Provider Payer Partners

Accountable Care Organization 2.0

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Blue Shield of California

Innovation

"Nothing great was ever achieved without enthusiasm."

- Ralph Waldo Emerson

The development of an Office of Innovation is essential in today's Health Care Reform

What works today will NOT work tomorrow!

National recognition

Leading innovation and transforming provider relationships

"Most significant was the providers' willingness to work with Blue Shield in partnership rather than as adversaries across the bargaining table."

Managed Healthcare Executive
For decision makers in healthcare

"Simply by working together, the three were able to reduce the number of times patients had to be readmitted to the hospital by 15 percent."

The New York Times

"One of the oldest and largest ACOs in the country."

HealthAffairs

"This program is on our radar screen as one of the best examples of patient care in the country, and the kind of care that people elsewhere hope to enjoy in the future."

HHS.gov
U.S. Department of Health & Human Services

"Blue Shield is the ONLY health plan that has developed a model/structure that works – through this process we have been able to work with some of the best and brightest in the field."

- ***Facey/Providence***

"Dr. Stuart Levine has challenged our team to think in new ways around population management and how to realign critical clinical resources to improve our ability to impact quality and cost."

- ***AppleCare***

Here's what we're after with ACOs

Quadruple Aim

cost of healthcare ↓

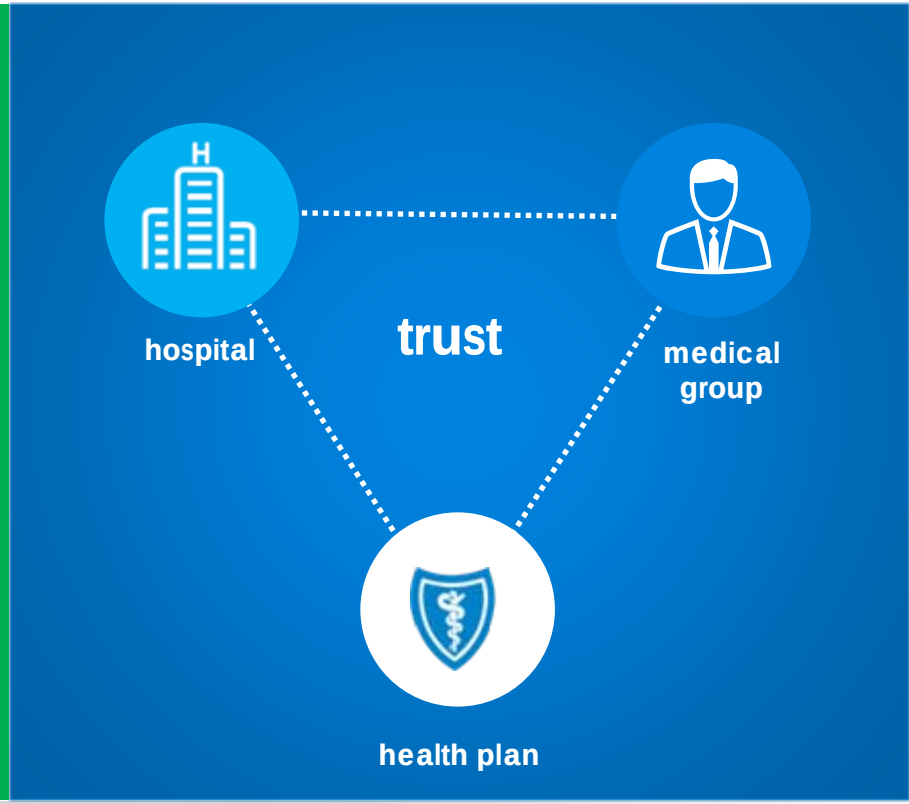
patient experience ↑

improved health quality outcomes ↑

provider satisfaction ↑

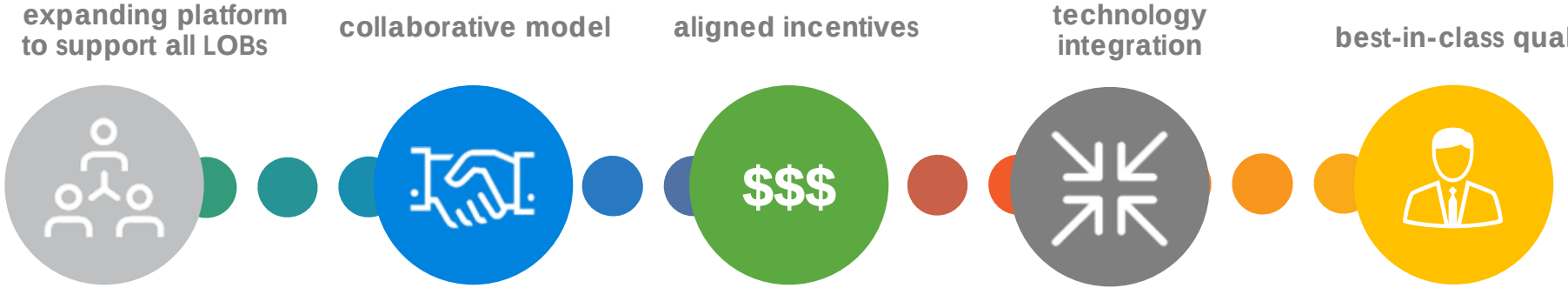
What Blue Shield means by ACO

- three-way partnership between the hospital, physician and health plan
- model built on partners with “will & skill”
- aligned incentives
- multi-year commitment
- senior executive level engagement and governance
- pass along savings to customers prospectively



How it works

Driving change through accountability, transparency and aligned incentives



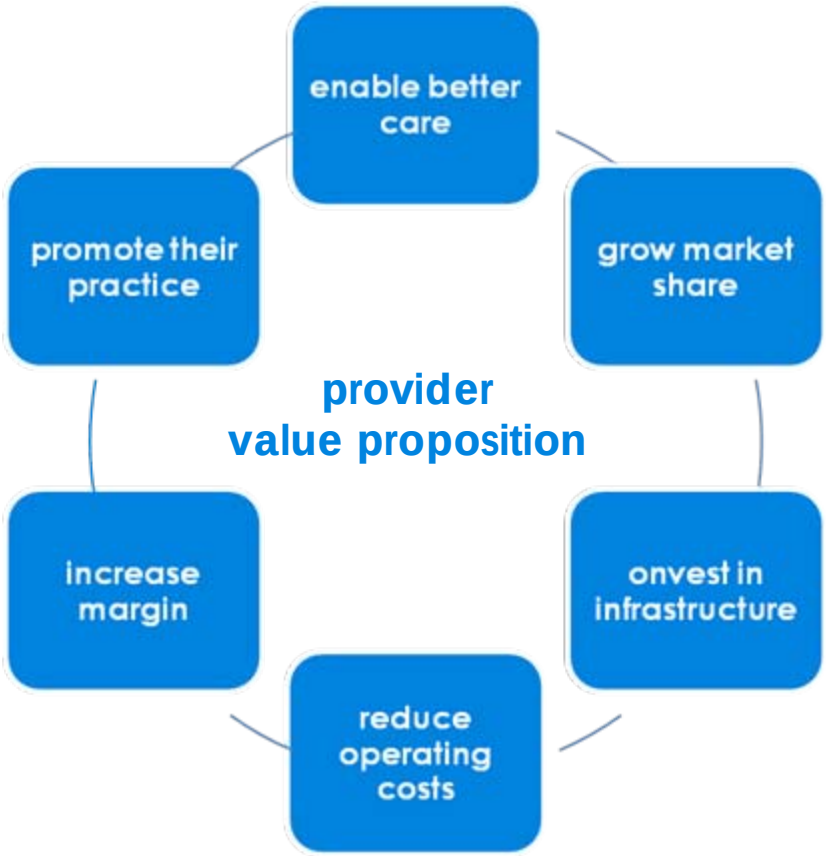
- To date built on HMO platform – now implementing for PPO and MA & MediCal
- Unique collaboration with medical groups, hospitals and Blue Shield
- Value-based payments and aligned incentives
- Data integration and information sharing
- Quality outcomes and member satisfaction

Reward what matters

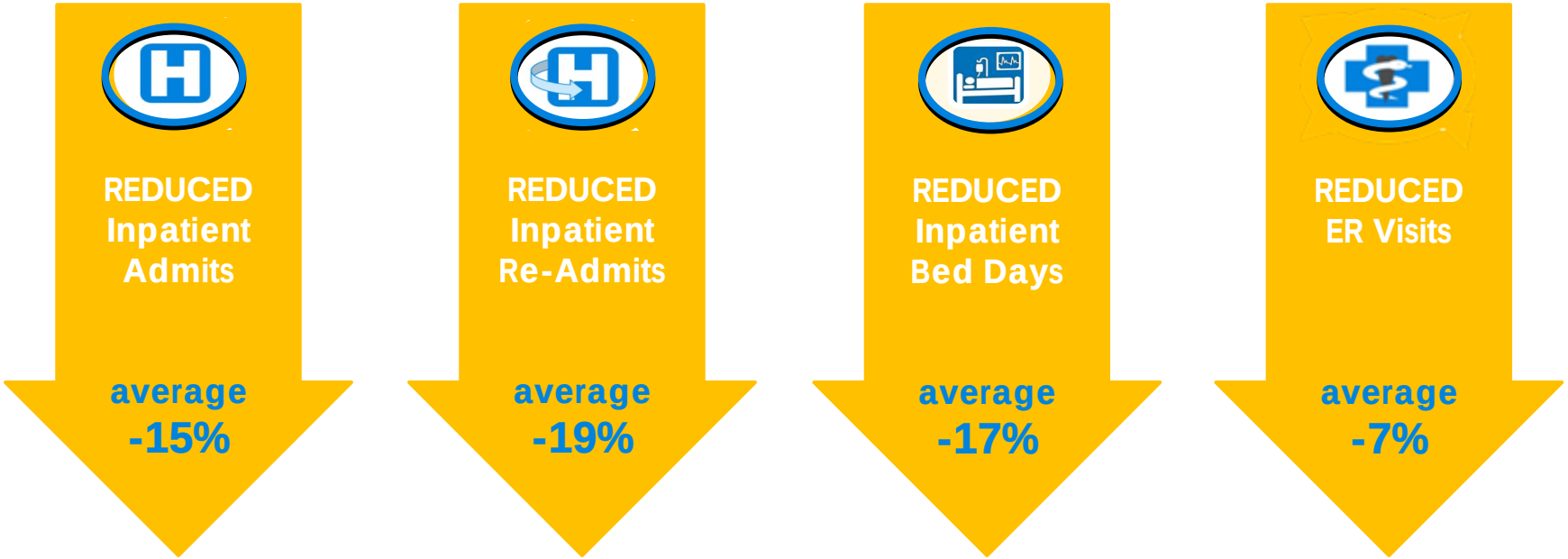
A new provider compact

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 Program overall results to date



Together, ACO partners are delivering great results

The ACO program is delivering significant results across multiple markets and provider organizations.

Annualized Non-ACO
7.1% annualized trend

Annualized ACO
4.0% annualized trend

$313 million aggregate savings

Where are we now?

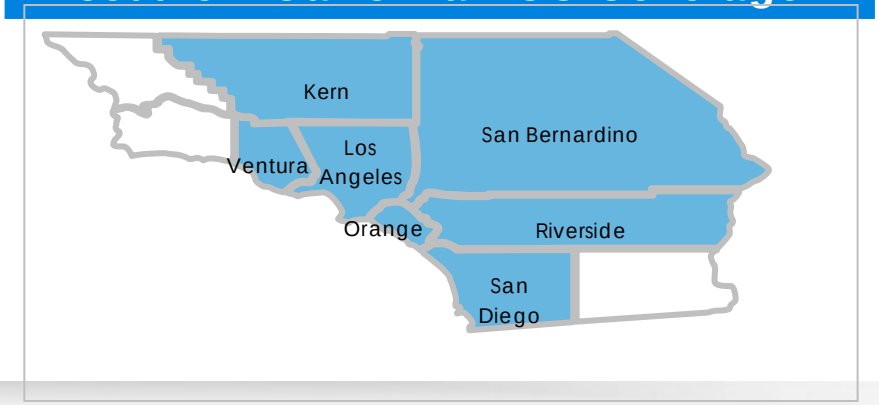
33
ACOs in 19 counties

Nearly 300K members today

50% membership by 2018

Blue Shield ACOs Today			
ACO	Number	Regions Covered	Members
HMO	24	17	282,000
PPO	7	6	9,100
Medicare	2	1	4,000
Total	**33**	**19**	**295,100**

Southern California ACO Coverage



With our ACO partners, we've been able to:

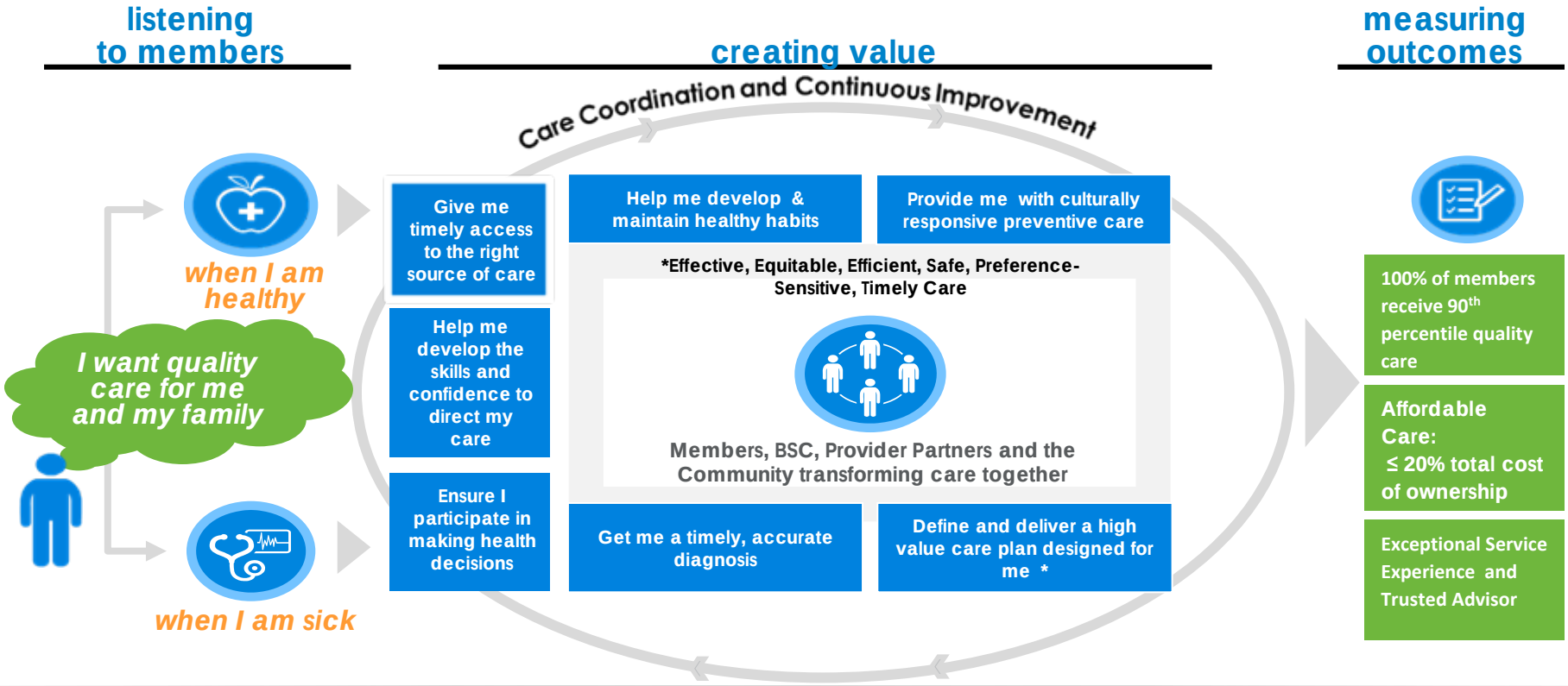
- Deliver care at below-market cost trends
- Improve the quality of care for all patients across all lines of business
- Achieve financial results that are sustainable for all parties

- Find and implement cost and quality improvements
- Enhance the awareness & appeal of value-based programs to consumers and employers

So far, so good . . . But we need to do more

We must **deepen our partnerships** in order to transform the healthcare delivery system, grow our market share & **provide care that is worthy of our family & friends**

Together we must deliver care that is worthy of our family & friends…

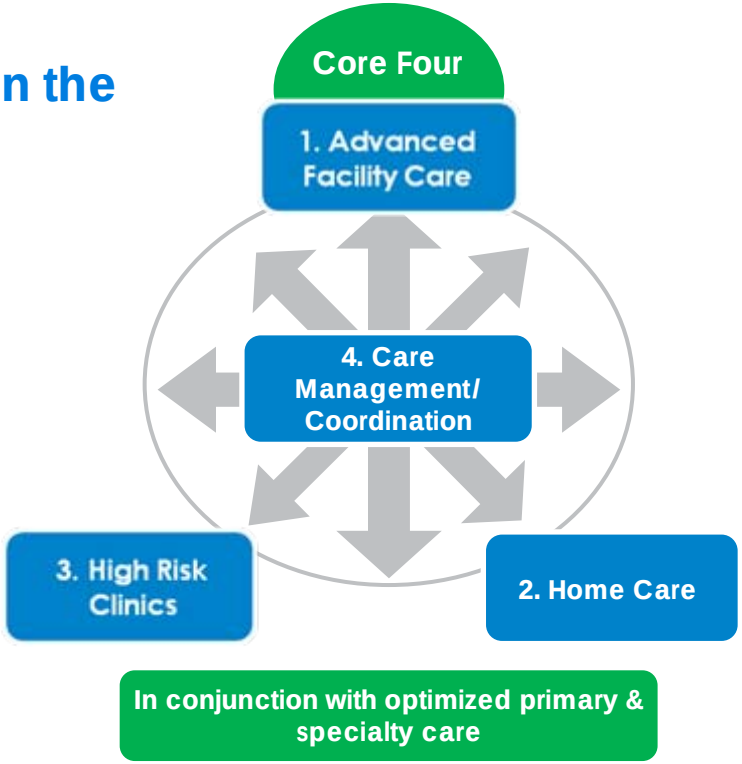


Shared clinical strategy

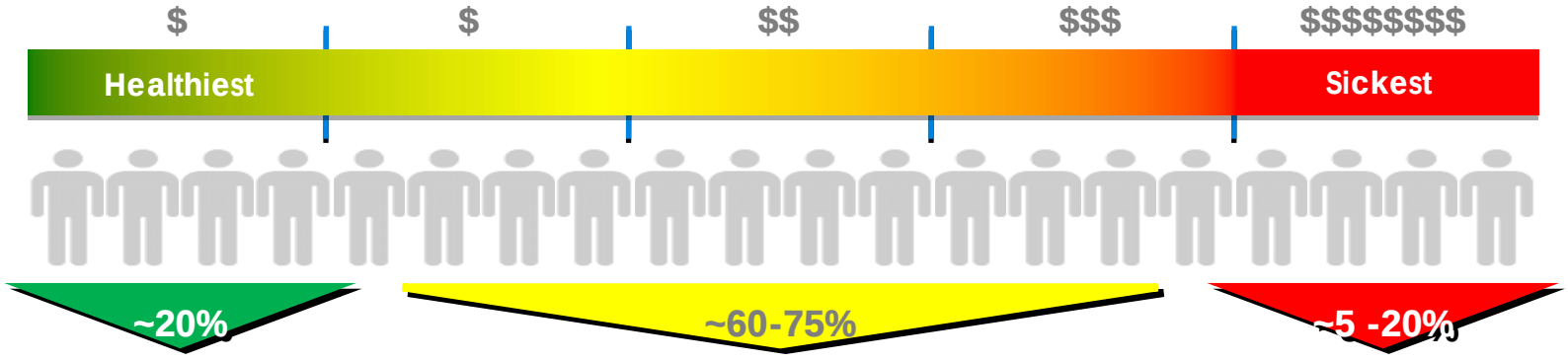
By deepening our partnership and **focusing on the Core Four**, we will improve the quality and experience of care... leading to membership growth.

Together we can:

- Improve day-to-day patient care and provide consistent "patient-centric service"
- More effectively manage the most challenging and complex patients
- Free up provider time, thus resulting in improved patient engagement and outcomes
- Improve quality of care, resulting in decreased utilization and increased margin



Improving care for the sickest patients is critical



1. Advanced Facility Care

healthiest patients = wellness and self care

caring for the most complex = dollars and bandwidth to invest in primary care

2. Home Care

3. High Risk Clinics

4. Care Management & Coordination

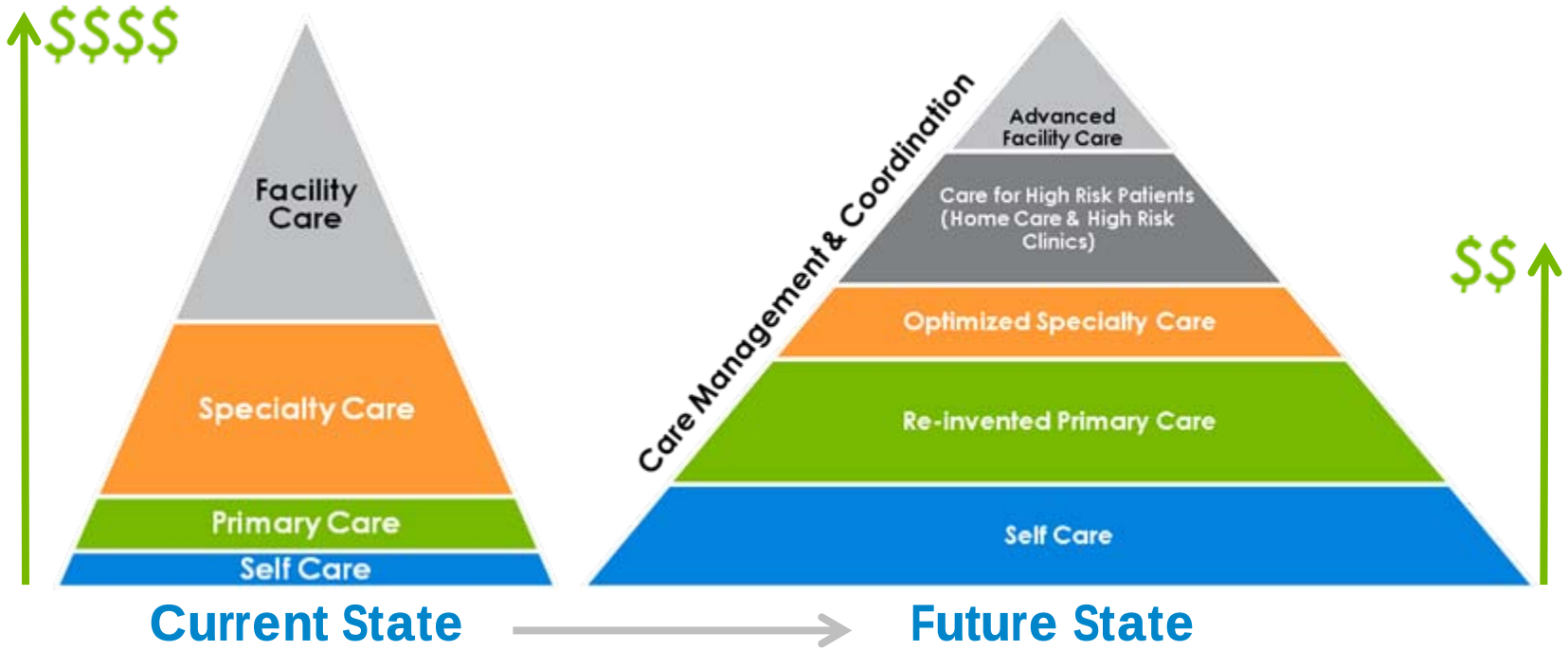
CORE FOUR

Optimized Primary & Specialty Care

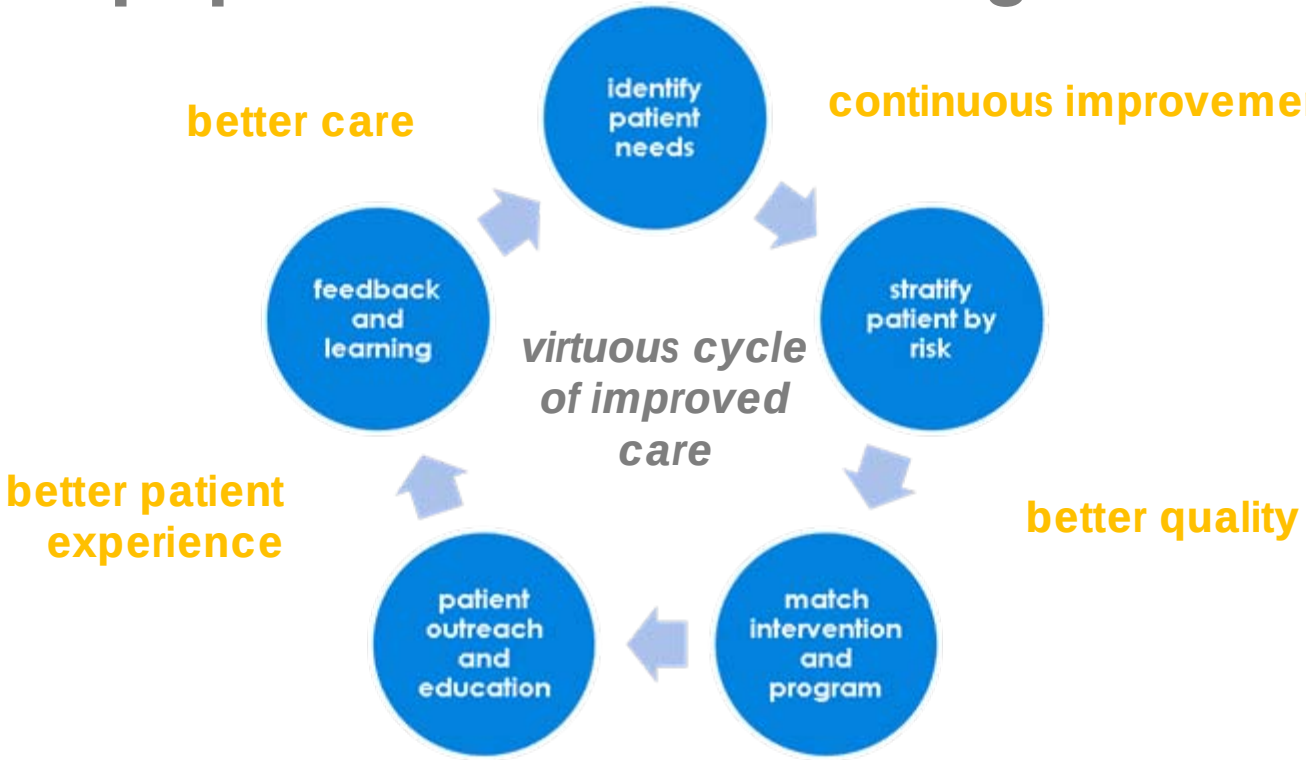
Health Education, Wellness, Decision Support, Preventive & Self Care

What do we mean by deepening our partnership?

Driving savings to improve care & grow market share



Proactive population health management



Stratifying patients into the appropriate clinical program

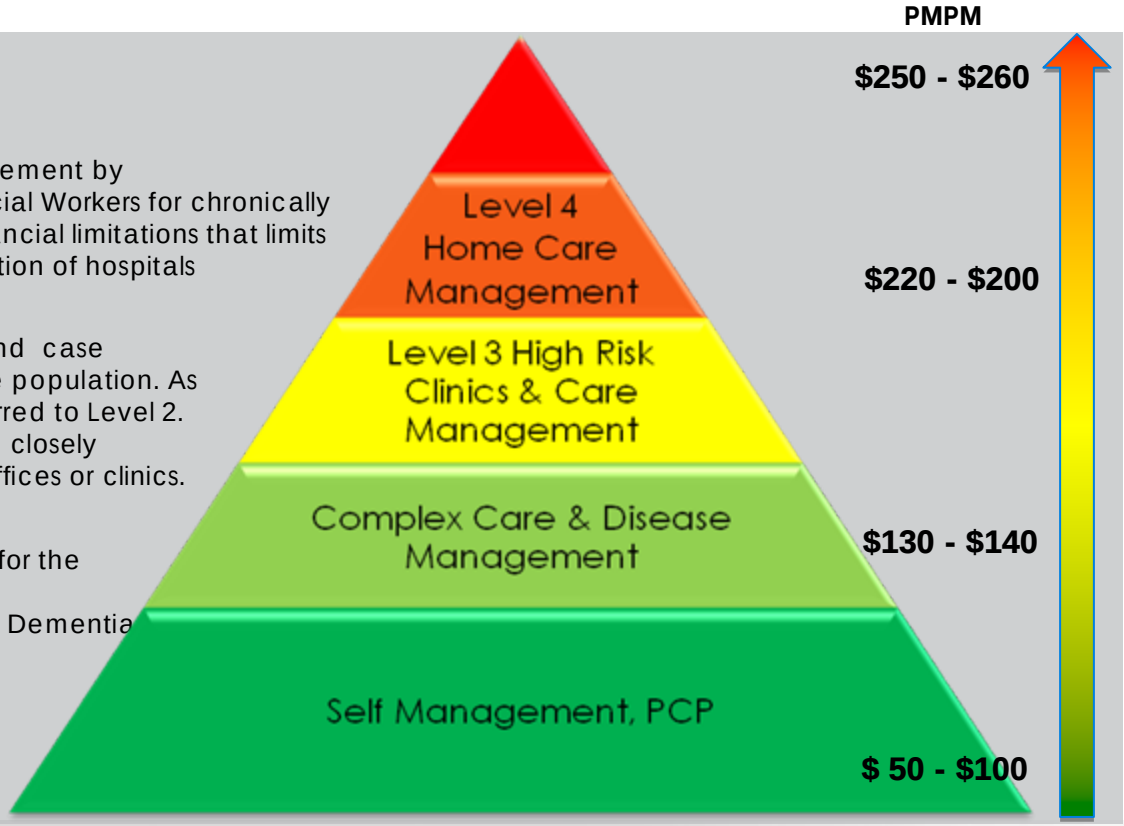
Hospice/Palliative Care

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.



Applying six pillars of care

Advanced technology integration into all aspects of care delivery is a critical success factor- CalIndex and patient/ physician portals

patient centric risk stratification matched with care intensity

- *Embedded CM/ Health Coaching*
- *Patient Engagement & Education*
- *Preventative Care*
- *Self-Care*
- *Retail Clinics*

- *Specialty Practice of the Future*
- *Innovative Contracting*

- *Complex Case & Disease Management (in person/ telephonic)*
- *Care Transitions*
- *Patient Advocates & Health Coaches*
- *Cross-functional Care Mgmt Team*

8-12% of seniors
2.5 – 3.5% commercial

- *Long Term "Geriatric" / Chronic Condition*
- *Short Term (6 months or less): Chronic Pain, Cardio, Ortho, Oncology, Behavioral Health*
- *Group Visits / Specialist Collaboration: CHF, COPD, Diabetes*
- *Post Discharge Clinic*
- *Free Standing Infusion Centers & Wound Care*
- *Retail Clinics->AICU*

6-8% of seniors
1-2% commercial

- *Palliative Care / Hospice*
- *ESRD Medical Home*
- *Long Term Home Care*
- *Intermediate Home Care*
- *Short Term Acute Care Transitions /Trauma Care*

2-4% of Seniors
.5% commercial

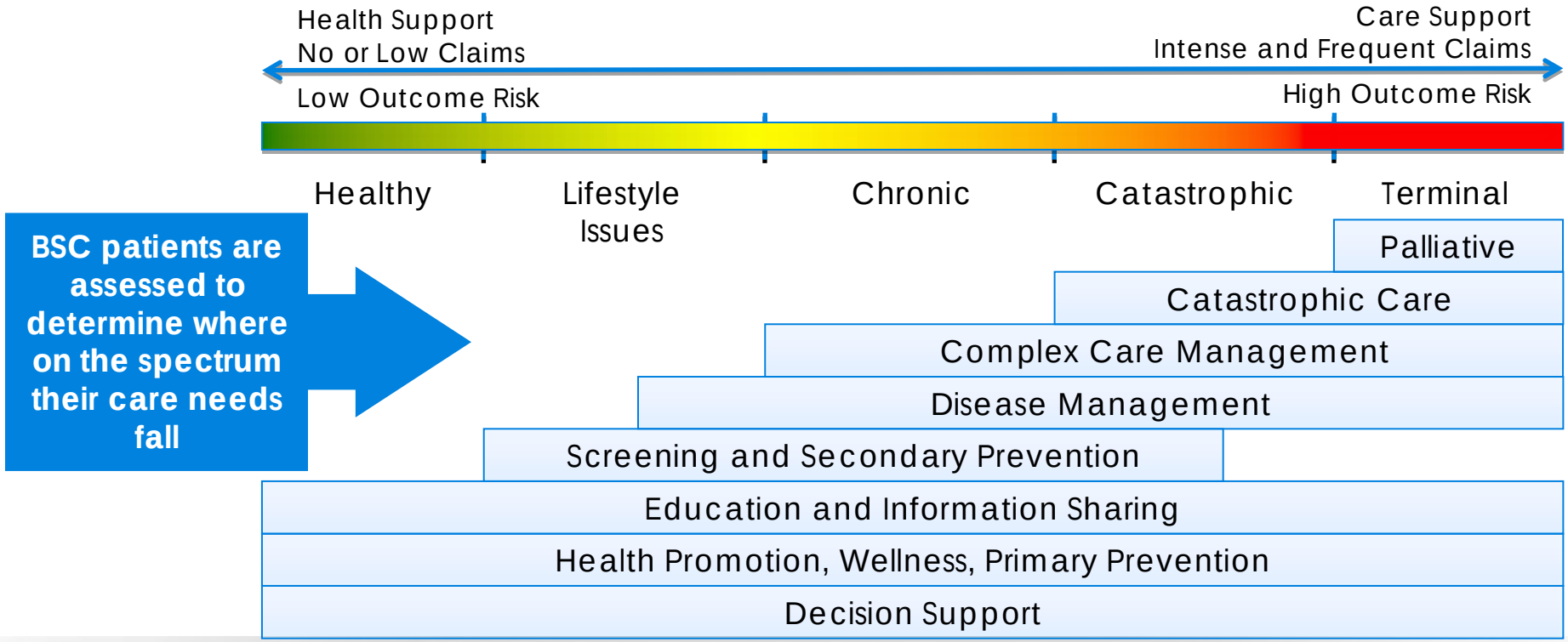
1. Primary Care
2. Specialists
3. Care Mgmt
4. High Risk Clinics
5. Home Care
6. Facility Based Care

Low Outcome Risk / No or Low Claims — **Intense and Frequent Claims / High Outcome Risk**

$50-$100	$100 - $200	$200 - $250		$300 - $350*
Healthy	Lifestyle Issues	Chronic	Catastrophic	Terminal

**Per patient treated per month; MMI cost is repurposed ~10-15% premium investment to achieve at least ~$500M in hospital savings*
~7-10: 1 ROI to reduce total Cost of Care

Stratifying patients into the appropriate clinical program (continued)

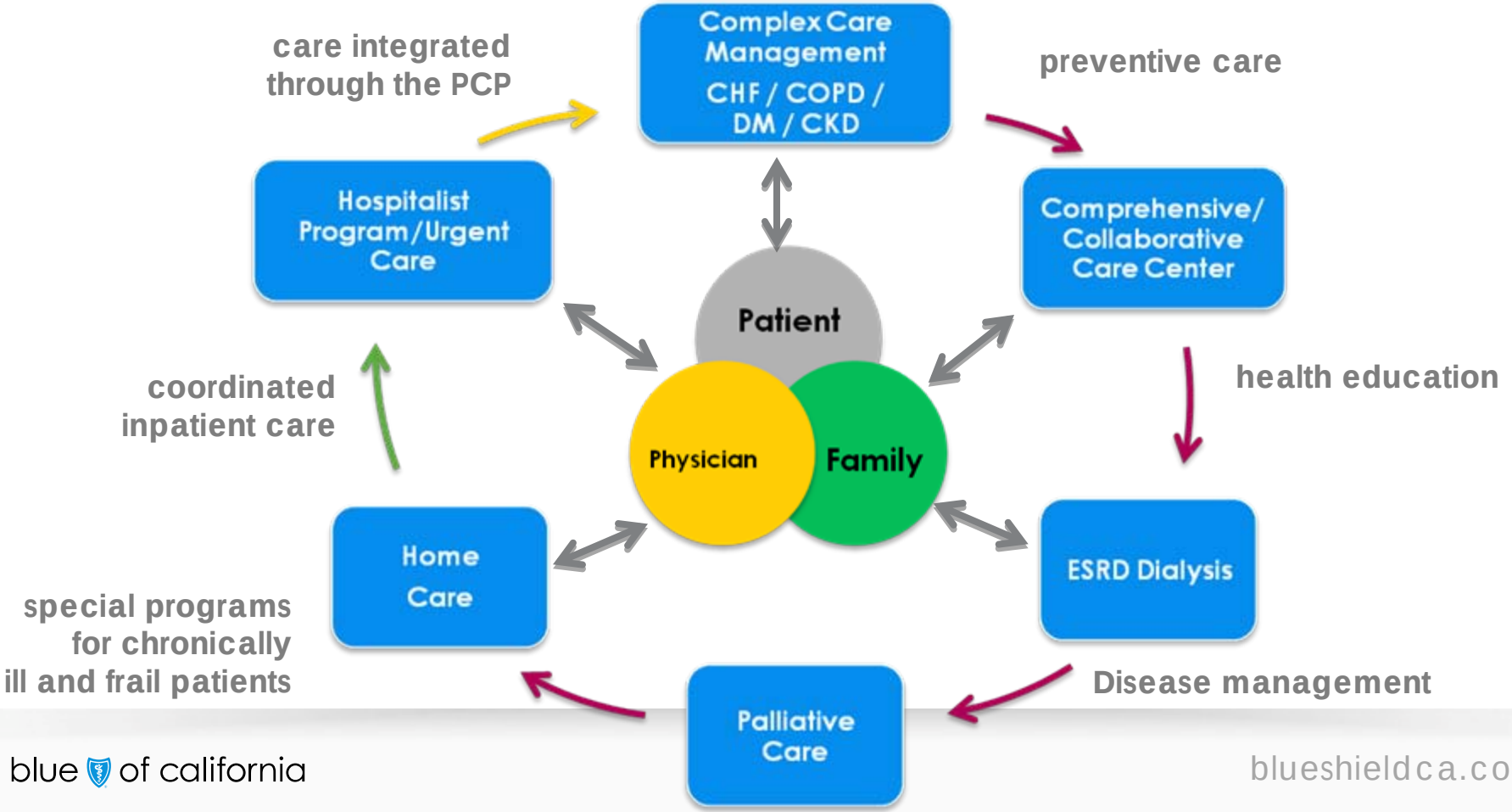


Physician risk stratification

Employed	Contract
"Great" ▪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%	**"Excellent"** ▪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%
"Good" ▪Embed Care Mgmt. ▪Shift 5% – 8% Seniors/ 1.5-2% Comm*	**"Average"** ▪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

Care coordination model



Care coordination achieving patient engagement and family empowerment

Care Coordination is a collaborative process between providers, clinic care teams, care coordination nurses, social workers and other members of the health care delivery team.

The Care Coordination process involves:

- ✓ Patient outreach
  - Proactive coordination of risk-stratified, high-priority patients.
  - Event-triggered outreach following IP admission or high risk ED utilization.
  - Physician-identified at-risk patients.
- ✓ Assessment and identification of health concerns
- ✓ Development of individualized care plans in collaboration with physician and continued monitoring of the plan's effectiveness
- ✓ Active and engaged follow up beyond the 'four walls of the clinic', along the full continuum of care.

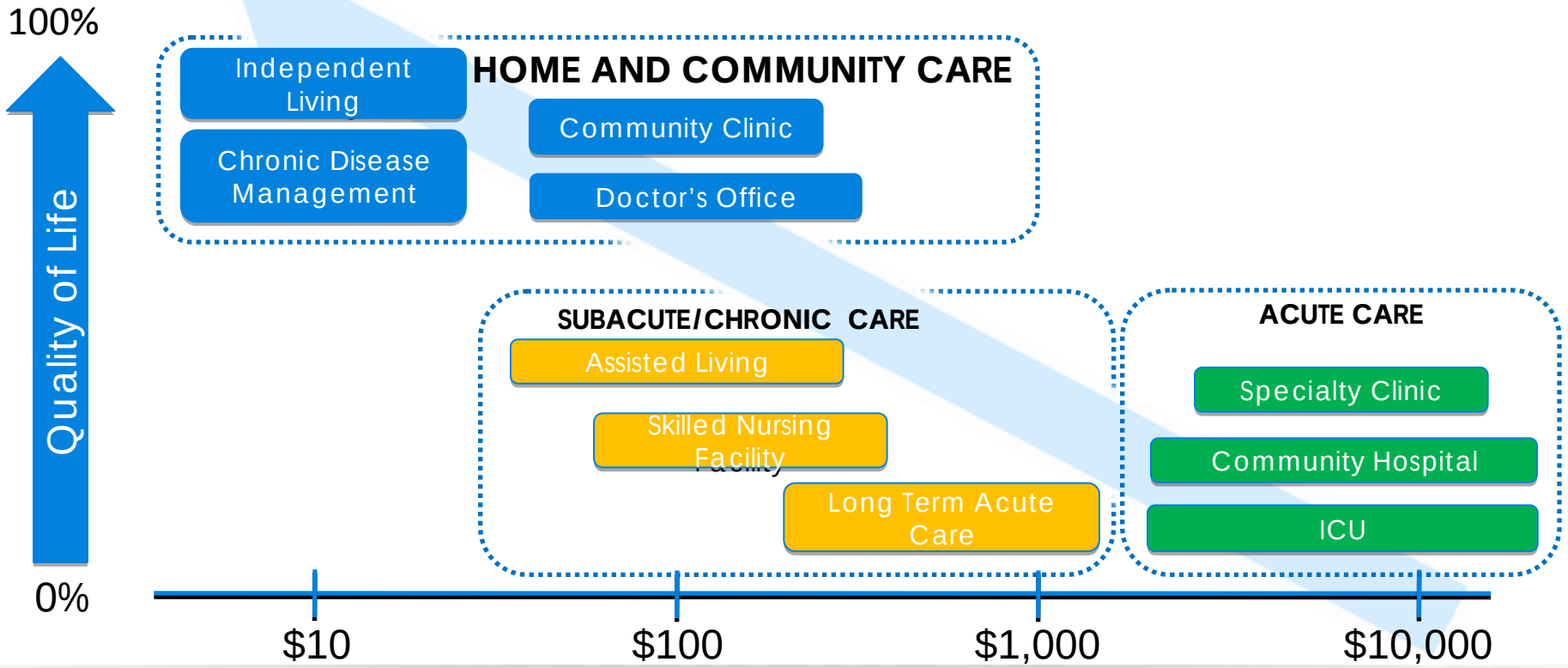
Improving performance with ACO providers

Leveraging the Medical Management Inventory Tool to drive change

Medical Group Name:	(GROUP NAME)	
Date Assessed:	(DATE)	
CRITICAL FACTORS	**MAX POINTS**	**Score**
CATEGORY 1 (45 points)		
Hospitalist (Acute Hospital) - 12 points	12	
Hospitalist (SNF) - 8 points	8	
Hospital Care Management Program - 11 points	11	
Post Hospitalization/High Risk Clinic - 10 points	10	
Hospital - 1.5 pts	1.5	
Medical Director Leadership - 2.5 pts	2.5	
Total	**45**	
CATEGORY 2 (39 Points)		
Urgent Care Centers and Specialty clinics - 6 pts.	6	
Ambulatory Case Management Program - 33 pts.	33	
Total	**39**	
CATEGORY 3 (16 point)		
Physician Report Card/Incentive System - 16 pts.	16	
Total	**16**	
Final	**100**	

Medical Group Name:	(GROUP NAME)	
Date Assessed:	(DATE)	
Score indicates effectiveness in reducing cost		
CRITICAL FACTORS	**MAX POINTS**	**SCORE**
CATEGORY 1 (45 points)		
Hospitalist (Acute Hospital) - 12 points		
1. Case Load per Hospitalist = 1:12 pts.	1	
2. Hospitalist Coverage on-site 7am-7pm	1	
a. Hospitalist Coverage on-site 7pm-7am	1	
b. Hospitalist Coverage Monday - Friday only	1	
c. Hospitalist Coverage Sat. Sun.& Holiday	1	
post Hospitalization/High Risk Clinic - 10 points	1	
3. ER Intercept Program at Primary Hosp	1	
a. ER Intercept at Adjoining Hosp within 5 miles	1	
b. Hospitalist Available for Evening/Family Rounds	1	
4. Employed vs. not Contracted	2	
5. Contracted differential Case Rate Pay net for ER Intercept	1	
Subtotal	**12**	**0**

Value proposition for the healthcare system of the future



What care transformation looks like

Advanced Facility Care

- hospitalists and SNFists
- reduced admissions, readmissions and length of stay
- care coordination
- reduced ER visits
- care transitions
- improved quality and patient experience
- medication reconciliation

What care transformation looks like

Home Care

- care for chronic conditions
- reduced admissions
- medication management
- reduced patient deaths in the hospital
- palliative care
- reduced total hospital days
- care transitions

What care transformation looks like

High risk clinics

What care transformation looks like

Care Management / Coordination

- disease management
- reduced admissions
- complex case management
- reduced ER visits
- care transitions
- improved patient engagement/ satisfaction
- team-based care

At the end of the day . . .

We have a historic opportunity to transform health care

to build a better delivery system together from the inside out

blue of california