Rewarding Care Management at the Point of Care

Value-Based Payment and Pay for Performance Summit

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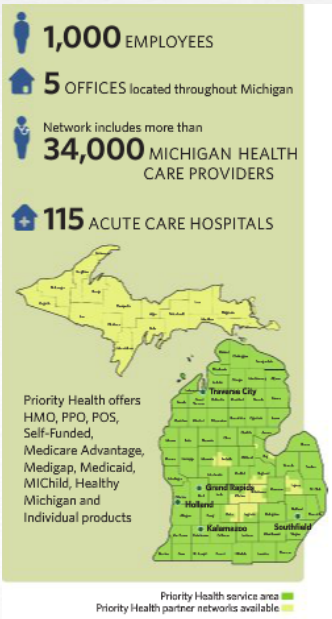
- Health plan of Spectrum Health
- 30 years experience
- 700,000+ members
- Introduced physician incentives in 1997



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PCP incentive program
Guiding principles

- Promote quality/efficient care
- Engage providers and staff
- Standard measures and “excellent” targets
- Provide actionable data
- Disclose performance

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PCP incentive program design

- Practice group measurement
- All products
- Reward based on patients in measure
- No minimum membership requirements
- HEDIS 90th percentile targets

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2015 PCP incentive program

- 23 measures
- $29M budget ($3.80 pmpm)

2007 National Driving Value in Health Care Award

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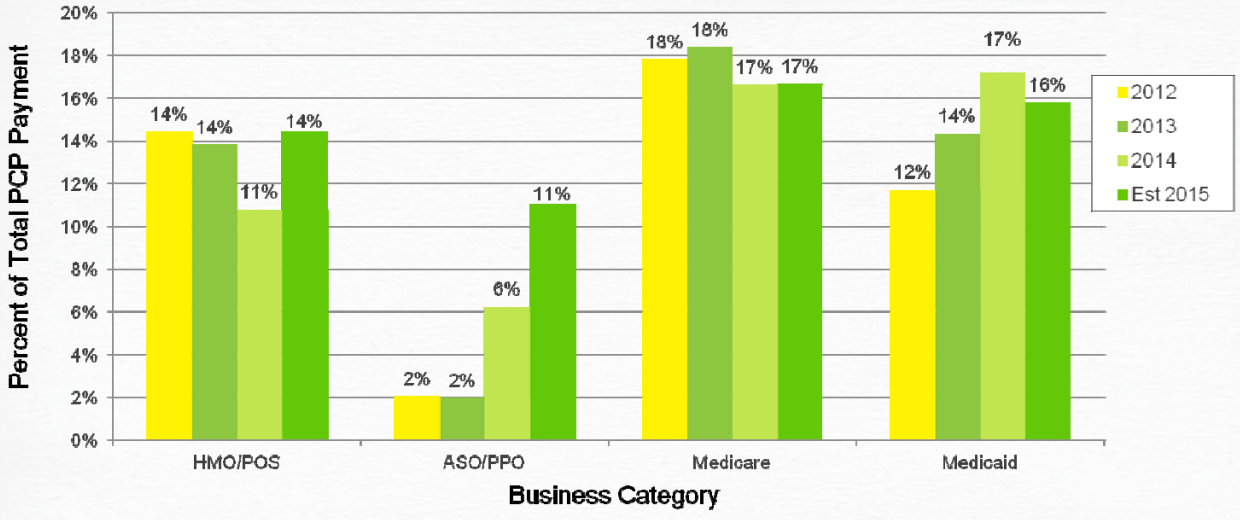

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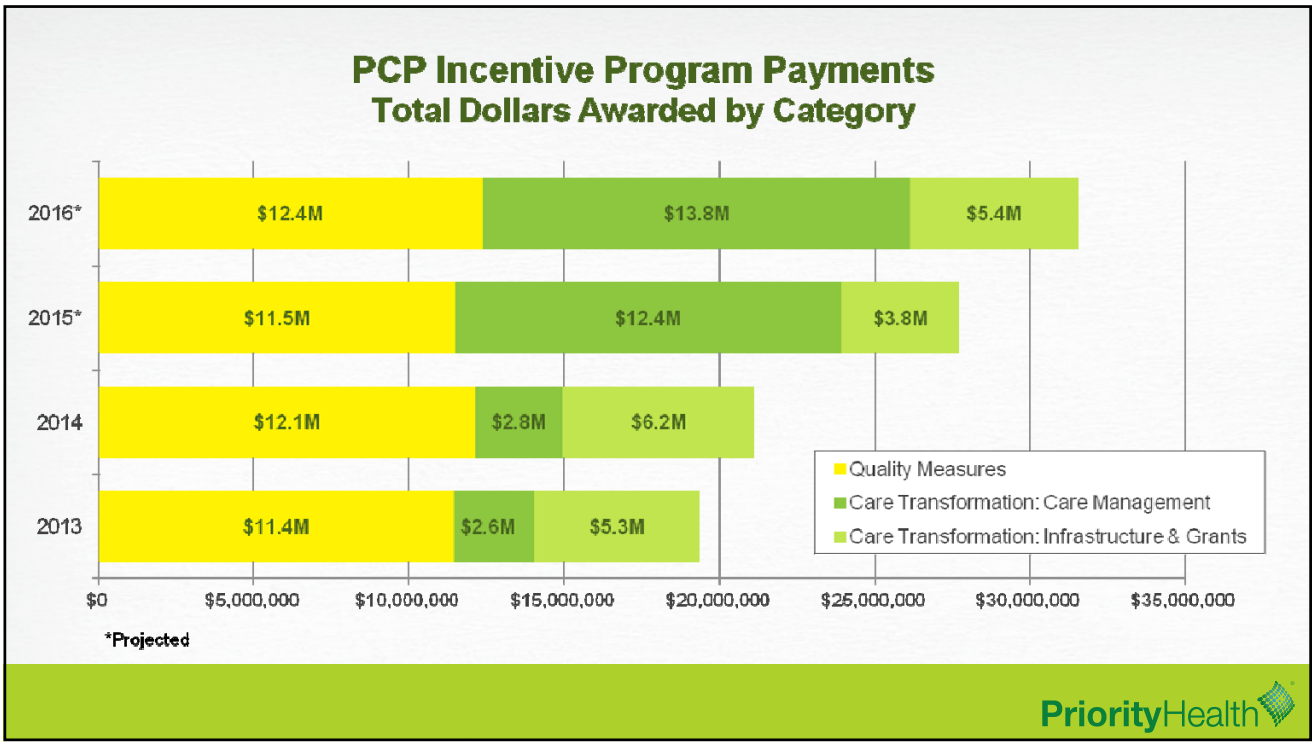
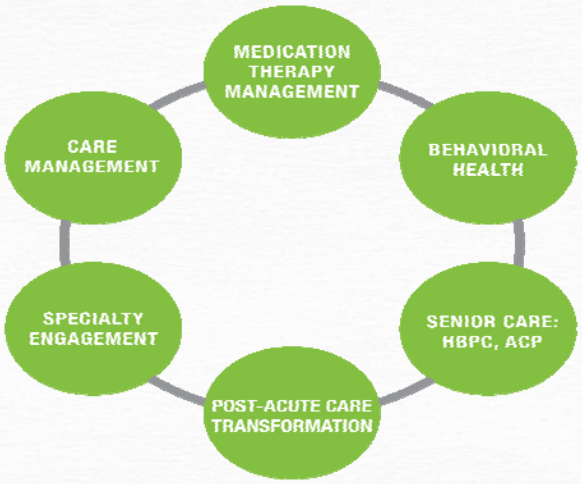


Chronic disease management plan

Working with providers to change care delivery



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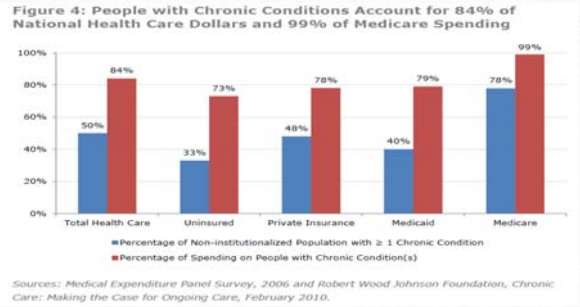
The Business Case for Care Management Expansion

More than half of Americans suffer from one or more chronic diseases. Each year millions of people are diagnosed with chronic disease, and millions more die from their condition. By our calculations, the most common chronic diseases are costing the economy more than $1 trillion annually - and that figure threatens to reach $6 trillion by the middle of the century.
Yet much of this cost is avoidable.

Clinical and Economic Risk demands population health focus



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Transforming the Model of Care

The business and clinical case supporting Point of Care Collaboration

Care Management is recognized as a central force in the management of care – coordinating the coordinators is a critical effort so as to optimize scale, and avoid duplication.

- Promote broader management of the complex chronically ill and rising risk
- Close gaps in care
- Drive alignment of care management to the medical home (care plan, EMR, provider)
- Offer patients options based on how they prefer to engage
- Risk based contracts demand that providers understand their population

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Care Management Incentive:
Purpose

- Promote broader care management engagement
- Promote continuous improvement
- Sustainability (revenue through billing)

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Care Management Incentive:
Program requirements

- Care manager(s) in practice site
- Trained with nationally recognized programs
- Licensed as qualified health professional
- Team-based care
- Risk stratification for patient selection
- Integration with health plan care management

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Care Management Incentive:
Program measurement

- ≥ 2% of unique health plan members
- Based on billed claims for CM services
  - Telephone assessment & management services
  - Complex chronic care coordination services
  - Transitional care management services

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Care Management Incentive:
Reward

$3.25 pmpm for practice groups achieving target

- 2015 projected payment ~ $12,090,000

Billed claims for care management services

- 2015 projected payments ~ $ 2,260,000

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Supporting our Point of Care Partners

- Provide financial support through incentives and reimbursement
- Offer enhanced targeting lists(risk stratification) to help practices better understand their population and identify gaps in care
- Foster initial and ongoing training in the art and science of care management
- Enhance patient engagement techniques through motivational interviewing training
- Provide tools that show progress toward attainment of the CM engagement threshold
- Guide and optimize interventions through CM effectiveness data

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What challenges did we face?

- Varying degree of adoption readiness
- Limited risk stratification capabilities to identify patients who are clinically and economically appropriate
- Finite resources must be well purposed to promote scale and reduce duplication
- Care Managers may lack experience in the art and science of CM
- Initial construct may be disease specific rather than patient centered, limiting holistic management
- Billing challenges
- Measurement and evaluation capabilities are limited

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Care Management Effectiveness

What does success look like?

Process:

All high risk and rising risk members have CM services in alignment with their need and the manner that they prefer to engage.

Outcomes:

Effectiveness studies reveal clinical and financial benefit of care management

- Reduce avoidable utilization
  - Flat/negative IP/ED trends
  - Flat/negative total cost of care trends
  - Improved clinical outcomes
  - Improved member experience

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Practice Site Example

Total Members	905
Members w/CM Service	58
Percent of Members with CM Services	6.4%

Type of Care	Billed Services	Payments
Transitional Care	3	$ 875
Coordinated Care	91	$5,500
Telephone Services	176	$3,280
Total Billed Services	**270**	**$9,655**
Physician Incentive		**$35,290**

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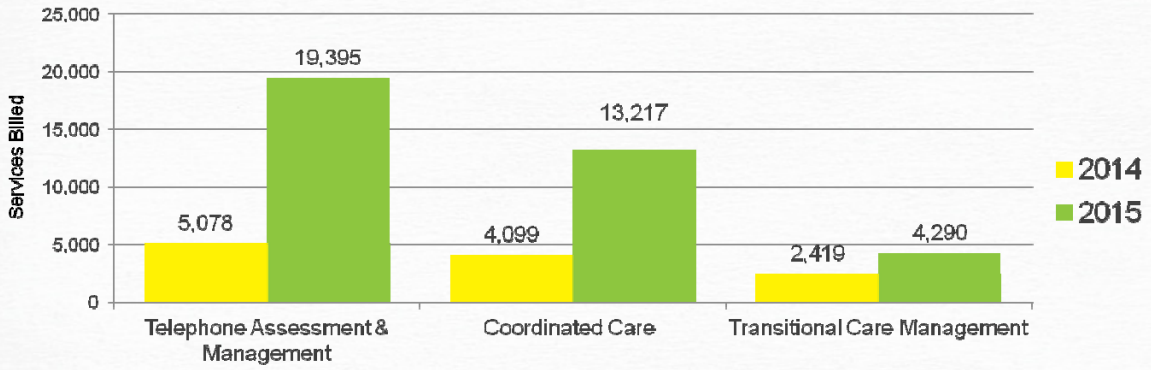
Results:

Billed services by category



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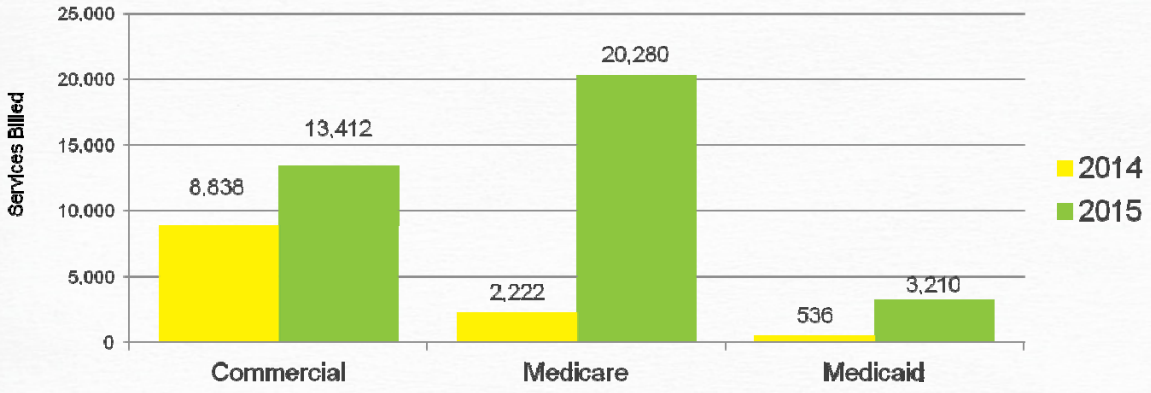
Results:

Billed Services by product



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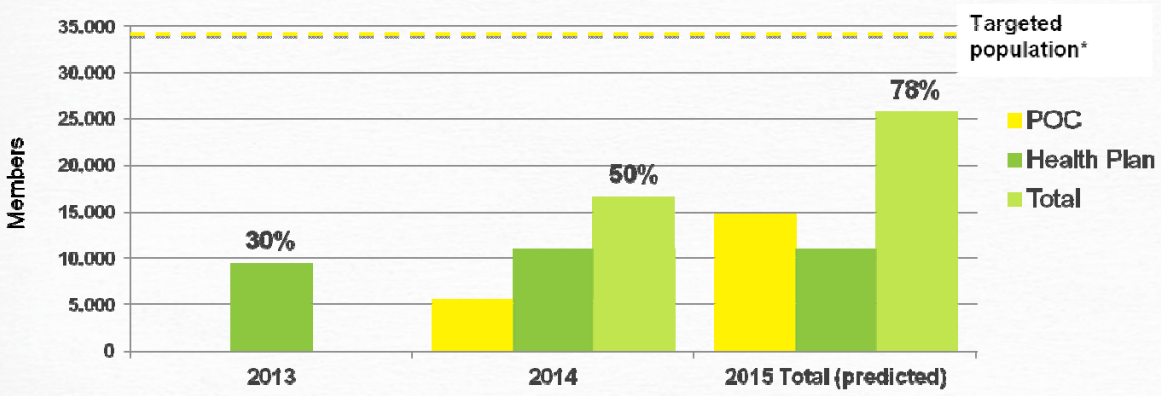
Results:

Closing the gap – total Priority Health population



* Highest risk members as determined through enhanced targeting reports

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Results:

Care management at the point of care

Average of ~50% increase in membership in practices with CM year over year

163% increase in unique members managed year over year

2013

144 - PCP practice sites

166,700 - members in practice sites with CM

2014

240 - PCP practice sites

225,000 - members in practice sites with CM

5,600 - unique members managed

2015

345 - PCP practice sites

370,000 - members in practice sites with CM

14,700 - unique members managed

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Care Management Incentive:
2016 measure update

- Exclude transitional care services from measure
- Increase percent of members with billed services from 2% to 3%
- 8 hours of continuing education

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Next Steps

- Measure program effectiveness
- Target high-risk members incentives/reimbursement
- Develop sustainability through direct reimbursement
- Develop health plan onsite care management training center
- Develop payment consistency with CMS and other payers
- Move to shared risk to reward cost savings of care management

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A healthier approach to health care®