Illinois
New Mexico
Oklahoma
Texas

Innovative Models
for Accountable Care

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November 28, 2011

Are they new??

What is different?

What needs to be different?

Will anything make a difference?

What is the difference we want to make?

Health Care Service Corporation (HCSC)

- More than **13.1 million** members
- Operating Blue Cross and Blue Shield Plans in
  - Illinois
  - Oklahoma
  - New Mexico
  - Texas

New Models: Intensive Outpatient Care Program (IOCP)

Top 10% of patients drive ≥60% of costs

How can we control costs without better managing these patients?

Physician-employed Case Manager for Highest-Risk 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**

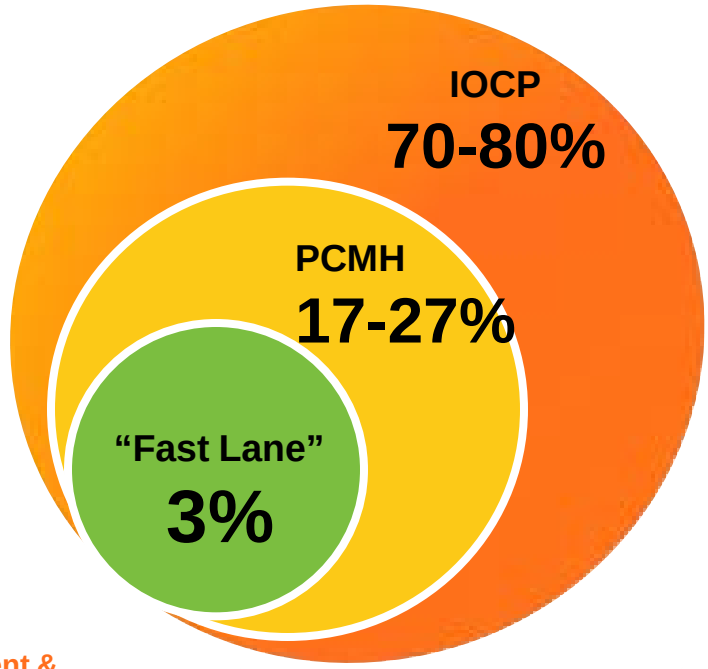
* **How well do our current programs address their needs?**

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

→20% NET SAVINGS

Primary Care Total Value Creation

VALUE CREATION:
Start with Focused Approach to Highest Cost Patients



	Persistent & Actionably High Cost	At Risk/Early Stage	Healthy
Population	**IOCP: High Risk PCMH**	**At Risk PCMH**	**Fast Lane**
Model Description	Individualized intensive active management of the sickest individuals within the population via dedicated manager support	"IOCP" Lite for early chronics and social/ behavioral engagement for at-risk individuals	Provision of access and low touch convenience services for the healthy
% Members	**10-20%**	**25-35%**	**55%**
% Costs	**50-60%**	**20-25%**	**20-25%**

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?

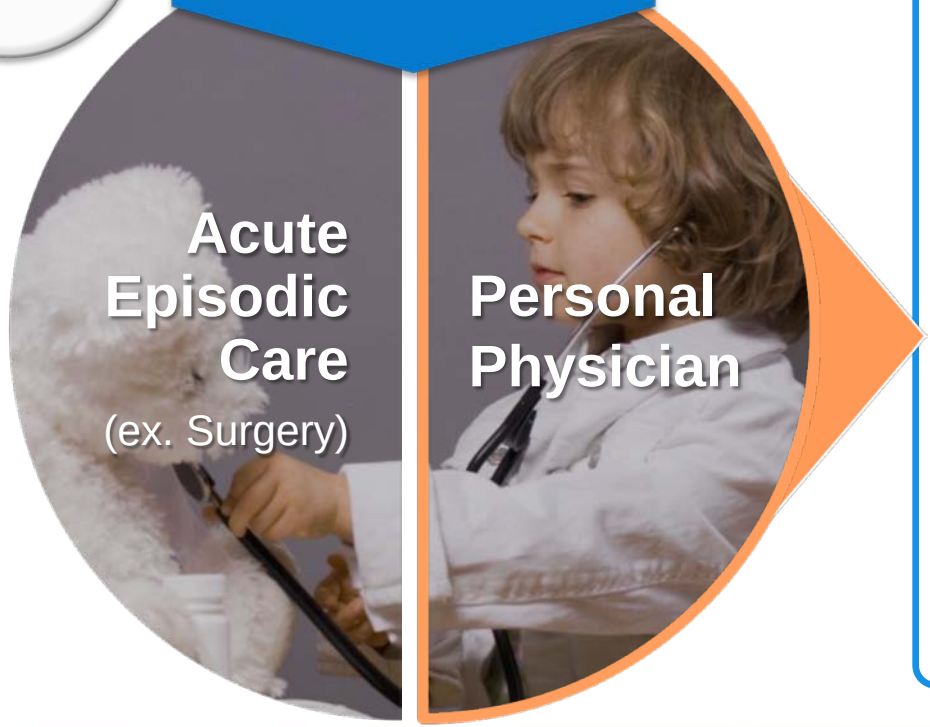
IF medical cost trend better than network **AND** meet patient quality, safety, and satisfaction metrics, **THEN** share in savings

Where?

New Models: Transferring Learning from HMO to PPO ACO Shared Savings Agreement

PPO

Total BCBSIL Members seeking care at Advocate



"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
- Dependent on hitting quality targets

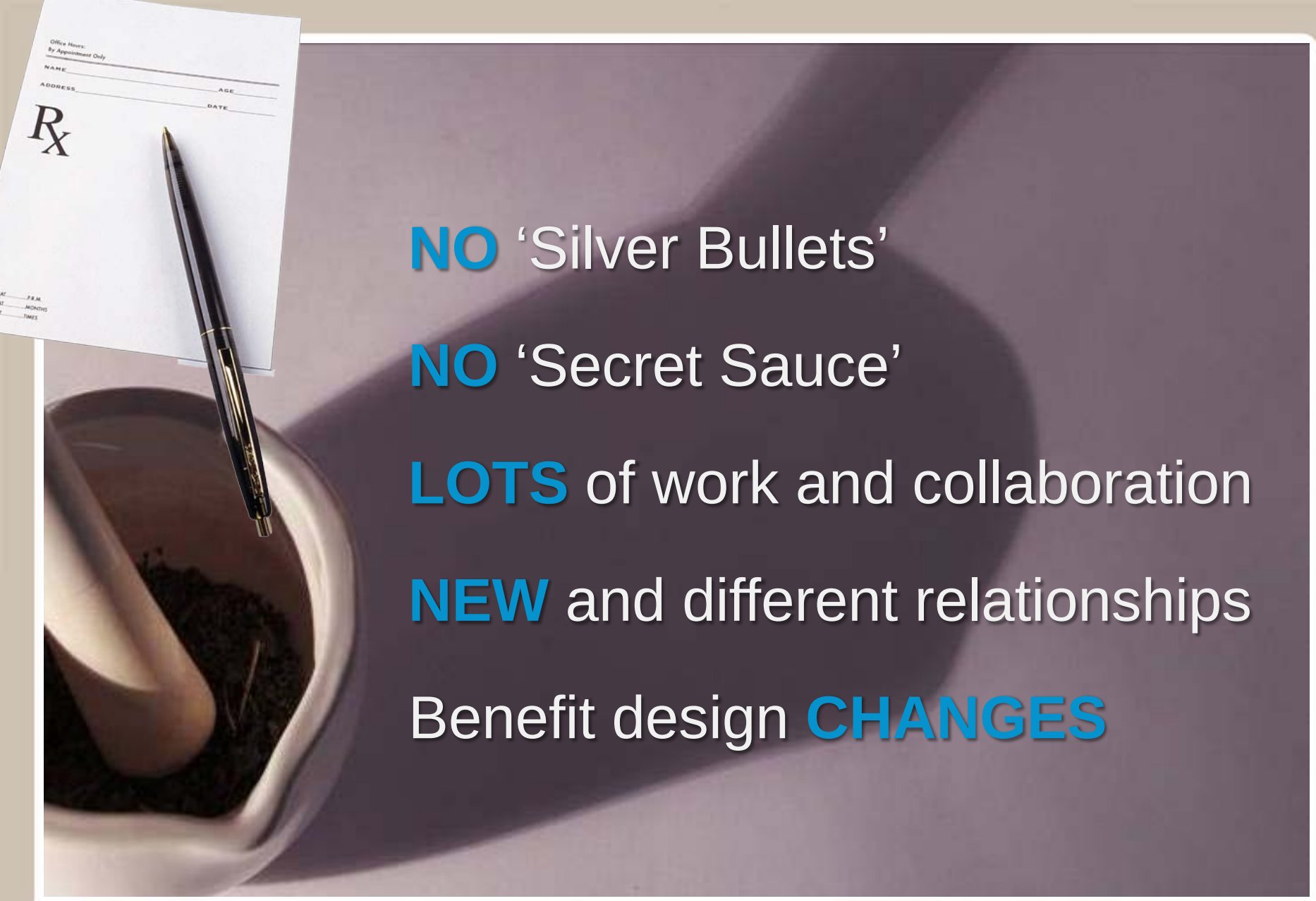
Accountable Models:

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; 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 and Analytics	Key metrics/dashboard for joint review
Ongoing collaboration	Clearly predefined metrics (dashboard) and joint oversight group/process

Network Management Future State Scenario

CURRENT		FUTURE-STATE
Adherence to generally accepted standards of care put; 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 BlueAdvantage, 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



NO ‘Silver Bullets’

NO ‘Secret Sauce’

LOTS of work and collaboration

NEW and different relationships

Benefit design **CHANGES**