Private Sector Accountable Care Innovation

June 18, 2019

Hoangmai Pham, MD, MPH

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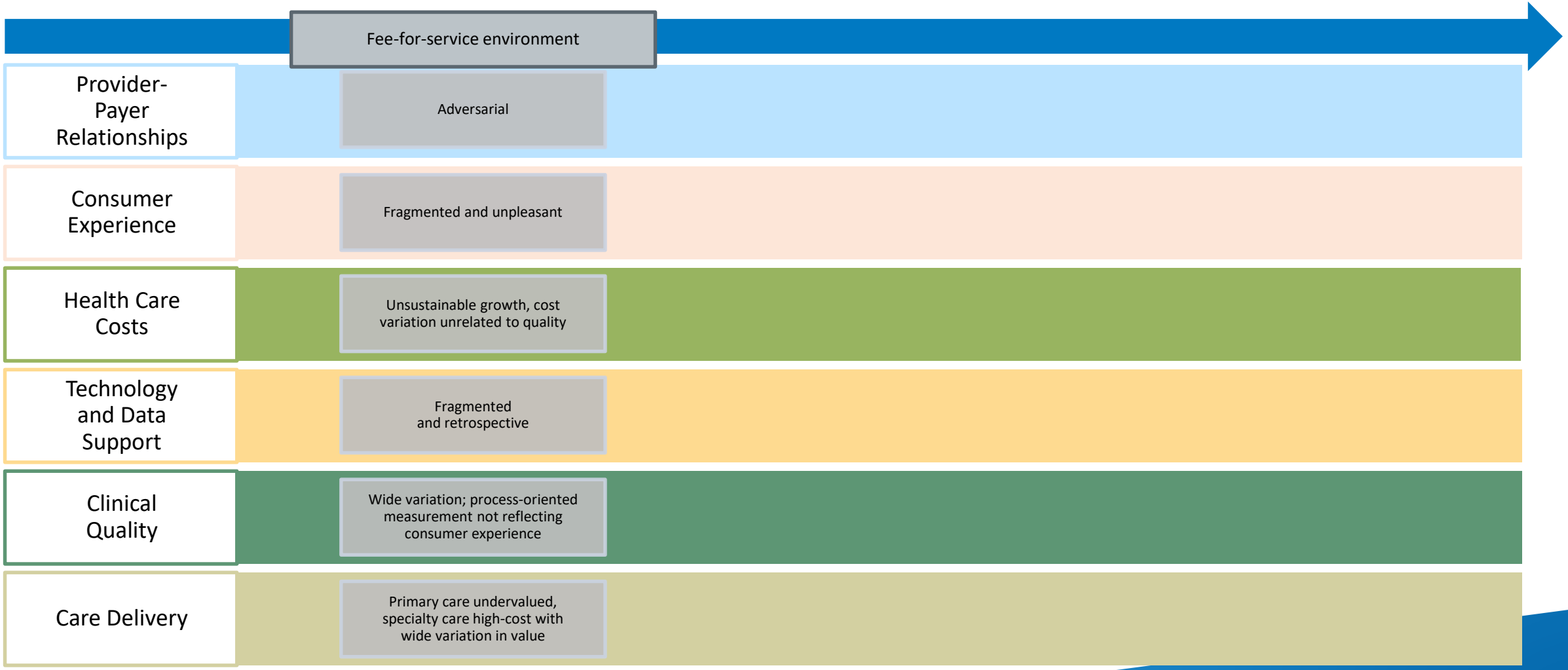
Value-based care and the evolving health system



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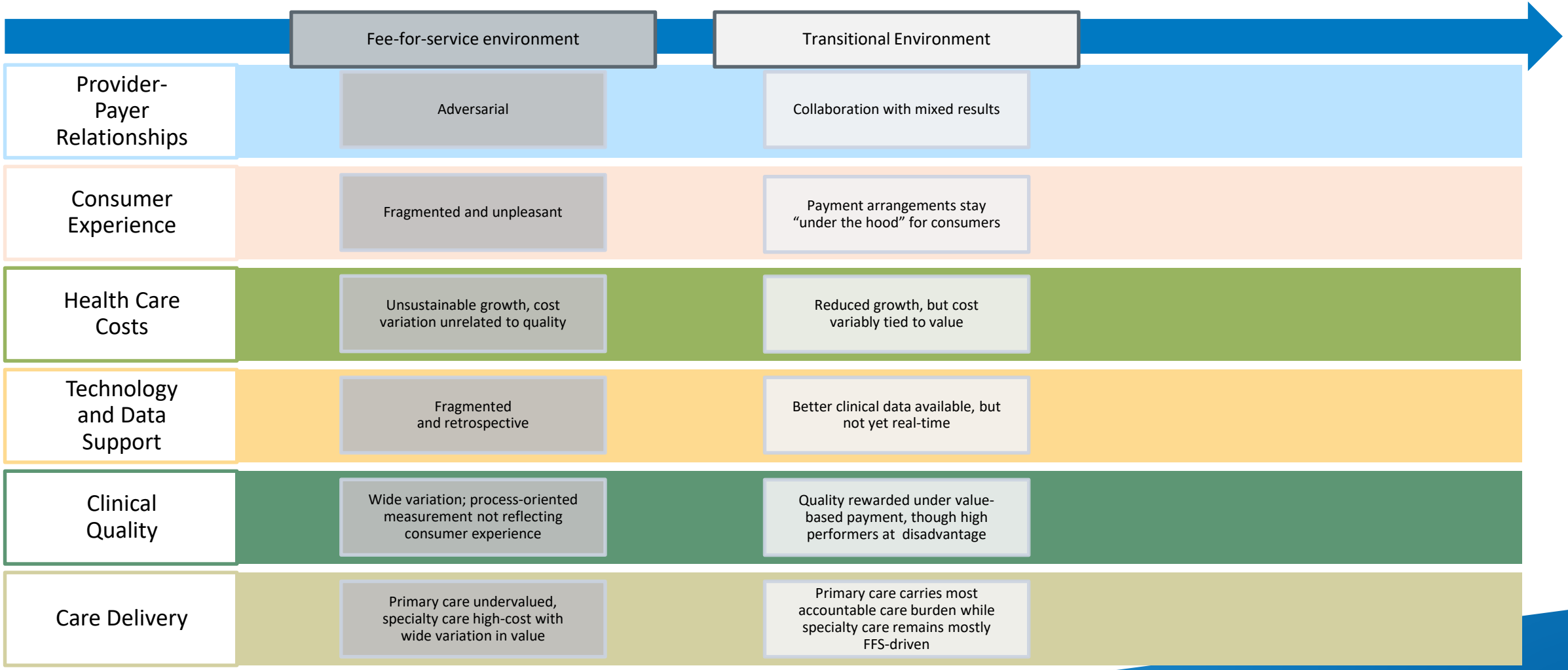
Value-based care and the evolving health system



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Value-based care and the evolving health system

	Fee-for-service environment	Transitional Environment	Fully value-based, High-Performance Health System
Provider-Payer Relationships	Adversarial	Collaboration with mixed results	Shared accountability, focus on high performing providers
Consumer Experience	Fragmented and unpleasant	Payment arrangements stay "under the hood" for consumers	Value-based arrangements drive a noticeably better experience for consumers
Health Care Costs	Unsustainable growth, cost variation unrelated to quality	Reduced growth, but cost variably tied to value	Predictable and controlled growth, with costs reflecting value
Technology and Data Support	Fragmented and retrospective	Better clinical data available, but not yet real-time	Timely exchange claims and clinical data coupled with technical assistance
Clinical Quality	Wide variation; process-oriented measurement not reflecting consumer experience	Quality rewarded under value-based payment, though high performers at disadvantage	High performers get sustainable payment arrangements; middle-low performers get support to improve
Care Delivery	Primary care undervalued, specialty care high-cost with wide variation in value	Primary care carries most accountable care burden while specialty care remains mostly FFS-driven	Fully integrated value based medical neighborhood with rational prices

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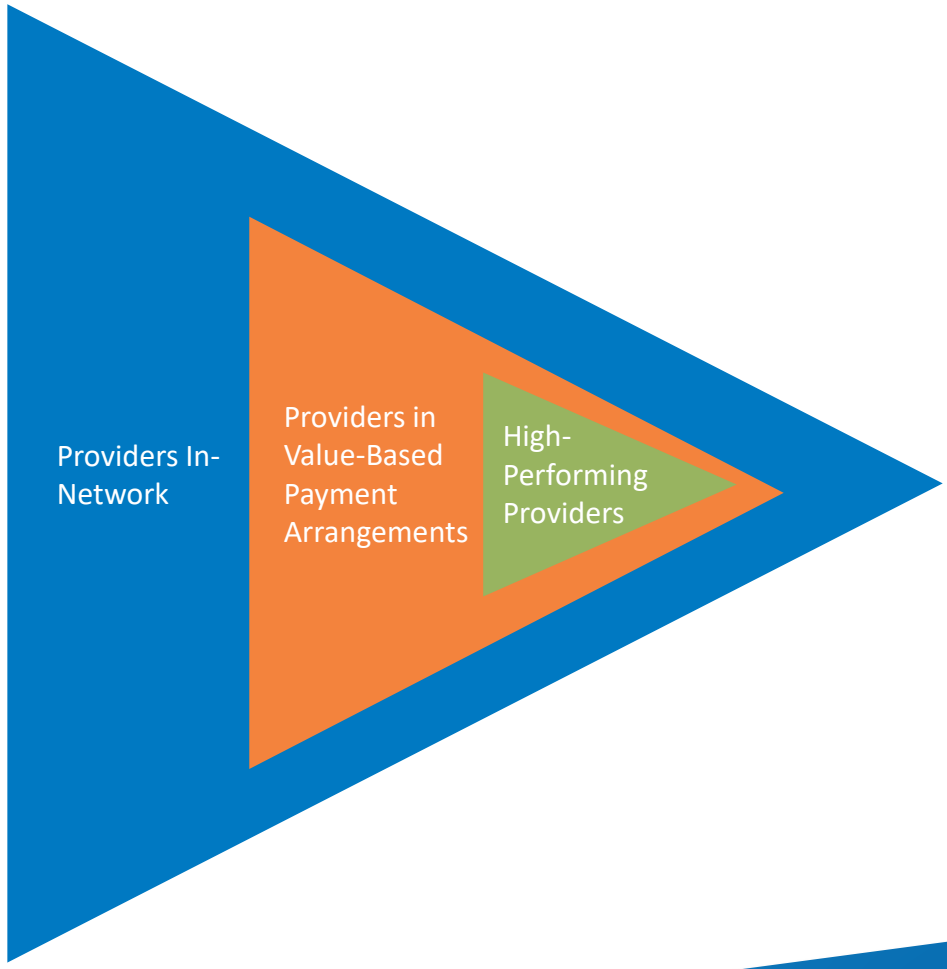
From “Land Grab” to curated collaboration

Anthem and other payers are moving beyond merely building a value-based footprint.

Many payers are building networks of high-performance providers. Anthem is ready to take it a step further by building entire products around high-performing, motivated providers who excel in delivering high quality care efficiently.



What’s driving this shift?

- With more than half our medical spend in value-based arrangements, we are approaching diminishing returns on the number of providers who perform well and are committed to engaging with us productively in these arrangements.
- Our employer clients are asking us to demonstrate ROI for value-based care arrangements – they are less interested in the scale of programs by provider count, and rather success delivering savings and better outcomes.

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Curated collaboration

Features and incentives for high-performing providers justify their commitment and investment in population health management and clinical quality improvement work.

- **Reduced administrative burden** – for example, waived prior authorization requirements - furthers trust and engagement for high performers.
- **Sustained performance incentives** – Incentives that recognize sustained excellence in cost and quality, not just incentives tied to year over year improvements, in order to keep high performers engaged.
- **Value-based insurance design** – Features that help to guide members to the best providers and the best care.
- **Incentives for taking on risk** – Proven high performers who take on shared financial risk can count on continuing care coordination PMPMs.

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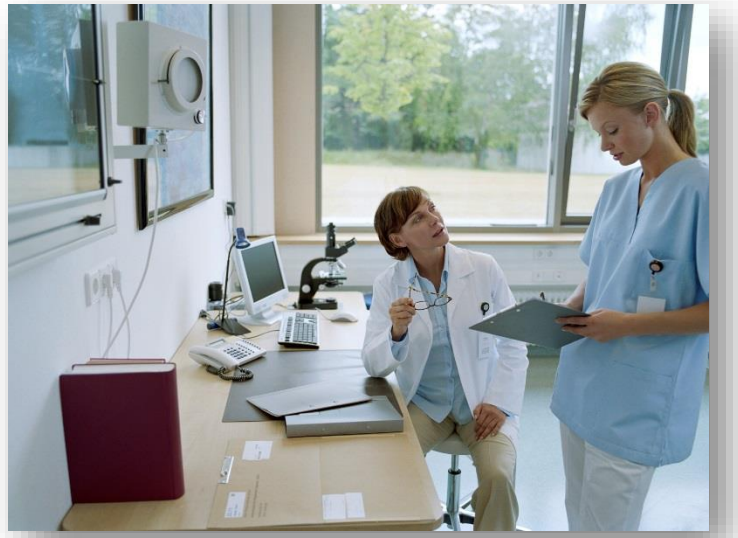
What about everyone else?

- Enhanced Personal Health Care, our value-based cost of care program for primary care, continues to evolve and drive better quality outcomes and lower overall cost of care. From 2014-2017, EPHC Commercial realized $1.8 Billion in savings.
- Smaller providers and those with low numbers of attributed patients can participate in a sister program, EPHC Essentials. Care delivery transformation support is virtual and self-paced.
- We continue work on maturing our value-based specialty care and facility programs, including bundled payments, pay-for-performance and Centers of Medical Excellence.



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The delivery system is shifting in tandem with payment models – in some cases not quickly enough

Primary care is shifting too slowly away from FFS model, holding back the rest of the system.

Consumer expectations are shifting, and payment will begin to be tied to consumer experience.

Primary care physicians continue to shift to employed and affiliated practice models, and primary care physicians are in short supply.

How payment and care delivery are linked

- Transformation means that care and services are better aligned with the needs of patients as opposed to payment
- Incentives for “basic care” must be disconnected from fee-for-service and providers treating whole-patients must have reliable cash flow.
- Fee-for-service is the wrong model for predictable primary care services, wellness, predictable acute and minor procedures, and chronic management. Payment should be tied to outcomes, patient satisfaction, awareness, and activation.

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Creating a value-based medical neighborhood

- Creating a fully value-based primary care system will support and spark reform for specialty and ancillary care payment. Only a fraction of health care spending is directly on primary care, but primary care referrals are still very influential in shaping when and where people receive care.
- More intensive efforts will be required to reshape specialty care payment, which is currently dominated by fee-for-service and pay-for-performance arrangements.

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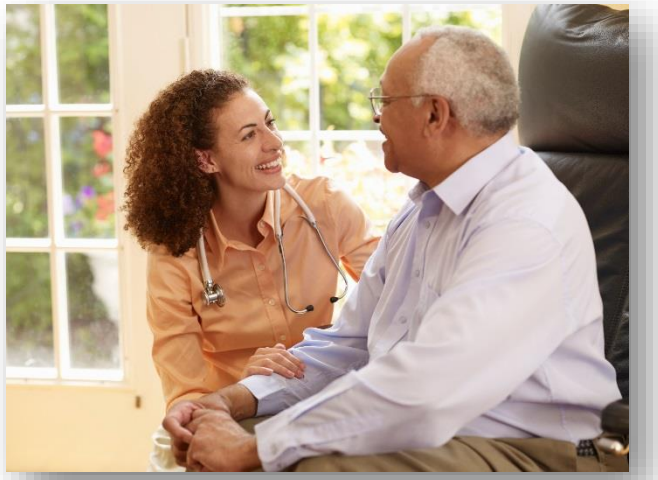
Making value-based care tangible for patients

- The value in value-based care has to be visible to consumers – especially in light of the shift to high-performance networks and products.
- Consumers want:
  - Lower cost healthcare with access to the highest quality providers
  - Superior experience with multi-channel access to care
  - Better health outcomes
  - Easy ways to stay actively engaged in their care



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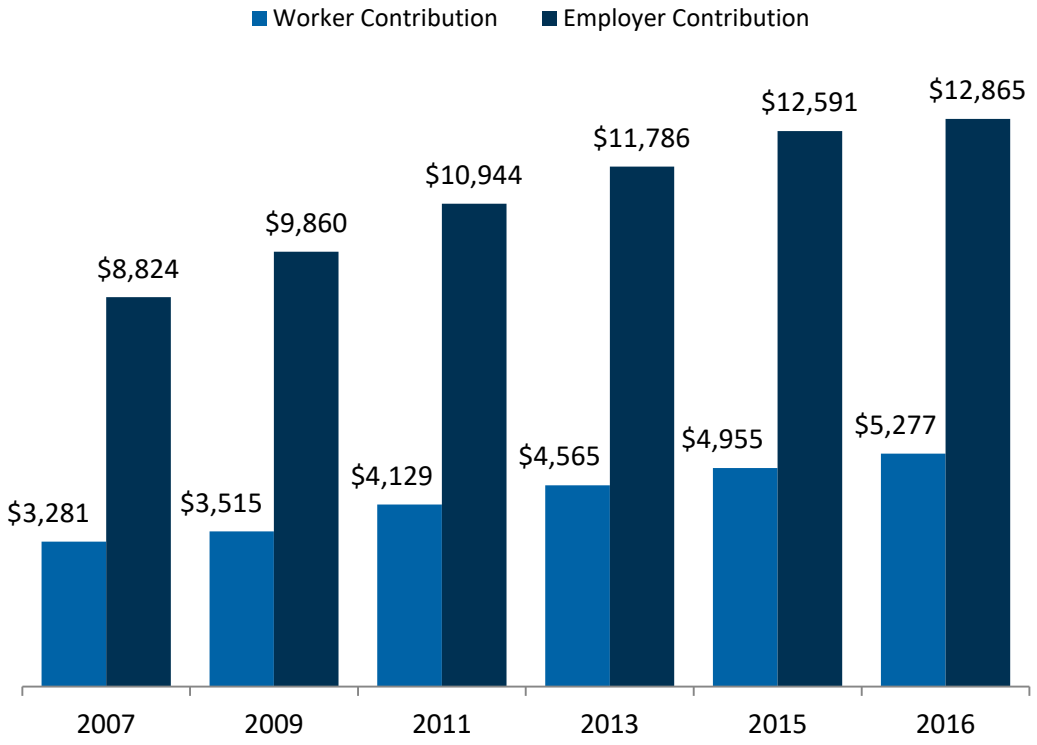
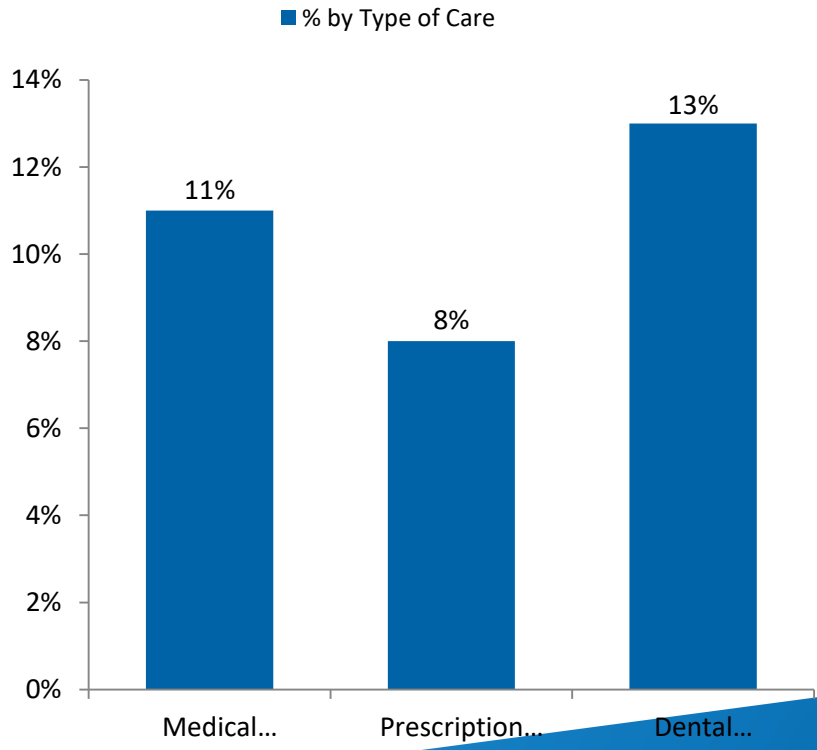
Rising healthcare costs are reaching a breaking point

Consumers out of pocket costs are rising, resulting in some delaying care or treatment

Average Annual Premium for Family Coverage[1] 2007-2016



% Who Have Avoided Medical Care in Past 12 Months Due to Cost[2] 2014



Source: 1) KFF, Employer Health Benefits 2016 Annual Survey. 2) CDC. Health, United States, 2015, 2016

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Unsustainable cost increases are pressuring employers

Employers try different tactics to curb costs:

- CDHPs
- Centers of Excellence
- Care and disease management programs
- Narrow networks

It's partially effective and unsustainable due to:

- Cost variations within the provider community
- Members don't have the right tools/incentives to distinguish between low and high performing providers

Employers are looking for new type of curated networks to help drive right care at the right time for their employees at an affordable rate.

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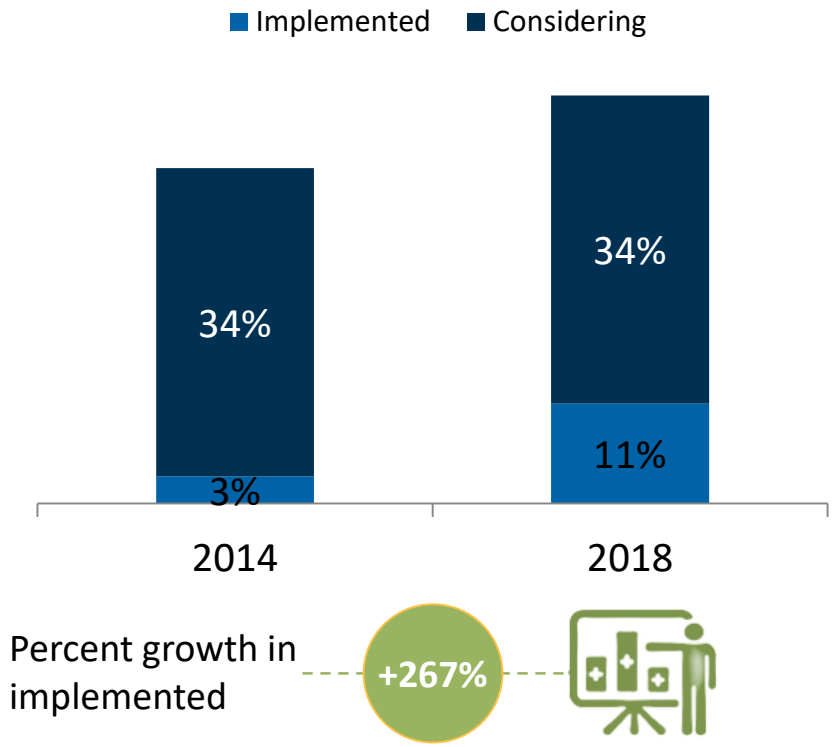
Demand for curated networks is growing

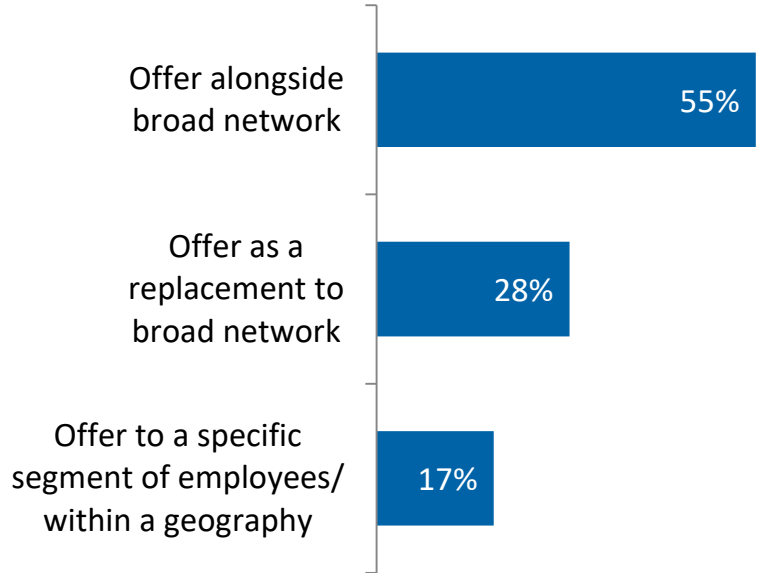
Percentage of employers who have implemented or are considering performance based networks or ACOs, 2014 and 2018

Performance-based networks



Source: PwC Touchstone Health and Well-being surveys, 2014 and 2018

Implementation Strategies for Innovative Network[3]
National Accounts = 429



Source: 2016 BCBSA NADM Network Survey, 2016 NADM Interviews

pwc.com/hri

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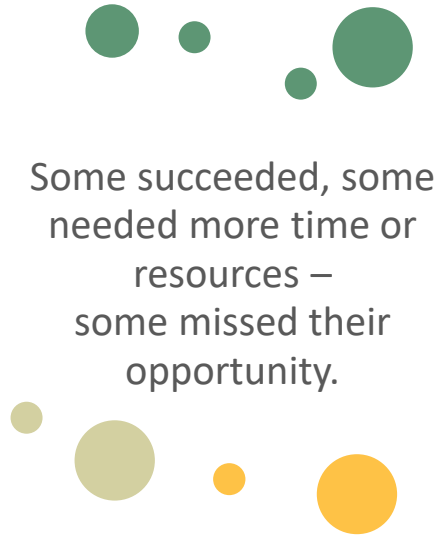
Our journey: Build → Identify → Steer

2012 — 2013 — 2014 — 2015 — 2016 — 2017 — 2018

Anthem invited primary care physicians (PCPs) across our networks to adopt a value-based payment model.



Some succeeded, some needed more time or resources – some missed their opportunity.

Anthem started building high-value networks and products around those who succeeded.

Building — **Identifying** — **Steering**

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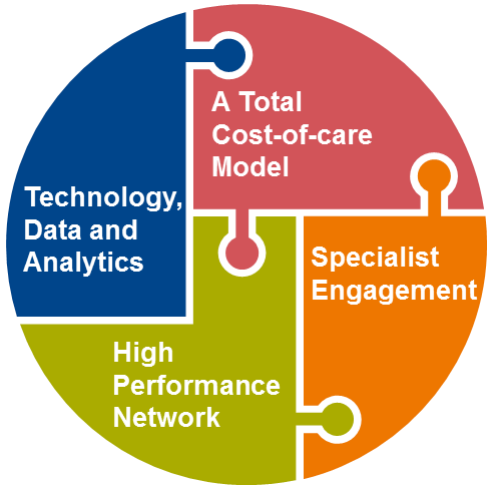
Cooperative Care



Input from nationally recognized provider groups and key employers drove refinements in our payment model, leading to improved outcomes, cost containment and a differentiated patient experience

Total Cost-of-care Model	Specialist Engagement	High Performance Network	Technology, Data and Analytics
"A Better Mousetrap": increased accountability for financial, clinical and experiential outcomes	Rewards specialists for improving care coordination and outcomes; discourages low-value activity	Greater affordability, deeper member engagement and superior member experience	Convenience for patients, better reporting for employers and providers, administrative simplicity

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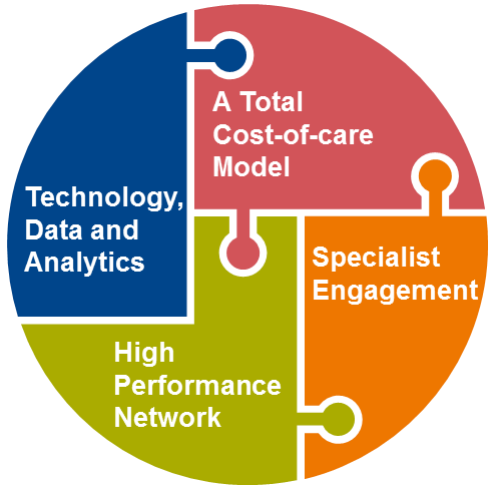
Cooperative Care

- Launched in 2019, Cooperative Care is a pilot model that pairs value-based payment with a high performance network and a tiered or narrow product
- Cooperative Care offers:
  - Enhanced incentives for high-performing providers
  - Engagement beyond PCPs to specialists and behavioral health
  - Outcomes-focused provider scorecard
  - Differentiated member experience through provider capabilities and digital tools

Cooperative Care has integrated requirements to direct member behavior and utilization:

- Required PCP selection, without gatekeeper requirements
- PCP and specialist eConsults (provider to provider interactions) are included as a care provider capability to reduce wasteful specialist visits (as well as shortened wait times)
- Extended access requirements (Online scheduling, 24/7 office hours)
- Multi-modal communication methods for provider-to-member interactions
- Bundled payment requirements ensure buy-in of high cost specialties



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Why the Medicare physician fee schedule matters beyond Medicare

Most commercial insurance fee schedules and even value-based programs are set relative to the Medicare fee schedule – it is the scaffolding holding up value-based payment arrangements between commercial health plans and providers.

Value-based payment arrangements: e.g. EPHC, bundles shrink cost of care

Some services are still over or undervalued even though services may be reorganized, total costs are lower and quality may be higher. **Relative value remains unaddressed.**

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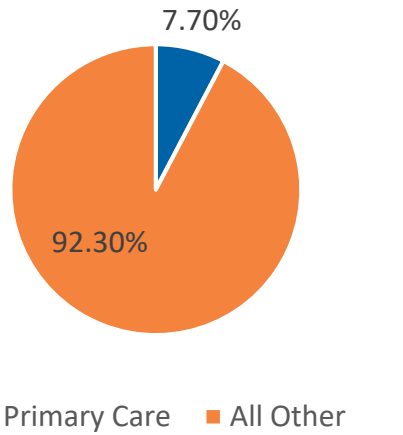
The physician fee schedule undervalues primary care

- Though in theory the Medicare fee schedule is based on a relative value scale, today's fee schedule is only loosely aligned with what we know improves health. Most notably, primary care is undervalued.
- Procedures, imaging, and other interventional activities - reactive care management - are valued higher than cognitive services aimed at managing and coordinating care effectively - proactive care management.

Medical and Drug Spending by PPO Plans, 2013-2014



Source: The Milbank Fund, 2017

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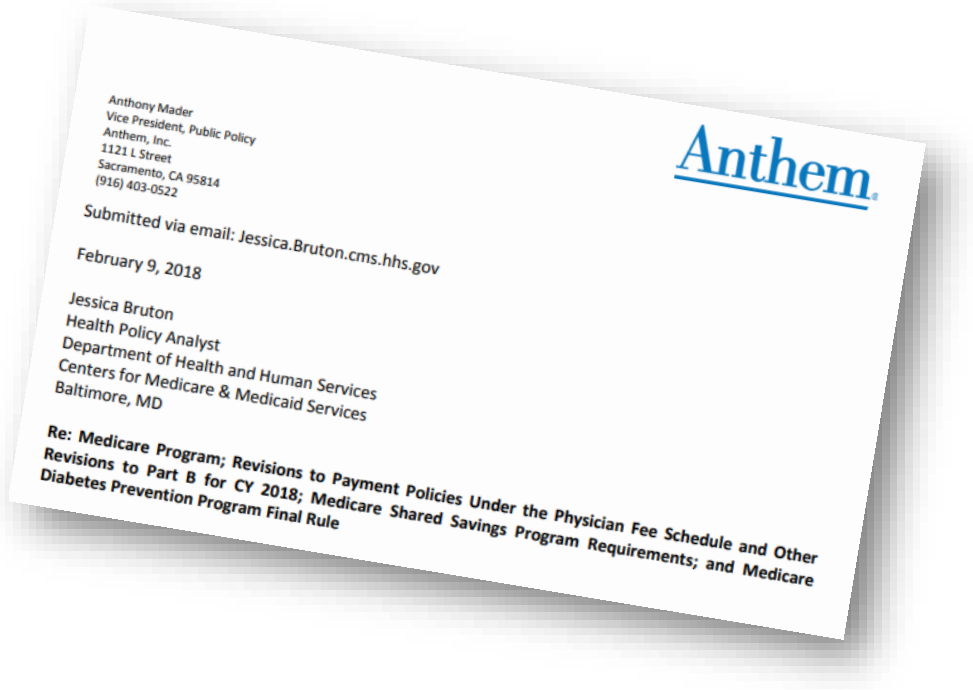
Who can make these changes

- CMS takes recommendations for revaluation under the Potentially Misvalued Codes Initiative, but routinely resorts to blanket fee schedule adjustments vs. targeted code reductions
- In February 2018, Anthem wrote to CMS to advocate for reevaluation of a set of services that we believe are overvalued.
- CMS is constrained from a regulatory perspective to a degree many private payers are not.
- We will continue to advocate for CMS action, but will also independently work address clear imbalances in our own fee schedule in an evidence-informed manner.



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Submitted via email: Jessica.Bruton.cms.hhs.gov

February 9, 2018

Jessica Bruton
Health Policy Analyst
Department of Health and Human Services
Centers for Medicare & Medicaid Services
Baltimore, MD

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program Final Rule

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Evidence-based care guidelines and specialists' own data will be our guide

- Third party researchers have identified portions of the fee schedule with clearly addressable time distortions
- Anthem plans to begin to address these distortions in our fee schedules, with input from external experts throughout the process
- Anthem's revaluations will happen through fee schedule updates and contractual negotiations.

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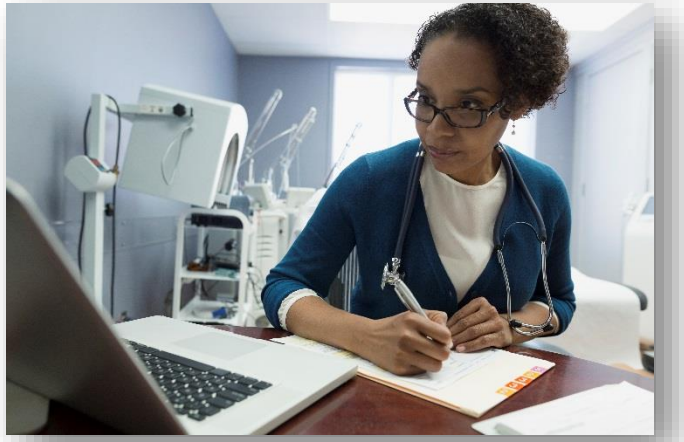
FFS Repricing is one component of a holistic payment redesign towards value

- We don't want to destabilize specialty practices – we want to ensure long-term success and promote collaboration between primary care and specialty practices.
- As we rebalance existing components of the fee schedule, we're simultaneously pilot new types of payments:
  - E-Consults to facilitate team-based care between specialists and primary care
  - Chronic care management codes to incentivize support for proactive condition management



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Thank you.

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