

Payer-Provider Partnerships to Share Risk and Improve Care

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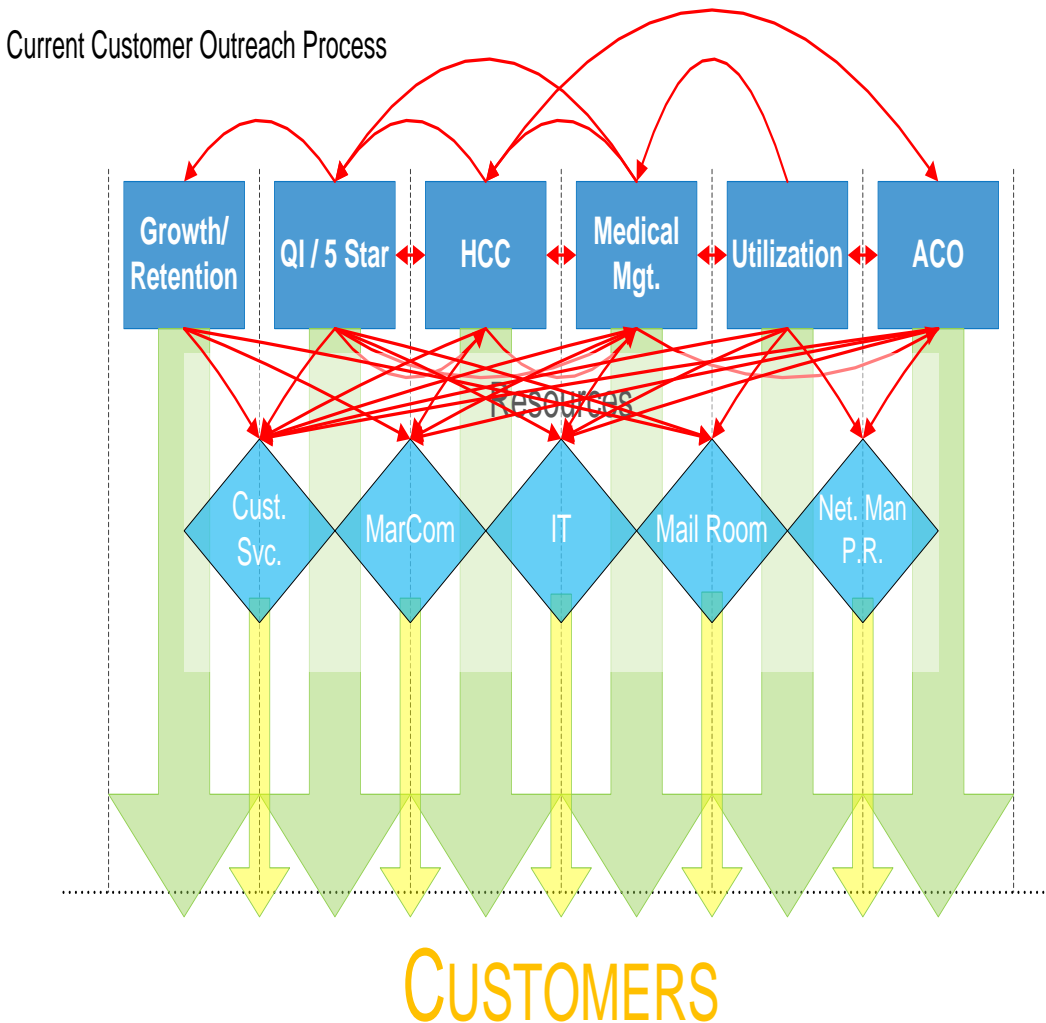
Payer-Provider Partnerships to Share Risk and Improve Care

THIS SESSION WILL EXPLORE MODELS IN WHICH HEALTH PLANS PROVIDE ANALYTIC, INFRASTRUCTURE AND OTHER SUPPORT SERVICES FOR DELIVERY SYSTEMS UNDER PAYMENT ARRANGEMENTS WHERE PROVIDER SYSTEMS SHARE FINANCIAL RISK FOR SPENDING AND QUALITY PERFORMANCE

Payer-Provider Partnerships to Share Risk and Improve Care

- WHAT FACTORS ARE DRIVING THE INCREASE IN “PARTNERSHIP ARRANGEMENTS” BETWEEN PROVIDER GROUPS AND HEALTH PLANS?
- TO WHAT EXTENT IS THE INCREASE IN PROVIDER SYSTEMS ACQUIRING INSURANCE LICENSES A CREDIBLE THREAT?
 - THE CALIFORNIA DELEGATED MEDICAL GROUP MODEL OF CARE

Typical Population Management System, 2014

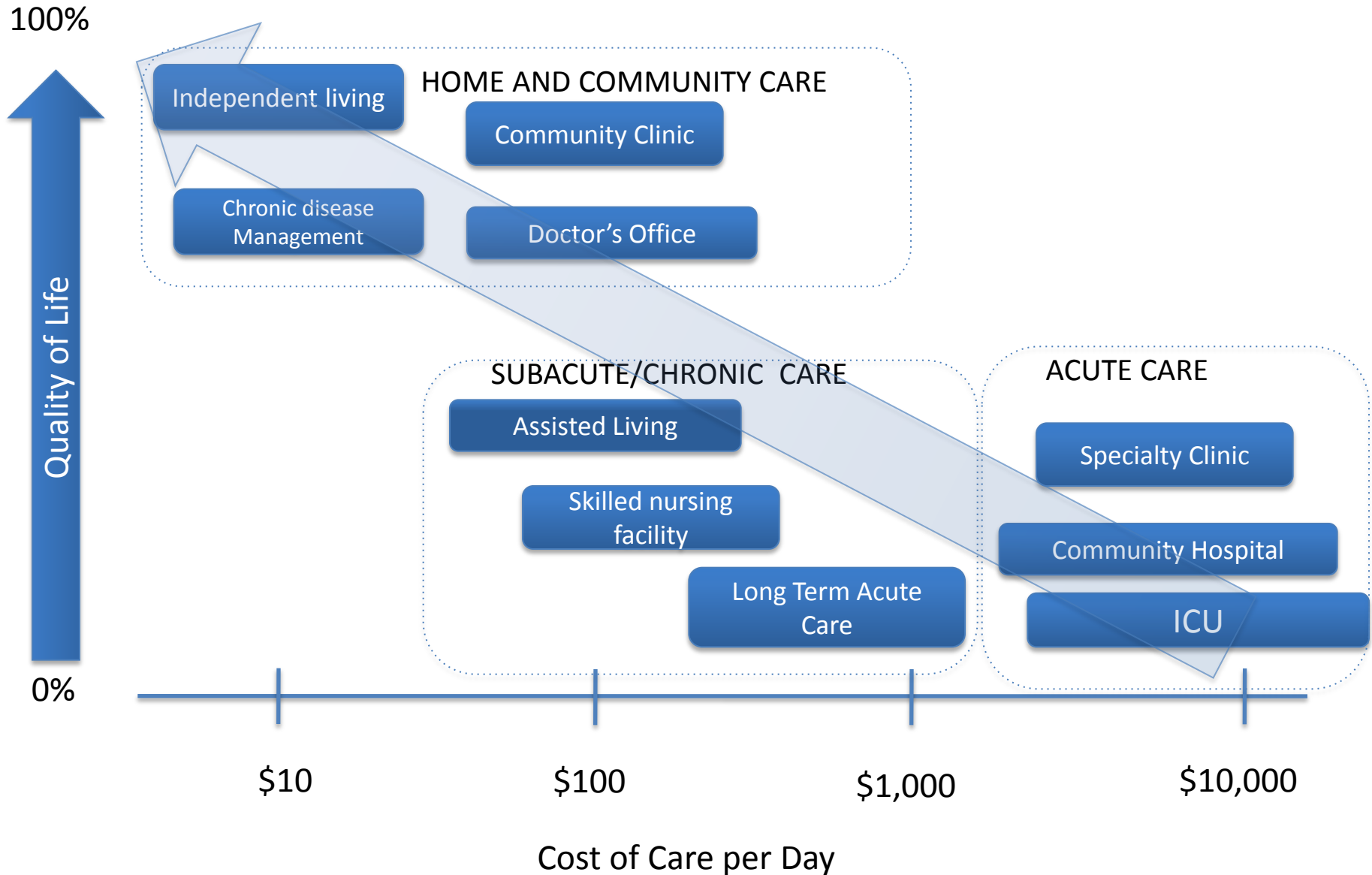


- Disconnected
- Reactive
- Redundant
- Inefficient use of Resources
- Creates Patient Frustrations
- Patients get Lost within the system

Payer-Provider Partnerships to Share Risk and Improve Care

- WHAT ARE THE “GOALS” OF HEALTH PLANS SEEKING PARTNERSHIPS VERSUS THOSE OF PROVIDERS SEEKING PARTNERSHIPS?
- REAL PARTNERSHIPS TO ACHIEVE THE TRIPLE AIM VS NEW FINANCIAL ARRANGEMENTS VS FEAR OF DISINTERMEDIATION?

The Value Proposition for the Healthcare System of the Future



Current State Versus Best Practice

- ✓ Average Medicare FFS Hospital Days/1000 = 2,500
- ✓ Best Practice Medicare Advantage Hospital Days/1000 in Full Risk Provider Organizations- 500
- ✓ Like the idea of current state vs. best practice – consolidating the different areas you have below into one or two slides – assuming the evidence is strong: Utilization, EOL, SNF – but expanding it to national savings estimates will get you much flak from this crowd

Payer-Provider Partnerships to Share Risk and Improve Care

- THE DIFFERENT TYPES OF “PARTNERSHIP ARRANGEMENTS” THAT ARE DEVELOPING ACROSS THE MARKETPLACE
 - THE THREE LEGGED STOOL
 - BACK ROOM MSO
 - PROVIDERS AS AN ARM OF THE HEALTH PLAN

Payer-Provider Partnerships to Share Risk and Improve Care

- THE CHARACTERISTICS OF AN IDEAL PAYER-PROVIDER PARTNERSHIP FROM THE PERSPECTIVE OF EACH PARTY
 - ALIGNED INCENTIVES
 - INVESTING IN MEDICAL MANAGEMENT INFRASTRUCTURE
 - HOSPITALIZATION IS A FAILURE OF THE DELIVERY SYSTEM/ HOSPITAL AS AN EXPENSE CENTER
 - PATIENT ENGAGEMENT
 - HAPPY DOCTORS = HAPPY PATIENTS

The Benefits of Linking Clinical Risk to Financial Risk

- ✓ Quality Care is always the one and only Goal!
- ✓ Quality Care is always less expensive
- ✓ Do anything in exchange for a hospital admission, hospital day, ER visit
- ✓ The One Hundred Cent Health Care Dollar is the Pathway to Managing Care
- ✓ Managed Care is a Patient Focused Approach to Care- IT IS NOT AN INSURANCE PRODUCT
- ✓ Investing in Medical Management, Patient Engagement and Social/ Behavioral Support

Payer-Provider Partnerships to Share Risk and Improve Care

- HOW MUCH ARE HEALTH PLANS WILLING TO INVEST IN HELPING PROVIDER SYSTEMS DEVELOP STRONG POPULATION MANAGEMENT CAPABILITIES?
- TO WHAT EXTENT ARE THEY WILLING TO TAKE A LONG-TERM APPROACH (I.E., SPEND MORE NOW TO REDUCE SPENDING LATER) VERSUS LOOKING FOR IMMEDIATE COST SAVINGS?

How Do You Structure a Graduated Risk-taking Program for Providers?

- ✓ If necessary- must feel, act, and function as full risk
- ✓ Consider provider partnerships
- ✓ Soft-landing for providers
- ✓ Medical management Infrastructure redesign
- ✓ Pay for delivery system infrastructure- take it out of risk pool
- ✓ Align incentives between plan, physicians, and hospitals

Payer-Provider Partnerships to Share Risk and Improve Care

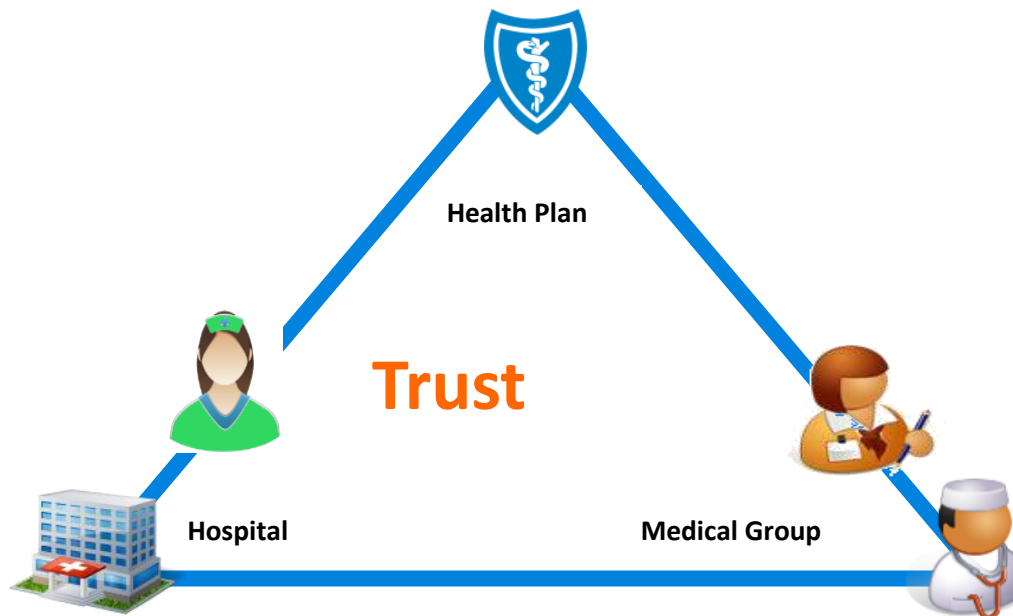
- WHAT ARE THE BARRIERS TO GOOD WORKING RELATIONSHIPS BETWEEN PROVIDERS AND HEALTH PLANS? WHAT IS NEEDED TO CHANGE THE ADVERSARIAL NATURE OF NEGOTIATIONS BETWEEN PLANS AND PROVIDERS? CAN HEALTH PLANS CREATE A MORE COLLABORATIVE CULTURE AMONG OPERATIONAL STAFF (AS OPPOSED TO SENIOR MANAGEMENT).
- IS THE ENDGAME FOR HEALTH PLANS THE CREATION OF NARROW OR TIERED NETWORK PRODUCTS BUILT AROUND PARTNER HEALTH SYSTEMS?

The Blue Shield ACO Experiment

Turned Real and Driving
Success

To create a new kind of partnership that enables us to:

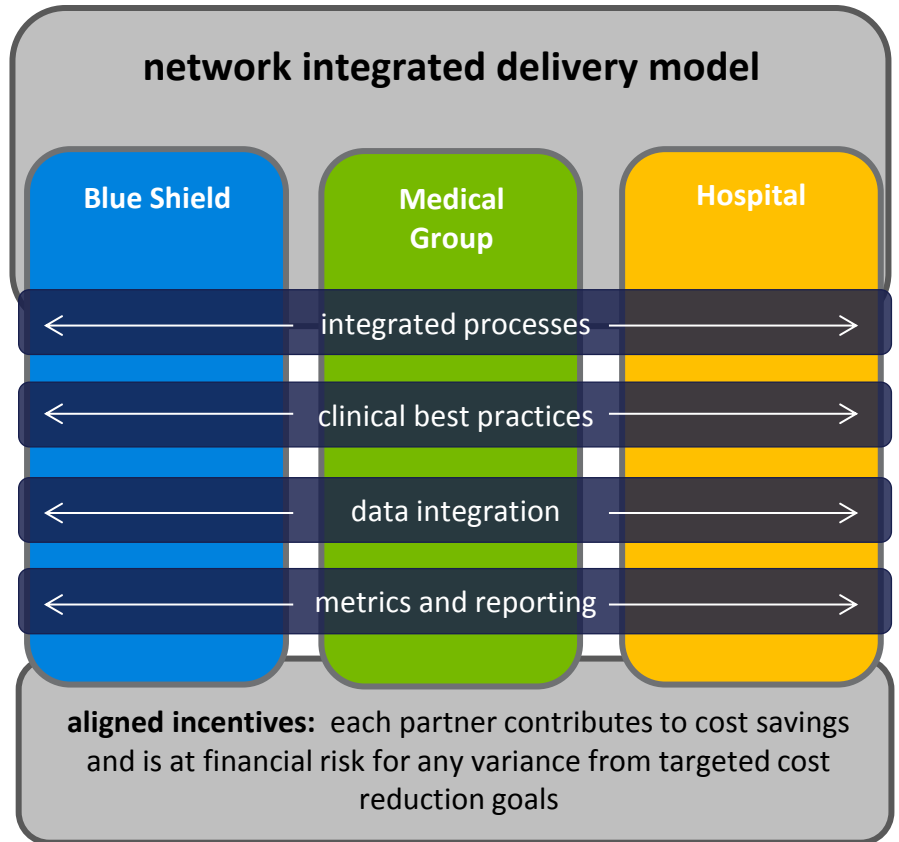
- Deliver below-market trends
- Achieve financial results in acceptable and sustainable returns for all parties
- Find cost and quality improvements
- Increase market share



How it works

Driving change through accountability, transparency and aligned incentives to:

- To date build on HMO platform – now implementing for PPO and Medicare Advantage
- Unique collaboration with medical groups, hospitals and Blue Shield
- Value-based payments and aligned incentives
- Data integration and information sharing
- Quality outcomes and member satisfaction

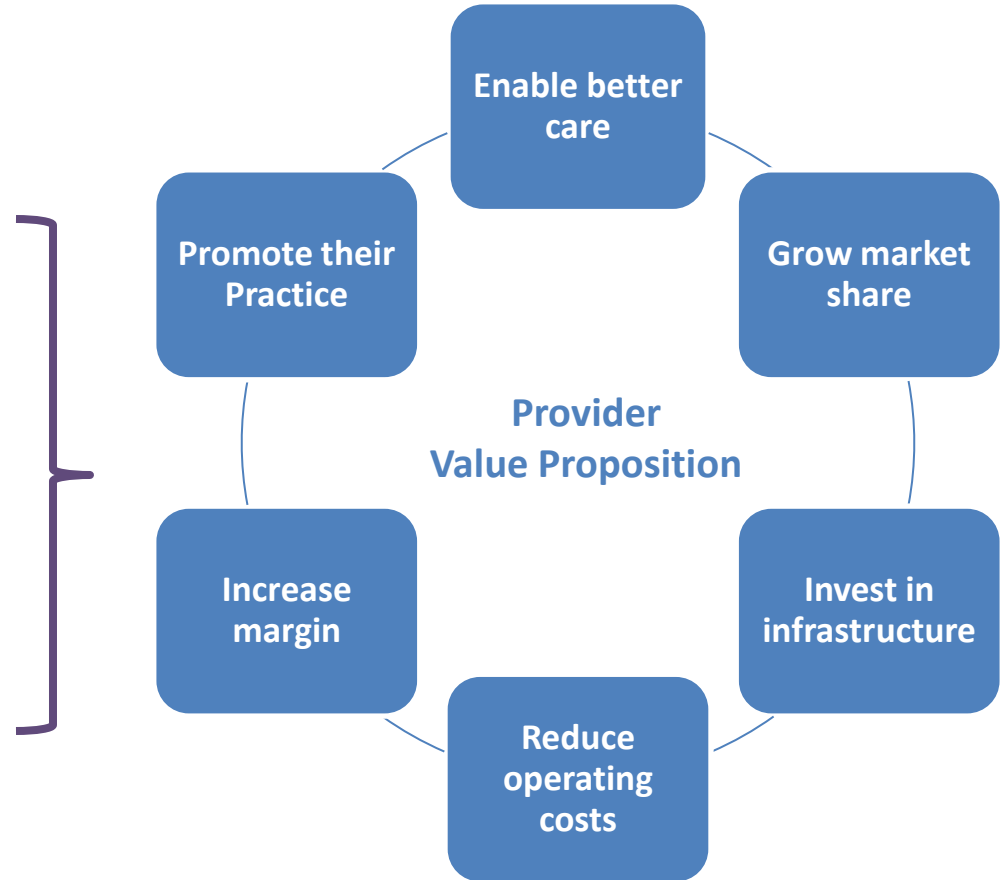


reward what matters

a new provider compact

Provider Partner Performance Expectations

- Provide effective evidence-based, preference sensitive, personalized care
- Take waste out of the system
- Be accountable for and get paid based on results, not activity
- Integrate with our systems and processes to serve our members
- Grow membership with us



ACO – transforming care

path to technically integrated care system transformation

2010

Phase 1: Build the Foundation & Re-Engineer Process

- Establish trust and governance
- Build initial integration between partners
- Establish workgroups and accountabilities
- Identify healthcare gaps and duplicative efforts
- Intervention examples: integrated discharge planning, readmissions reduction, physician variation

2011 - 2012

Phase 2: Refine/Innovate as a Team

- Refine work from year 1
- Retooling & redeploying resources
- Data-driven analysis
- BSC embedded in the delivery system (e.g., shared office, daily clinical huddles)
- Greater focus on outpatient interventions (e.g., physician variation, ED alerts)



Current State

Phase 3: Virtual Integration

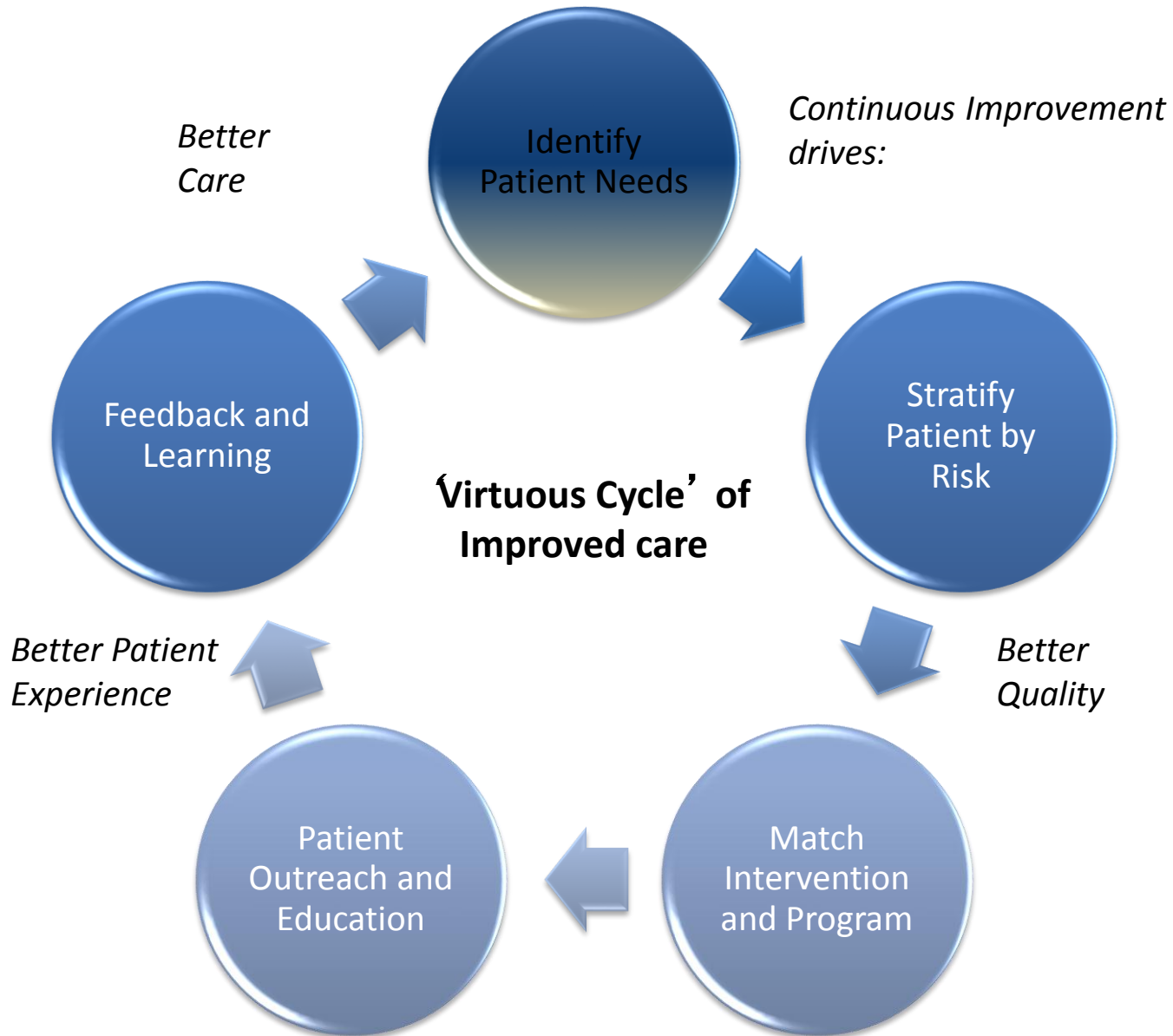
- Virtual care team
- Patient-Centered Medical Home
- Outpatient Palliative Care
- Phase 1 Technical Integration (i.e., Cal INDEX)
- Enhanced Wellness
- Scalable (e.g., SF, Santa Cruz, San Joaquin)
- Phase 1 Oncology Practice of Future

End State

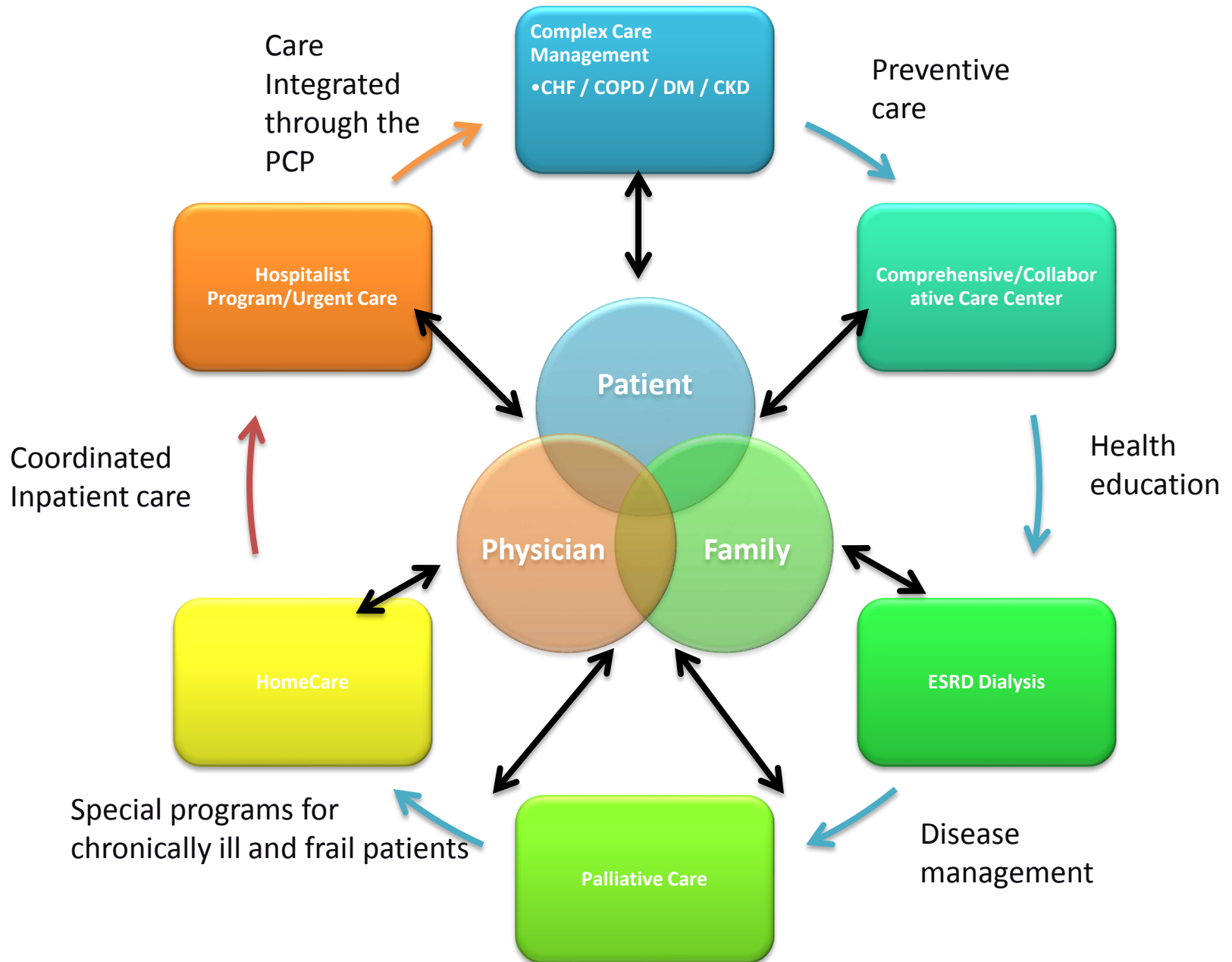
Transformation

- Full adoption of enabling technology
- Member-centered care
- Have seamless integration with provider partners
- Care models of the future deliver best-in-class performance
- Members are fully engaged in their total health

Proactive Population Health Management



Care Coordination Model



Patient And Family Engagement

A Critical First Step in Care Management

Beyond traditional care plans that focus on treatment goals and clinical activities

Our care plans incorporate the accumulated knowledge of clinical and non-clinical actions that have demonstrated quality & total cost of care results



Stratifying Patients into the Appropriate Clinical Program

Hospice/Palliative Care

Home Care Management

Provides in-home medical and palliative care management by Specialized Physicians, Nurse Care Managers and Social Workers for chronically frail seniors that have physical, mental, social and financial limitations that limits access to outpatient care, forcing unnecessary utilization of hospitals

High Risk Clinics and Care Management

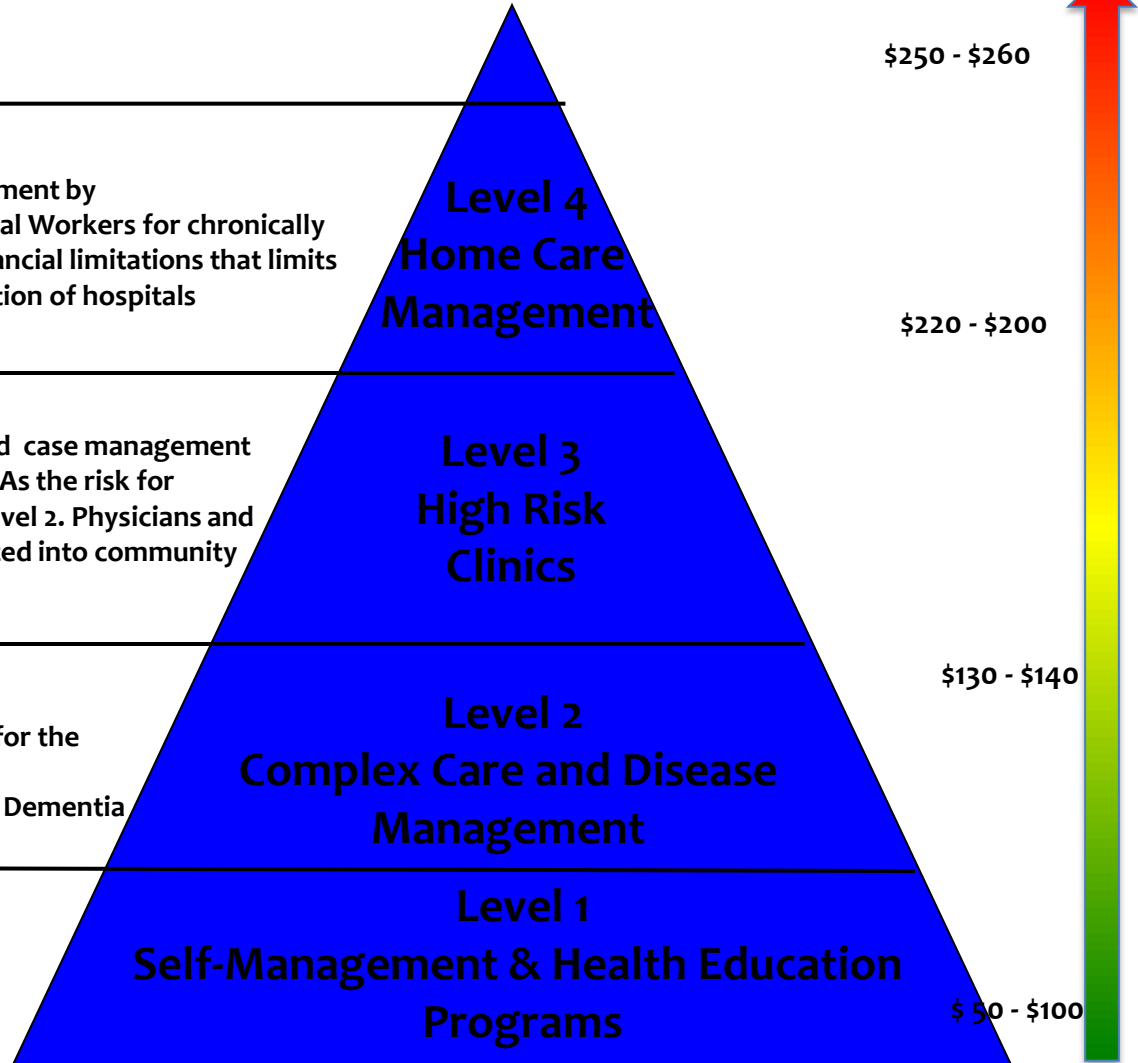
intensive one-on-one physician /nurse patient care and case management for the highest risk, most complex of the population. As the risk for hospitalization is reduced, patient is transferred to Level 2. Physicians and Care Managers are highly trained and closely Integrated into community resources and Physician offices or clinics.

Complex Care and Disease Management

Provides long-term whole person care enhancement for the population using a multidisciplinary team approach. Diabetes, COPD, CHF, CKD [ESRD-PCMH], Depression, Dementia

Self Management, PCP

Provides self-management for people with chronic disease.

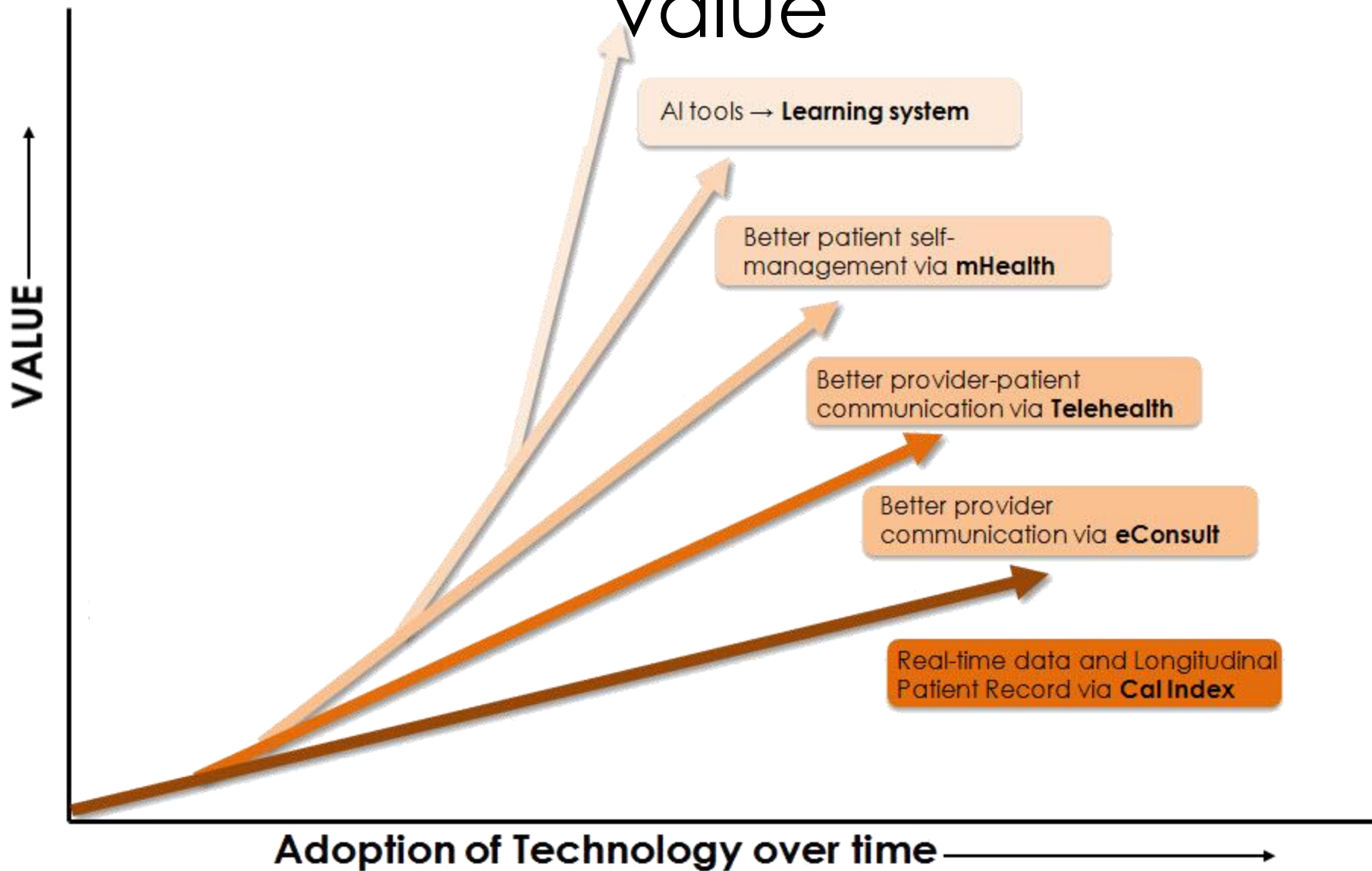


Physician Risk Stratification

| <u>Employed</u> | <u>Contract</u> |
|--|---|
| <p style="text-align: center;">“Great”</p> <ul style="list-style-type: none"> • Embed Care Mgmt. • Shift 1% – 2% Seniors/ 0.5% Comm* • 30/ 1000 senior members on the Composite Scores for Ambulatory sensitive admission (12 categories as defined by AHRQ) • Readmission rates = 7% | <p style="text-align: center;">“Excellent”</p> <ul style="list-style-type: none"> • Embed Care Mgmt. • Shift 8% – 10% Seniors/ 2-2.5% Comm* • 35/ 1000 senior members on the Composite Scores for Ambulatory sensitive admission (12 categories as defined by AHRQ) • Readmission rates = 9% |
| <p style="text-align: center;">“Good”</p> <ul style="list-style-type: none"> • Embed Care Mgmt. • Shift 5% – 8% Seniors/ 1.5-2% Comm* | <p style="text-align: center;">“Average”</p> <ul style="list-style-type: none"> • Shift 20% Seniors/ 5% Comm* |

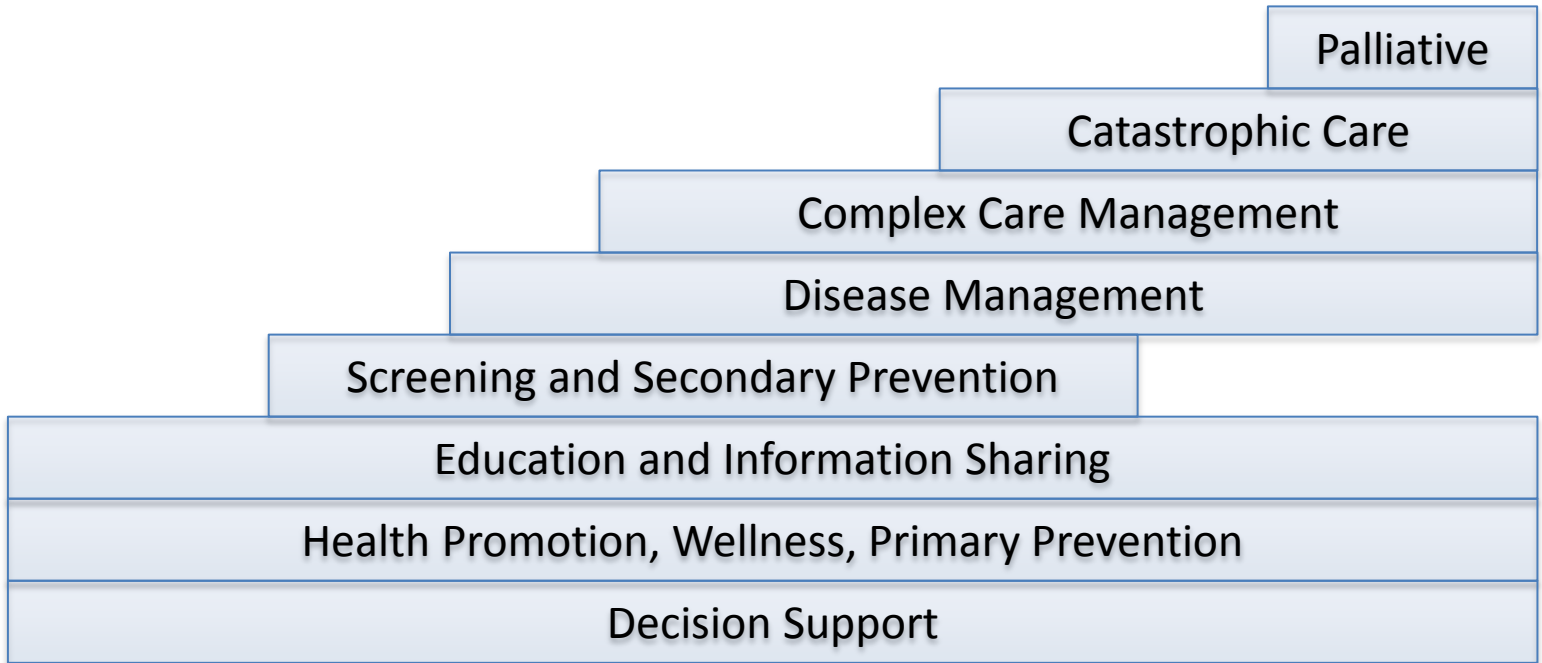
- Denotes shift of senior population to high risk care centers
- For Commercial Patients, target 5% of total patients for moving to high risk programs

technical integration drives value



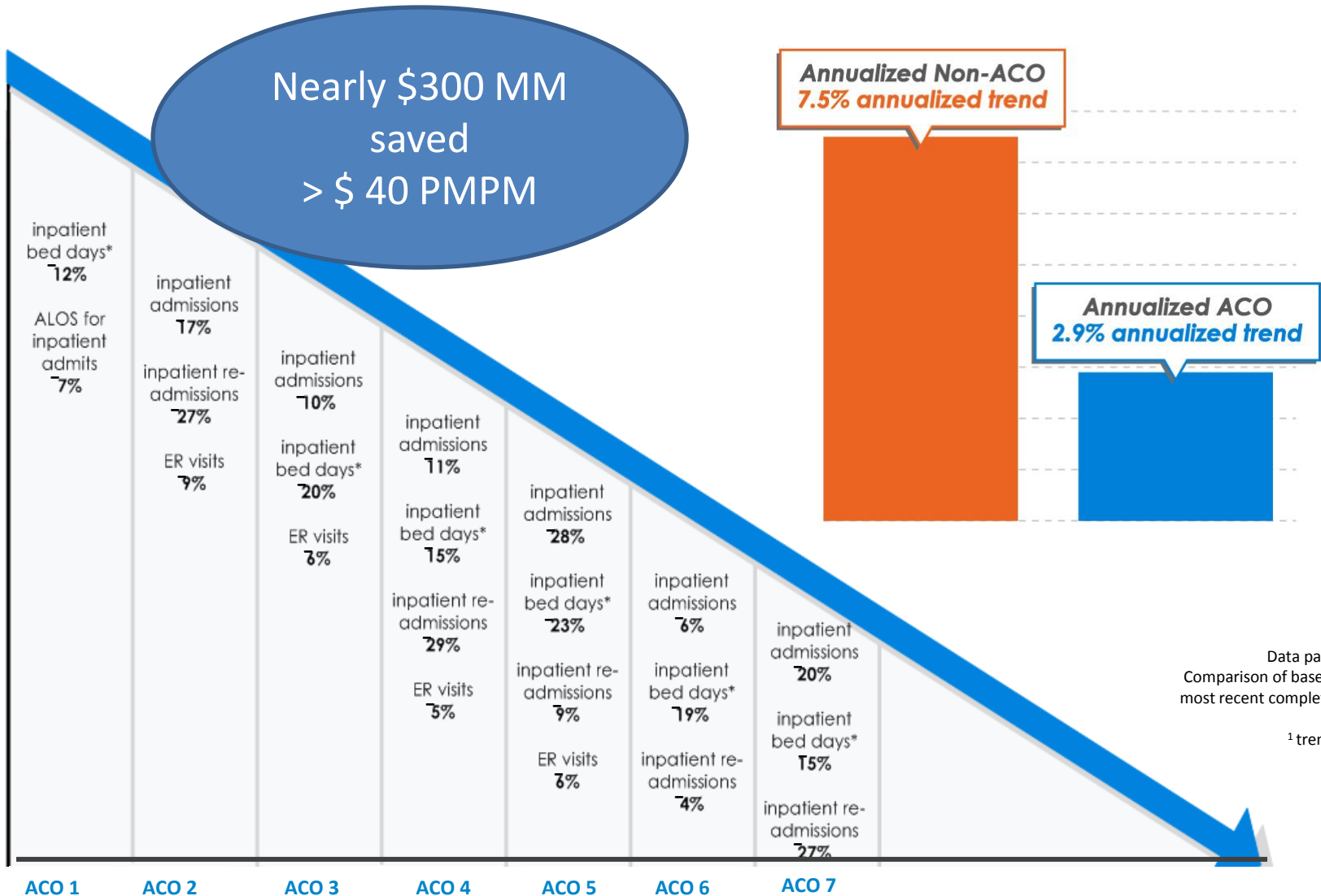


Healthy Lifestyle Issues Chronic Catastrophic Terminal



Program Results to Date

Includes ACO partners with experience through CY 2013



Data paid through 12/13
Comparison of baseline (pre ACO) to
most recent completed ACO contract
period
1 trend as of Feb 2013

Developing a directly contracted (PPO) ACO network is also important (and will take time)

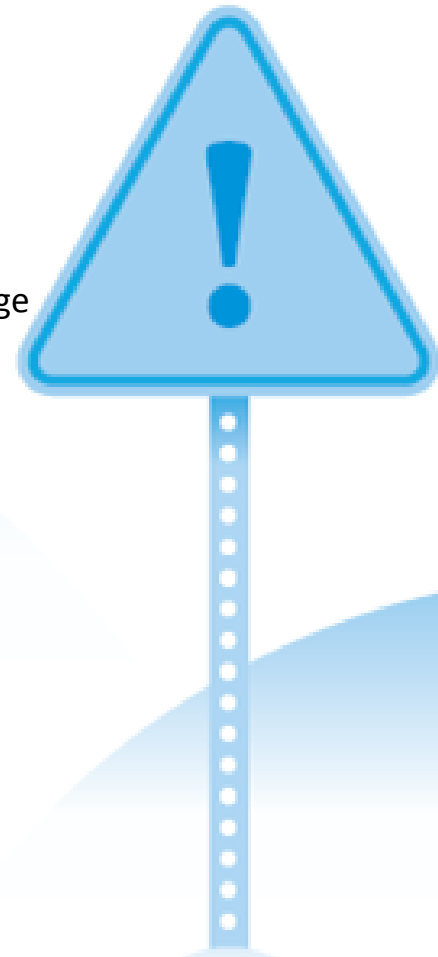
- Expanding ACO model to PPO product – preferred model to leverage our ACO group model, but need to have a Medical Group Model as well as an alternative option for markets without organized groups or for Physicians who do not join Organized Medical Groups or IPA's
- Allows self-funded and national account clients to access an ACO
- Our plan is to convert our Exchange network into a PPO ACO over time and make it available to all appropriate lines of business
- Embraces the same principles as HMO ACO but must be implemented differently
 - Aligned incentives (but through individual physician pay rather than physician group)
 - Adoption of patient-centered, evidence-based care (but Patient Centered Medical Home and Practices of the Future will have to be built and integrated by Blue Shield)
 - Full adoption of Cal Index HIE (but through individual physician offices)
 - Integrated, team-based care (but without an organized physician group)

so far so good, but we need to do better

risks and challenges

- Limited technology integration
- Offered in limited geographies
- Primarily HMO, which impacts overall price competitiveness
- No product overlay – results “watered down” over network
- Limited provider bandwidth and resources in an environment of unprecedented change
- ROI for providers (e.g., increased membership) not always immediate
- No “direct” ACO model

Our expansion plans must address these risks



Lessons Learned

- **Senior leadership engagement is** critical
- **Financial integration** – upside and downside- is key
- Quality is foundational but **quality is not enough**
- **Hospitals must have a seat at the table** – they are too much a part of the problem
- **Transparency is key** to changing the dialogue between plans and providers
- **Financial model must link success/failure across partners** - only this will compel a new kind of information sharing and collaboration
- **Program learnings must applicable to a provider's entire book of business**
- Success requires significant **investment of time and resources** across all partners
 - Clinical expertise and resources
 - Data aggregation (claims, Rx, authorizations)
 - Reporting/actionable information
 - Program management
- And, critically – **strategic alliances supported by contractual relationships work** – ACOs do not require joint ventures

our three-year roadmap

Key Strategic Milestones

2015

- Add Medi-Cal Line of Business
- Total of 28 ACOs and 20% membership
- Brilliant Basics in all Provider Partner Delivery Systems
- Medical Management Infrastructure Re-design across all ACO Provider Partnerships
- Develop and pilot Quality and incentive programs for HMO and PPO product
- Enhanced technology integration with all ACOs and other potential provider partners
- All Lines of Business
- Medicare Advantage, Commercial HMO and PPO- Direct ACO, and MediCal

2016

- Expand PPO Partnership network to Small and Large Group and Direct ACO
- Total of 35 ACOs and 30% membership
- Sophisticated Medical Management Infrastructure for all ACO Provider Partners and extension of this for all PPO products
- Specialized Programs caring for the high risk patients across all ACO partner Groups
- Expand technology integration to 26 ACOs and other potential provider partners

2017

- Expand PPO Partnership network to Mid/Large and Premier
- Total of 40 ACOs and 70% membership
- Practices of the Future: Medicine of tomorrow Today
- Innovative Patient Defined Medical Homes in all mature ACOs
- Expand technology integration to 34 ACOs and other potential provider partners

* Preliminary number will be available August 1st