Patient Centered, Value Based Provider Arrangements: WellPoint’s New Normal

The Alliance for Health Reform: PCMH Briefing

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WellPoint is committed to transforming the system

Fee-for-Service

Introduction of Value-Based Payment

Drivers of Cost

- Fragmentation
- Lack of accountability & coordination
- Narrower focus of providers
- Waste; repetitive units

Healthcare Costs

1960 - 40 years of FFS - Today

Without value-based payment

With value-based payment

Bending the Cost Curve

- Aligned reimbursement
- Empower with data
- Invest in practice transformation

40 years of FFS
Primary care is the foundation of our healthcare system

Significant opportunities to enhance and leverage primary care

**Insufficient Resources Directed to Primary Care**

<table>
<thead>
<tr>
<th>Description</th>
<th>Statistic</th>
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</thead>
<tbody>
<tr>
<td>Forecasted PCP shortage by 2020</td>
<td>45K</td>
</tr>
<tr>
<td>Americans without access to primary care</td>
<td>60 Million</td>
</tr>
<tr>
<td>Wait for non-emergency appointment</td>
<td>20.3 Days</td>
</tr>
<tr>
<td>PCPs accepting new patients</td>
<td>49.8%</td>
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</tbody>
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**Initiatives Empowering Primary Care Drive Better Outcomes**

- 23% FEWER HOSPITAL ADMISSIONS
- 18% FEWER AVOIDABLE ER VISITS
- 9% LOWER READMISSION RATE
- 15% BETTER ON DIABETES MEASURES

ACA related market expansion and provisions reinforce need to strengthen primary care

References: Association of American Medical Colleges, American Journal of Managed Care, Health Affairs
## Empowering PCPs Works: Results from Our Pilots

Our patient centered care pilots nationwide demonstrated improved health and lower costs.

<table>
<thead>
<tr>
<th>State</th>
<th>PCMH</th>
<th>Hospital Admissions</th>
<th>ER Visits</th>
<th>Diabetes Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorado</td>
<td>PCMH</td>
<td>18% fewer</td>
<td>15% fewer</td>
<td></td>
</tr>
<tr>
<td>New Hampshire</td>
<td>PCMH</td>
<td>3.6% fewer</td>
<td>6.1% fewer</td>
<td></td>
</tr>
<tr>
<td>New York</td>
<td>PCMH</td>
<td>12-23% fewer</td>
<td>11-17%</td>
<td></td>
</tr>
<tr>
<td>Connecticut</td>
<td>PCMH</td>
<td>8% fewer</td>
<td>4% fewer</td>
<td></td>
</tr>
<tr>
<td>California</td>
<td>ACOs</td>
<td>35% increase</td>
<td>44% increase</td>
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</tbody>
</table>

- 18% fewer hospital admissions
- 15% fewer ER visits, improvement in all diabetes measures
- 3.6% fewer hospital admissions
- 6.1% fewer ER visits, improvement in all diabetes measures
- 12-23% fewer hospital admissions
- 11-17% fewer ER visits
- 8% fewer hospital admissions
- 4% fewer avoidable ER visits
- 9% lower readmission rate
- 35% increase appropriate mammograms
- 44% increase appropriate antibiotics for bronchitis treatment
Scaled, comprehensive approach that drives change by rewarding and empowering physicians

Building blocks for health care transformation include BOTH payment and care delivery reform solutions

**PAYMENT INNOVATION**
Moving from volume to value-based payment models

**PROVIDER EMPOWERMENT**
Providing information, tools, practice support and resources to thrive under an outcomes-based compensation model

**POPULATION HEALTH**
Promoting accountability and care coordination across the healthcare continuum to improve the overall health of the population

**PERSONALIZED CARE PLANS**
Ensuring awareness and alignment of care plans among the provider team, our care management and caregivers
Our New Normal of Collaborating with Physicians in a Patient-Centered, Value-Based Manner

Key Components of Our New Contracts Focus on Improving Quality and Affordability

**PAYMENT REFORM**

- Incentives enabling delivery of patient-centered, value-based care
  - Quality care foundational to value-based payment
    - PMPMs for care outside traditional visit
    - Opportunity to share in savings when quality thresholds are met
  - Annual performance evaluation

**CARE DELIVERY TRANSFORMATION**

- Support for participants to operate in a value-based environment
  - Practice care coordinator works closely with Anthem staff
  - Actionable data and tools supports patient care and engagement
  - Learning Collaboratives supports education, best practice sharing
Enable Provider Transformation to Improve Access, Patient Health Outcomes and Costs

**Transformation Team**

1. Community Collaboration Manager
2. Care Consultant
3. Provider Clinical Liaison

**SUPPORTS**

<table>
<thead>
<tr>
<th>Small, Independent PCPs</th>
<th>IPAs PHOs</th>
<th>IDSs, ACOs, Hospital Systems</th>
</tr>
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<tbody>
<tr>
<td>Practice Care Coordinator (PCP, Care Team)</td>
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**AVAILABLE ANTHEM CAPABILITIES / TOOLS ENABLING TRANSFORMATION**

- Clinical registry tool
- Class leading reports
- Care plan resources
- Collaborative Learning
- Educational resources

Promotes patient-centered health care decision making at all patient touch points: pre-visit, at site of service, post-visit/follow-up
Case Study: Improved Coordination and Chronic Care Management

Enter Enhanced Personal Health Care

Transformation Team educated practice on available resources: reports, clinical registry and care management

• Appeared on Hotspotter with history of diabetes, hypertension
• Appeared on Inpatient Authorization with surgeon referring patient back to PCP
• Clinical registry tool, MMH+, showed no medical care since 2008 until recent hospitalization

Patient is on path to better health

• Care plan created and reviewed with patient: recommended lifestyle changes, self-management and Rx
• Patient adhered to care plan: attended classes, improved diet, tracked and reported HgbA1c regularly
• HbA1c level now normal; fewer Rx with better control

Background:
49 yr-old w/ diabetes, high blood pressure, and obesity. No recent PCP visits but had a recent hospitalization
Market Leading Value-Based Payment Footprint

- **110,000 Physicians**
  PCPs and specialists

- **44,000 Physicians**;
  **32,000 PCPs**
  2.7 million attributed members

- **90 health systems**

- **2,300 designated facilities**

- **760 hospitals**
  76% of inpatient admissions

Participating in Value-Based Arrangements
P4P, bundles, capitation, shared savings/risk arrangements

In Shared Savings/Risk Framework
Includes participation in CMS’ Comprehensive Primary Care initiative

Accountable Care Organizations (ACO)

Blue Distinction Centers of Excellence

Hospital Payment for Quality and Safety

Represents more than $30 billion of our annual commercial spend
Collaborating with Government

Opportunities exist to collaborate with healthcare stakeholders to accelerate transformation and generate efficiencies

Measure Standardization

Secure Data Exchange

It takes a village...
Questions