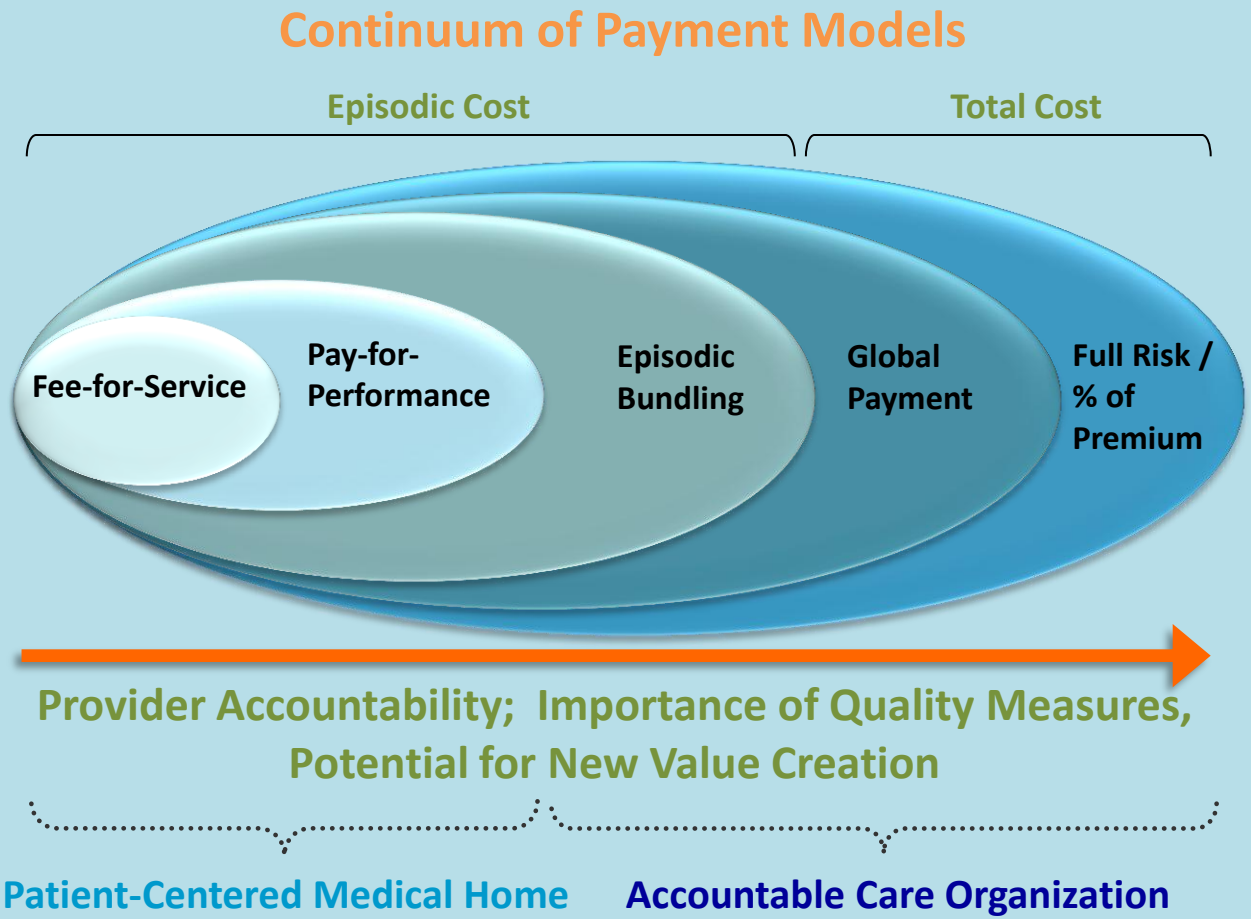
Why Is Our Goal for Medical Cost Trend to Approximate GDP Growth Rate? Look Ahead to 2014–2018

- Employer decision making
  - Continued high-pressure global economy
  - Availability of public and private exchanges
  - Cadillac tax
  - History of successful transition to defined contribution strategy for retirement funding
- + Deficit reduction: one way or another
- + Costs of subsidies
- + Costs of Medicaid
- = ?

Major Factors That Impact Future Claims



How Are We Thinking About Payment Reform? We Need to Move as Far to the Right as We Can



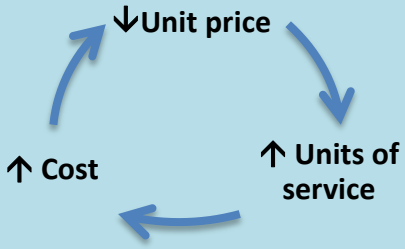
Deployment depends on a number of factors:

- Provider infrastructure and appetite for risk
- Provider-plan relationship

We Want to Help Providers Shift From Volume to Value

Limitations of fee-for-service (FFS)

- Vicious cycle



- Fails to address cost drivers:
  - Lifestyle & behavior change
  - Application of new technologies
  - Care coordination
- Doesn't support system redesign

Drive the change – **create a tipping point**

What do we want?

- Provider system redesign

+

- Providers compete on value

=

- Improved outcomes, experiences, and affordability of care for our members

A Simple Perspective: Let's Start Paying for What We Want to Buy

- (Apologies to well-intentioned providers, but …)
  Start by recognizing how perverse the current system is:
  - What if we bought other products and services the way we buy health care?
  - What if we bought health care products and services the way we buy other products and services?
- What do we want to buy?
  - Primary (and chronic disease) care: patient-centered medical home models (PCMH), intensive outpatient care programs (IOCP)
  - Hips, knees, heart, and lungs: Bundled episodes with outcome requirements (guarantees)
  - Population management (minus the insurance risk): Global capitation (HMO) or attribution logic and shared savings (ACO)

PCMH: Pay for Value-Added Activities

- What:
  - Care coordination
    - Between physicians
    - Transitions of care
  - Gaps vs. evidence-based care
  - Outreach and population management
  - Easy access via multiple modalities for acute and chronic care
  - Appropriate Rx
  - Appropriate referral to cost-effective
    - Specialists
    - Facilities
  - Continuous assessment for behavioral issues
  - For the highest-risk members: An individualized care plan (IOCP)

* Are we clear on the value creation chain for each of these?

* How easy is it to make and sustain the necessary changes?

- How:
  - Enhanced FFS
  - Pay for performance (P4P)
  - Care management fee

New Models:
Intensive Outpatient Care Program (IOCP)

Physician-employed case manager for highest-risk patients

Top 10% of patients drive ≥ 60% of costs: How can we control costs without better managing these patients?

- Multiple chronic diseases (DM, Htn, arthritis)
- Poor lifestyle choices (weight, smoking, activity)
- Incompletely treated depression, anxiety, substance abuse
- Life stresses >> Coping and support mechanisms

* How well do our current programs address their needs?

- Distinct from, and synergistic with, practice redesign (e.g., NCQA criteria) or provider clinical connectivity (MEDecision, Availity, etc.)
- RN employed in practice; dedicated to high-risk cohort: 1:150–200
- Offers medical and psychosocial support
- Coordinates and ensures care is connected to their physician
- Can expand beyond traditional primary care specialties

20% net savings

Bundles of Acute Care: Episode Construction & Data/Analytic Support: There Has to Be a Better Way to Pay for This Care

- Surgical, medical: Start with electives
- Episode duration: 30+ days
- Services: All in
- Risk adjustment: The minimal amount necessary
- P4P, Quality floors: Critical & evolve to pay for desired service/outcomes (guarantees)
- Claims payment by health plan with subsequent episode adjudication
- **Network Strategy:**
  - **Rapidly rising employer interest in narrower networks**
  - **Domestic medical tourism**

Proven Models: HMO Illinois

Value vs. Broad PPO:

Cost:
20+ %
lower PMPM

Over 800,000 members

Overall
member satisfaction:
92.2% vs. **91.5%**

Demonstrably higher quality with a total annual physician incentive payout of $70.2M

Proven Models: HMO Illinois *continued*

- Delivering patient-centered care for 28 years
- Grandfather of medical home/ACO models of today
- Primary care physician–guided care, which delivers verifiable results in improved member health
- How:
  - Part B cap
  - Risk adjustment
  - Significant quality P4P
  - Shared Part A risk pool
- Why it works
  - Organized groups and IPAs
  - Aligned incentives: $, utilization, & quality
  - Relationships
  - Shared learnings
  - Raising the bar year by year
- **Are ACOs a clumsy step to more widespread HMOs?**

New Models:
ACO Shared Savings Agreement

Who?

Advocate Health Care

- 10 hospitals and 2,700 physicians
- 250,000 attributed Blue Cross PPO lives
- 120,000 Blue Cross HMO lives
- $2 billion annual Blue Cross spend

What?

- Three-year (2011–2013) shared savings PPO agreement with upside and downside risk
- Three-year global risk HMO agreement

How?

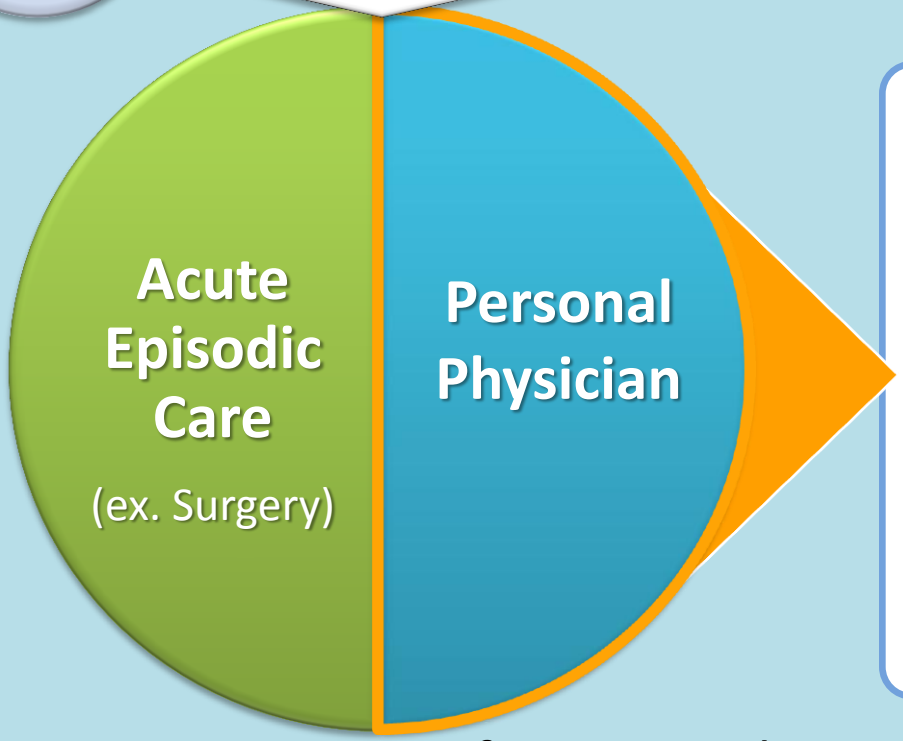
IF medical cost trend better than network **AND** meet patient quality, safety, and satisfaction metrics, **THEN** share in savings

Where?

New Models:
ACO Shared Savings Agreement *continued*

PPO

Total BCBSIL Members seeking care at the ACO



"Attributed" members

Total cost of care, including:

- **Physician**
- **Hospital**
- **Ancillary**
- **Rx, if applicable**

Shared savings model for beating aggregate network medical trend

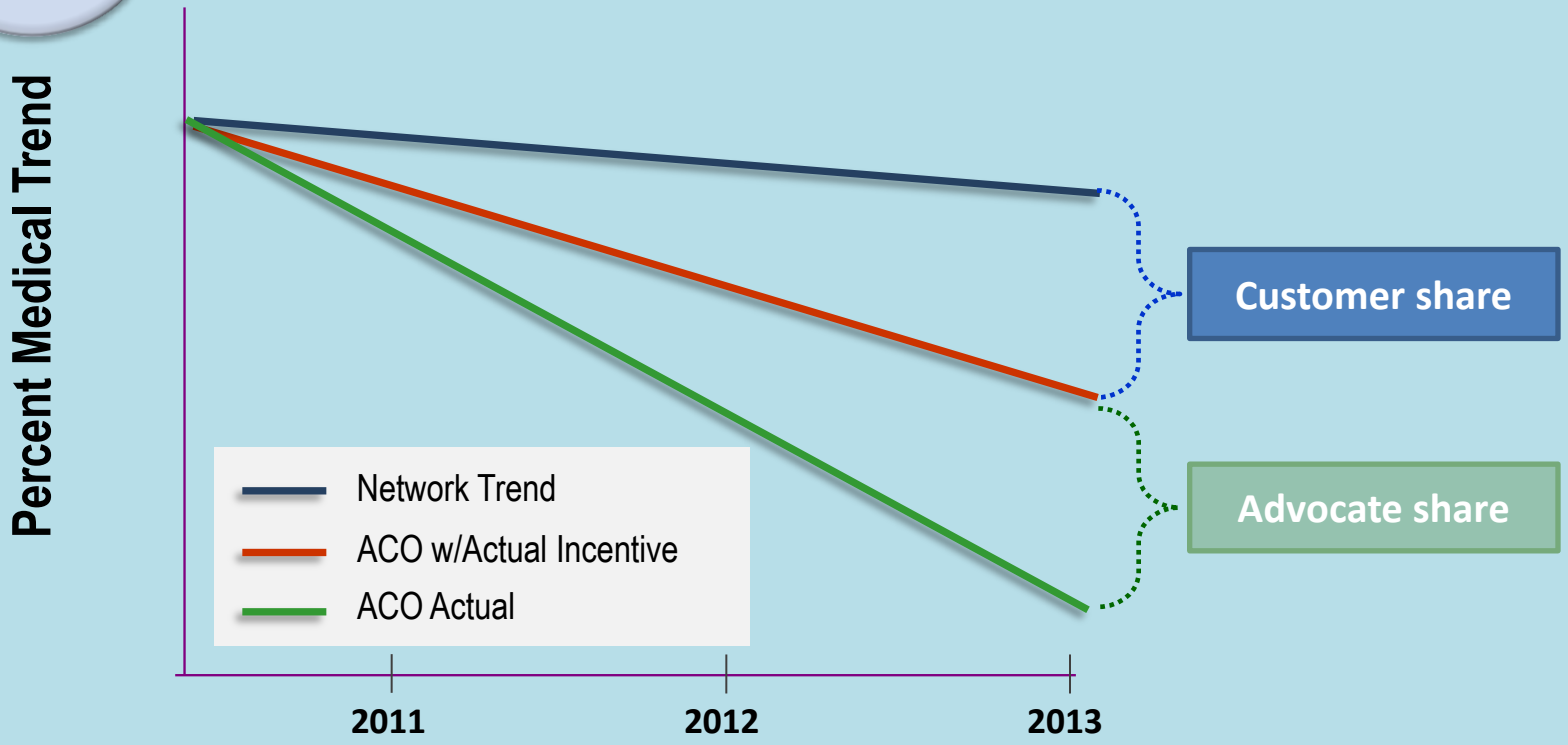
- **Guaranteed threshold**
- **Then shared savings**

So far, so good: 1st-quarter results

Shared Savings

PPO

Illustrative Only



HCSC (Advocate) ACO Compared to CMS

	HCSC (Advocate) ACO	vs.	CMS (Proposed)
PPO benefit, no restrictions on network access	✓		✓
Shared savings	Vs. market trend		Vs. complex formula for predicted costs
Attribution	Prospective		Retrospective
Concurrent data sharing	Yes, significant		Possibly
Quality requirements	Prospectively defined, likely to → fully payment of savings earned		Retrospectively defined, likely to reduce overall payment
Downside risk	✓		Two tracks
Attributable physicians	Traditional PCPs & cognitive subspecialties		Traditional PCPs

Paramount to Success: Continuous Quality Improvement

- Moving toward CMS' five domains
- Addition of small # of measures specific to commercial populations
- Fewest # of measures in each domain necessary
- Financial penalty for degradation (1st year)/failure to improve (years 2 & 3) in aggregate bundle of measures

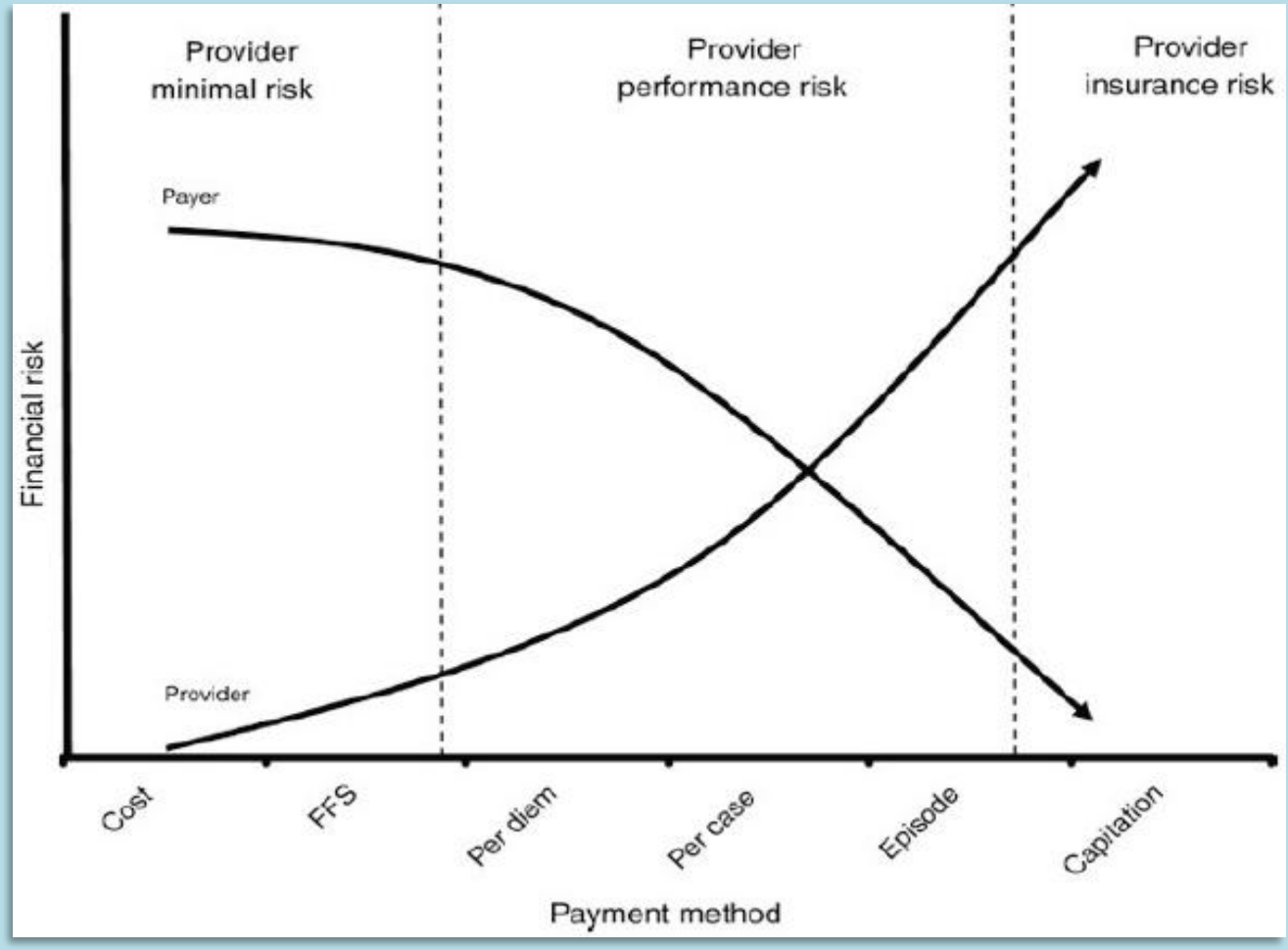
Key Operational Issues: General

- Who should pay the claims in these new arrangements?
- Chargebacks to ASO customers
  - P4P
  - PMPM
  - Shared savings
- Shared savings: How calculated?
- Risk adjustment

Accountable Models: How Do We Facilitate Provider Success and Avoid Historic Mistakes in Risk Transfer?

Selection of provider partners	**Clinical leadership and infrastructure (including key clinical programs; health information technology or HIT and analytics)**
	History of successful MCO partnerships
	Financial stability
Pace	Graduated increase in risk transfer (IOCP → bundling → partial risk → more risk) based on documented success
Don't mix insurance risk with medical management	Risk adjustment and size of risk pool
	Stop-loss, reinsurance
Ensure quality	Significant provider financial and contract risk around clearly predefined quality parameters
	Quality floor (e.g., BDC) or ceiling (P4P)
Data & analytics	Key metrics/dashboard for joint review
Ongoing collaboration	Clearly predefined metrics (dashboard) and joint oversight group/process

Continuum of Provider Risk-Bearing



JOURNAL OF AMBULATORY CARE MANAGEMENT, 3/10.

Let's Not Make This New Mistake: Provider Oligopolies

- We need competition on value
- Competition requires
  - Competitors
  - The ability to walk away from a negotiation: We increasingly are
  - Transparency of pricing: Our employers increasingly demand this

- Remember:
  - Days of cost-sharing are over!
  - Provider clout re: network inclusion is rapidly diminishing

Network Management Future State Scenario

Current		Future State
Adherence to generally accepted standards of care; documented medical necessity	Provider accountabilities	Clinical and financial outcomes, along a spectrum of accountability (e.g., episode bundling to global cap)
Unit prices (e.g., CPT, per-diem, DRG) with modest P4P; P4P primarily clinical	Payment	Based on accountability (i.e., payment aligned with clinical accountability); have major P4P; P4P aligns clinical and financial
Traditional; often adversarial: splitting a fixed pie	Relationship	Partnership: value creation
Broad PPO	Network / product participation	Broad PPO, HMO Blue Advantage, new/exchange/targeted products and networks
Traditional UM	Oversight	Protocols and processes agreed on up front, back-end audits as needed
Done by us	Disease, case, utilization management	Done by provider or us: who can do it better/more efficiently

Thoughts on Division of Accountabilities Between Health Plans and Providers

- Acute illness care
  - Care provision: Provider
  - Care coordination: Provider
- Chronic illness care: Providers + disease management
- Lifestyle modification: Employer, community, plan, provider
- Analytics
  - Population: Plan
  - Integration at individual patient level: Provider, with plan data incorporated
- Health system performance measurement and management:
  - Individual physician: Provider entity
  - Overall system accountability: Shared

Who can do it better/more efficiently?

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