Sixth National P4P Summit

Shaping Payment Innovation Through P4P Lessons Learned

Skip Walker, MD, Payment Innovation

Brent Higgins, MHA, Payment Innovation

Mike Belman, MD, MPH, Clinical Quality and Innovations

Robert Krebbs, Payment Innovation

Session 3.8
March 25, 2011

Agenda

Presentation Objectives:

- Background – Brent Higgins
- California Physician P4P – Mike Belman
- Enterprise Hospital P4P – Robert Krebbs
- Payment Innovation / ACOs – Skip Walker
- Drawing Conclusions – Brent Higgins
- Questions

Our Strategy

OUR MISSION

- Improve the lives of the people we serve and the health of our communities

OUR OBJECTIVES

- Create the best health care value in our industry
- Excel at day-to-day execution
- Capitalize on new opportunities to drive growth

OUR CORE VALUES

- Customer First
- Integrity
- Personal Accountability for Excellence
- One Company, One Team
- Continuous Improvement

Objective:
Create the best health care value in our industry

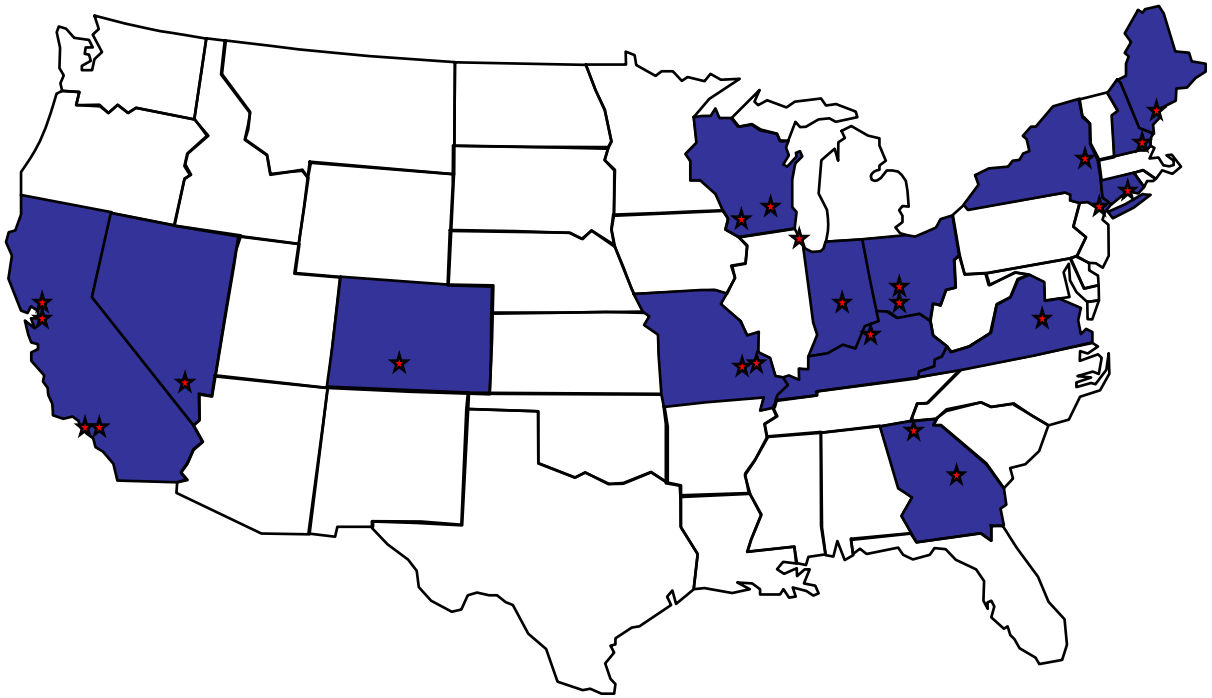
What we need to do:

- Manage cost of care for total cost affordability
- Drive innovation in paying / partnering with providers to drive improved cost, quality and health
- Find new, effective ways to manage risk and engage the member as a consumer

How does WellPoint create the best Health Care Value in the industry?

Market Overview

WellPoint Markets



Quick Facts

- 33.5 million members
- 14 Blue Plans
  - 2000's M&A
- 11% of US population has Anthem benefits

Framework Goals

- Scalability
- Flexibility
- Consistency

How do market dynamics shape the structure and strategy around P4P and other payment innovation initiatives?

Challenge Overview

System Challenges

Cost

- Rising premiums
- Volume

Delivery

- Fragmentation
- Quality

Market Dynamics

Cost

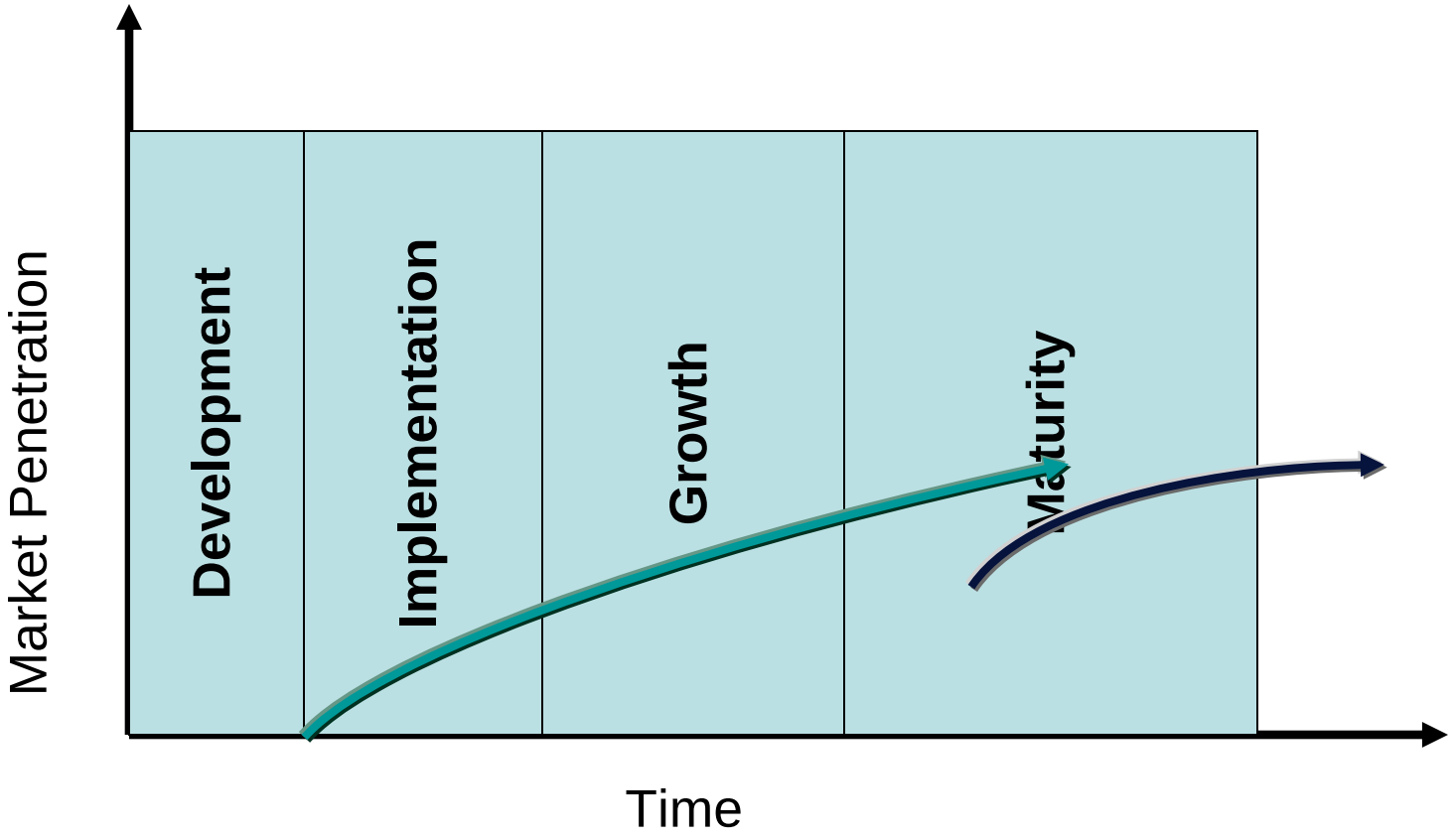
- Perverse financial incentives
- Geographic variation

Delivery

- Diverse markets, provider integration
- Quality
  - Member demographics
  - Unique market “cultures”

Is there a single solution to address system and market challenges?

WLP P4P Growth Cycle



What is the long-term value proposition of P4P? How does evolution impact viability?

How are P4P lessons learned used to create industry leading reimbursement methodologies?

California Physician P4P

Mike Belman, MD, MPH

Medical Director

Clinical Quality and Innovations

Introduction

- Integrated Healthcare Association (IHA) 9th year of statewide management
- Over 200 groups and IPAs in the program
- Incentives from 7 California health plans
- Metrics include Clinical quality measures, Patient Assessment Survey and Health IT Meaningful Use
- Shared Savings Program added in MY2007

Question:

- Have we improved quality in Anthem?
- Have we improved quality in low performing regions?
- Have we improved Anthem Blue Cross quality rank relative to National Health Plans?

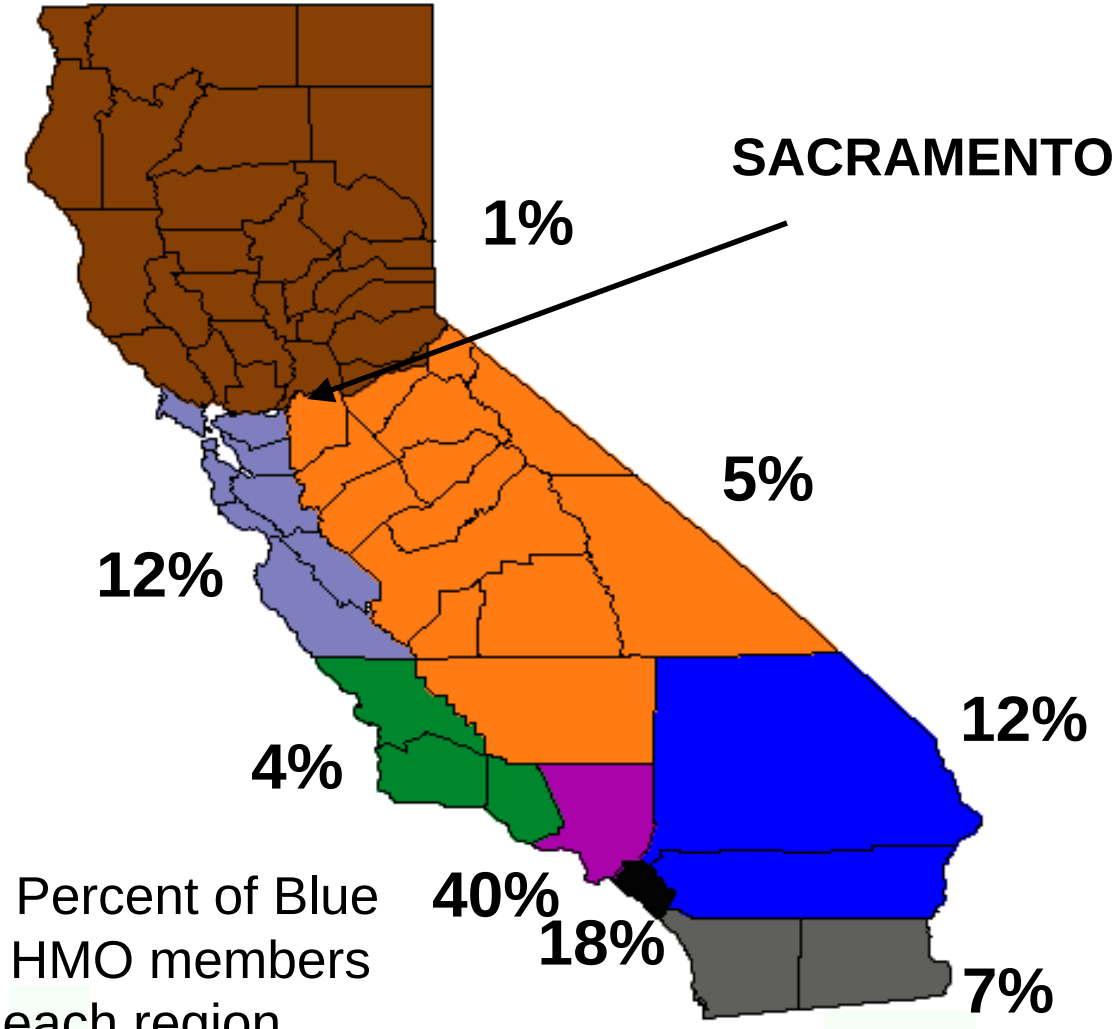
P4P Bonuses in California - IHA

P4P PAYMENT SUMMARY
FOR CALIFORNIA COMMERCIAL HMO AND POS
FOR MEASUREMENT YEAR 2008 – MEASUREMENT YEAR 2010

	Measure-ment Year	Aetna	Anthem Blue Cross	Blue Shield of California	CIGNA HealthCare of California	Health Net	United HealthCare /Pacificare	Western Health Advantage
Total Budget for IHA P4P Measures	2008	$2.2 M $0.51 PMPM avg	$25.5 M $1.64 PMPM avg	$12.5 M $0.98 PMPM avg	$2.70 M $0.87 PMPM avg	$3.5 M $0.25 PMPM avg	$4.88 M $0.51 PMPM avg	$0.42 M $0.57 PMPM avg
	2009	$2.2 M $0.51 PMPM avg	$23.4 M $1.63 PMPM avg	$13 M $1.09 PMPM avg	$2.30 M $0.97 PMPM avg	$3.55 M $0.28 PMPM avg	$3.6 M $0.50 PMPM avg	$0.418 M $0.51 PMPM avg
	* 2010	$2.4 M	$19.7 M $1.35 PMPM	$6.5 M	$2.7 M	$4.0 M	$3.8 M $0.50 PMPM	$0.81 M $0.925 PMPM

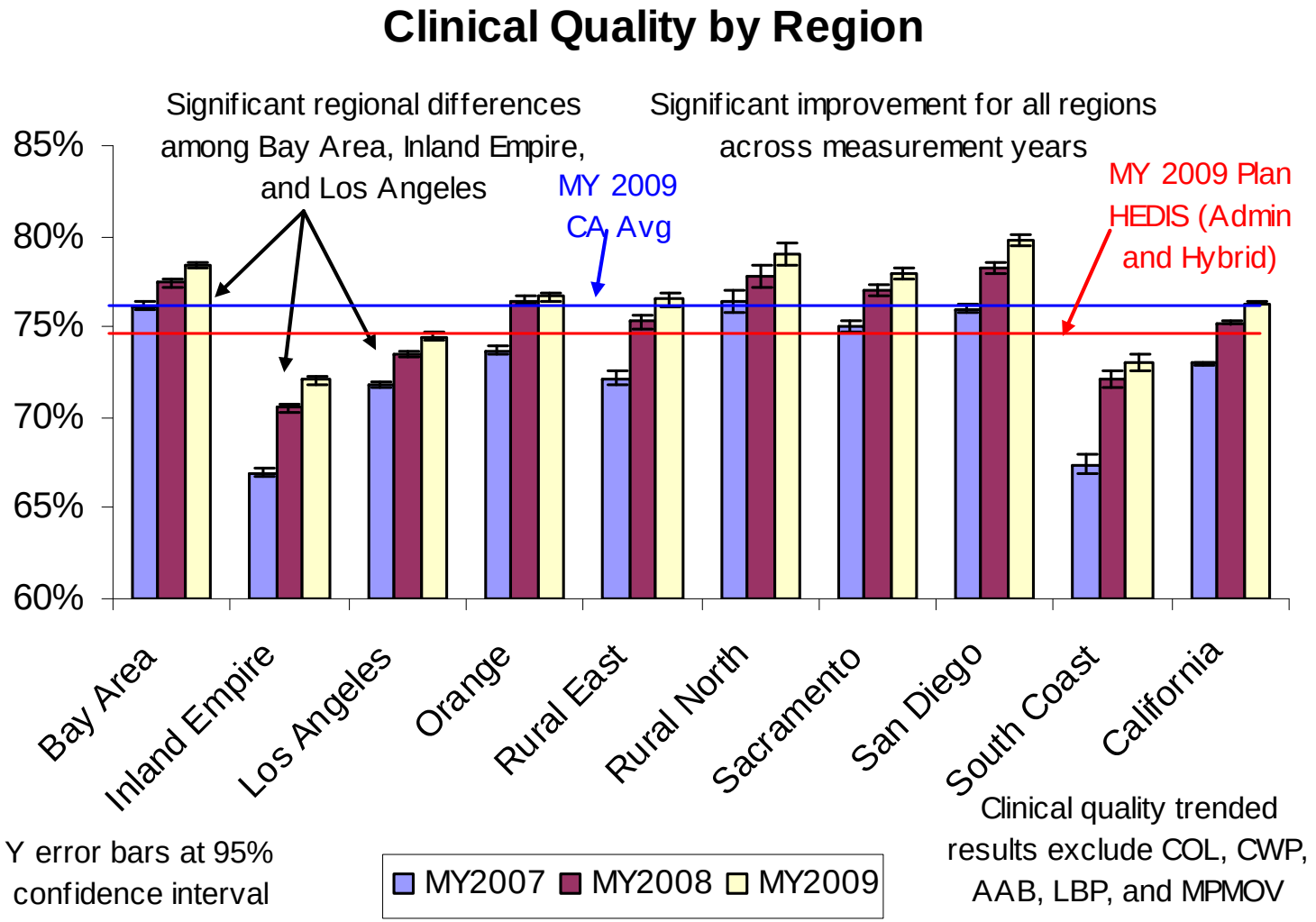
Source – IHA TRANSPARENCY REPORT – 2010 HEALTHPLAN
PAYOUT – Includes Shared Savings Payouts / * Projected $ for 2010 Payout

Anthem Blue Cross HMO Membership

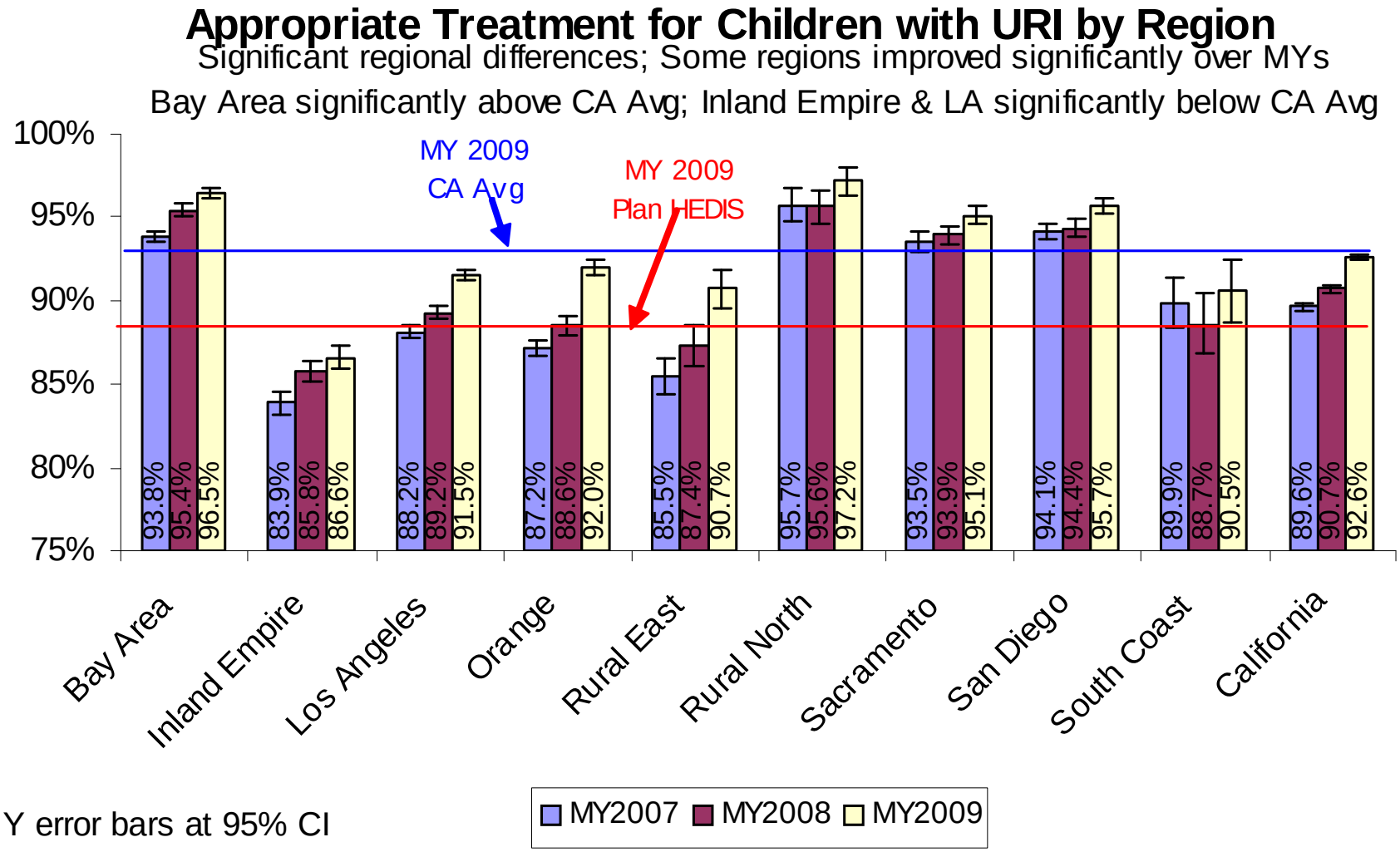


% =85 Percent of Blue Cross HMO members in each region

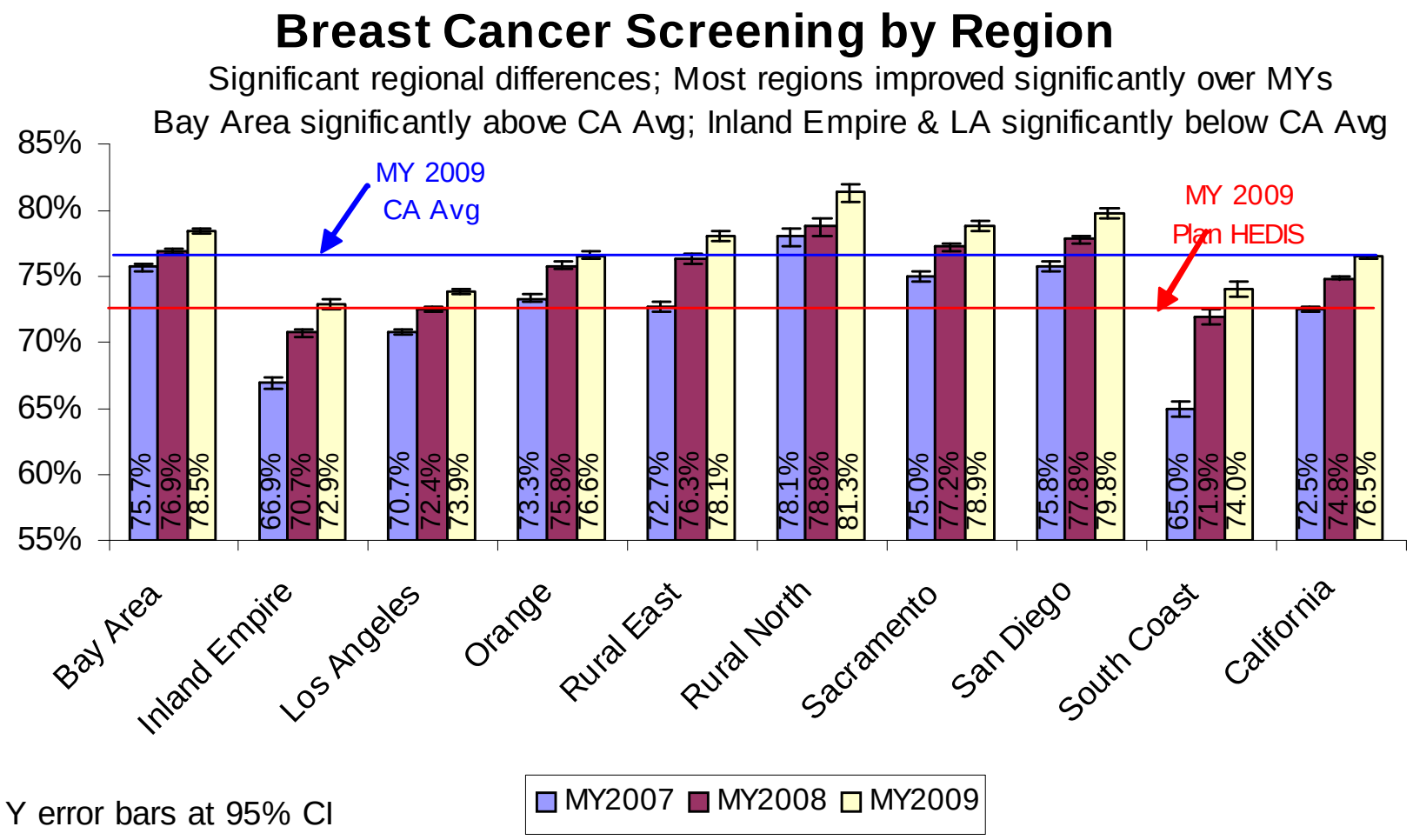
Clinical Quality by Region



Appropriate Treatment for Children with URI by Region



Breast Cancer Screening by Region

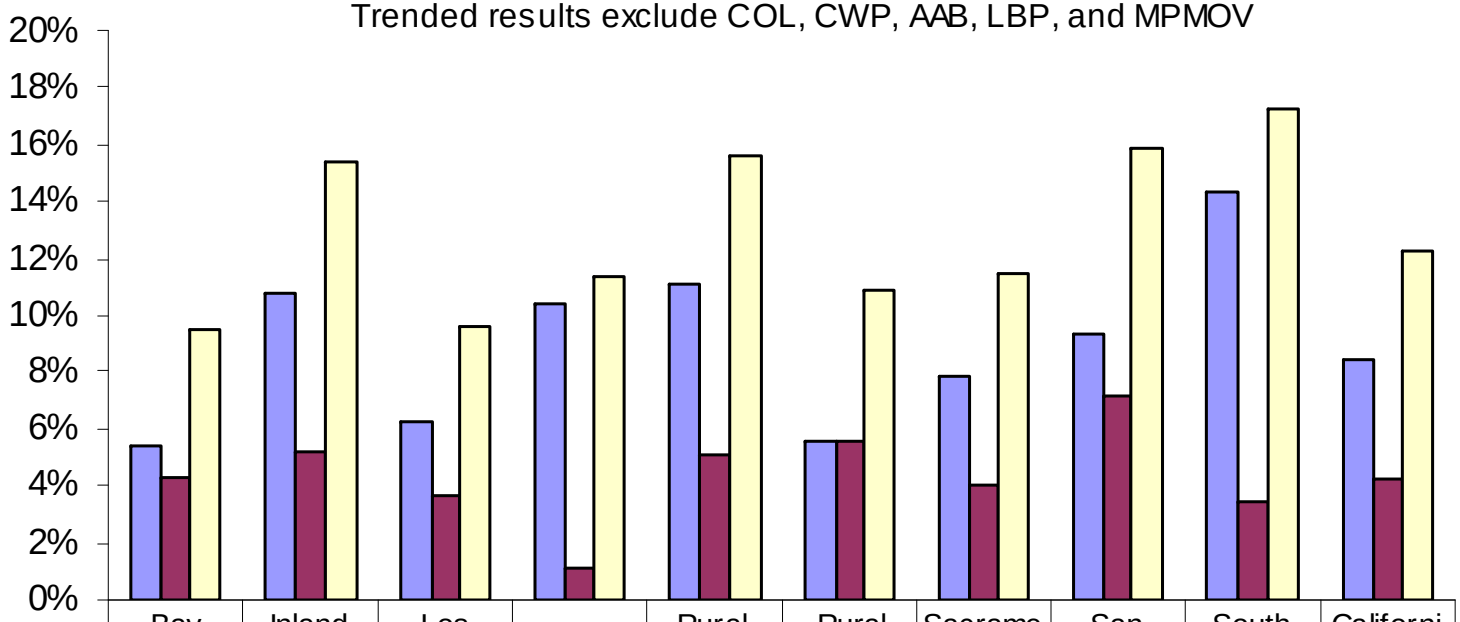


Y error bars at 95% CI

Clinical Quality
Relative Improvement by Region

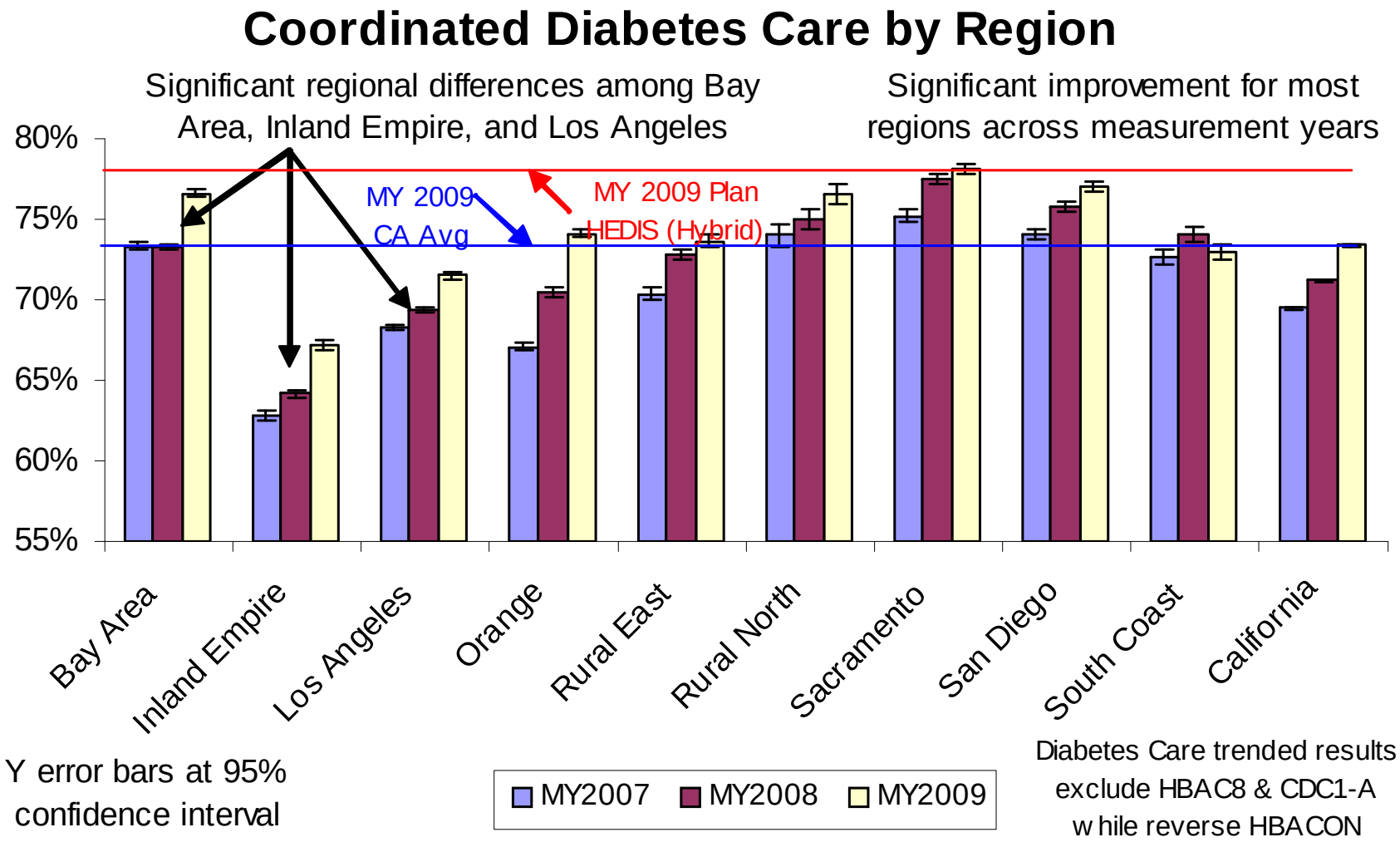
Clinical Quality Relative Improvement by Region

All regions improved across measurement years
Trended results exclude COL, CWP, AAB, LBP, and MPMOV



	Bay Area	Inland Empire	Los Angeles	Orange	Rural East	Rural North	Sacramento	San Diego	South Coast	California
'07-'08 RI	5.4%	10.8%	6.2%	10.4%	11.1%	5.6%	7.8%	9.3%	14.3%	8.4%
'08-'09 RI	4.4%	5.2%	3.6%	1.1%	5.1%	5.6%	4.0%	7.2%	3.4%	4.2%
'07-'09 RI	9.5%	15.4%	9.6%	11.4%	15.6%	10.9%	11.5%	15.8%	17.2%	12.3%

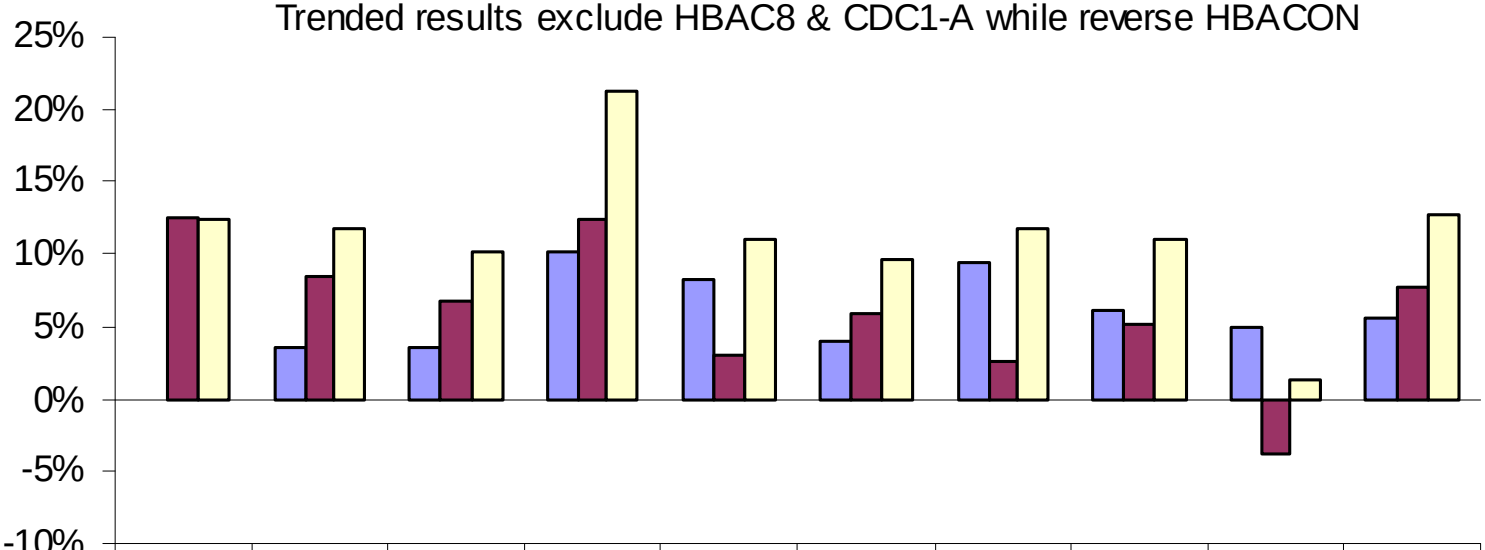
Coordinated Diabetes Care by Region



Coordinated Diabetes Relative Improvement by Region

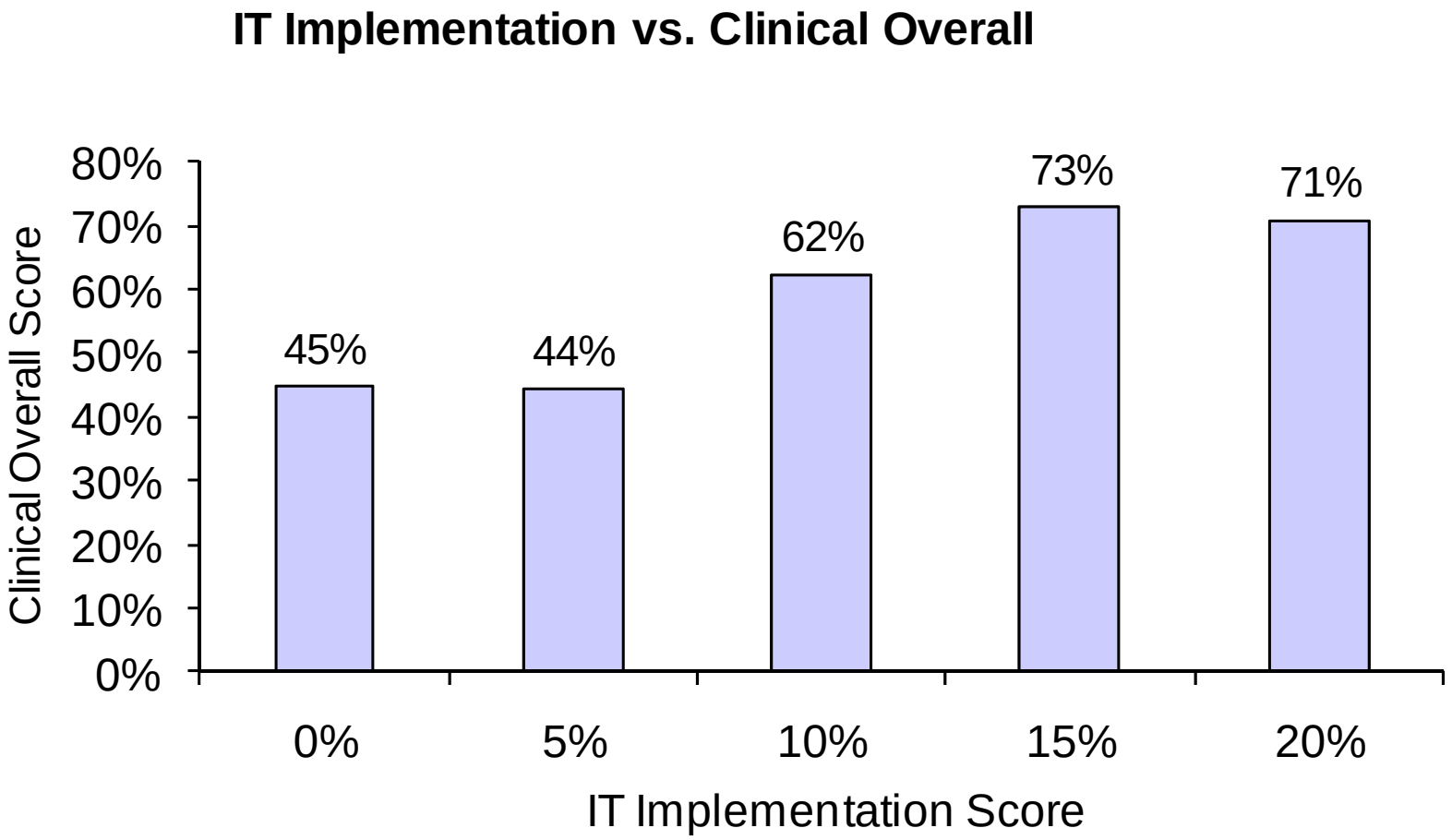
Coordinated Diabetes Care
Relative Improvement by Region

Almost all regions improved across measurement years
Trended results exclude HBAC8 & CDC1-A while reverse HBACON

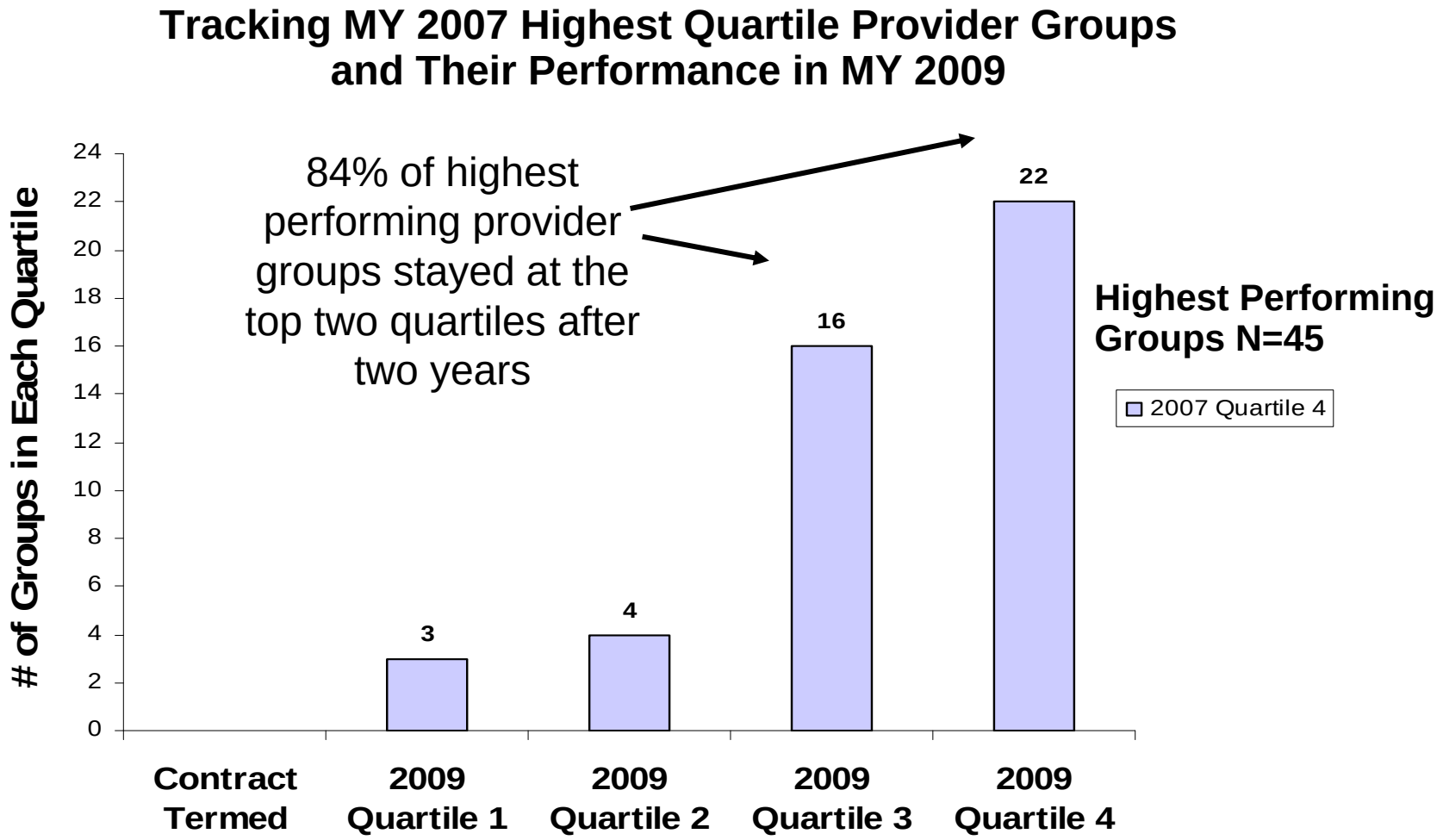


	Bay Area	Inland Empire	Los Angeles	Orange	Rural East	Rural North	Sacramento	San Diego	South Coast	California
'07-'08 RI	-0.1%	3.6%	3.7%	10.2%	8.3%	4.0%	9.4%	6.1%	4.9%	5.5%
'08-'09 RI	12.5%	8.5%	6.8%	12.4%	3.0%	5.9%	2.6%	5.2%	-3.8%	7.7%
'07-'09 RI	12.4%	11.7%	10.2%	21.3%	11.0%	9.6%	11.8%	11.0%	1.4%	12.8%

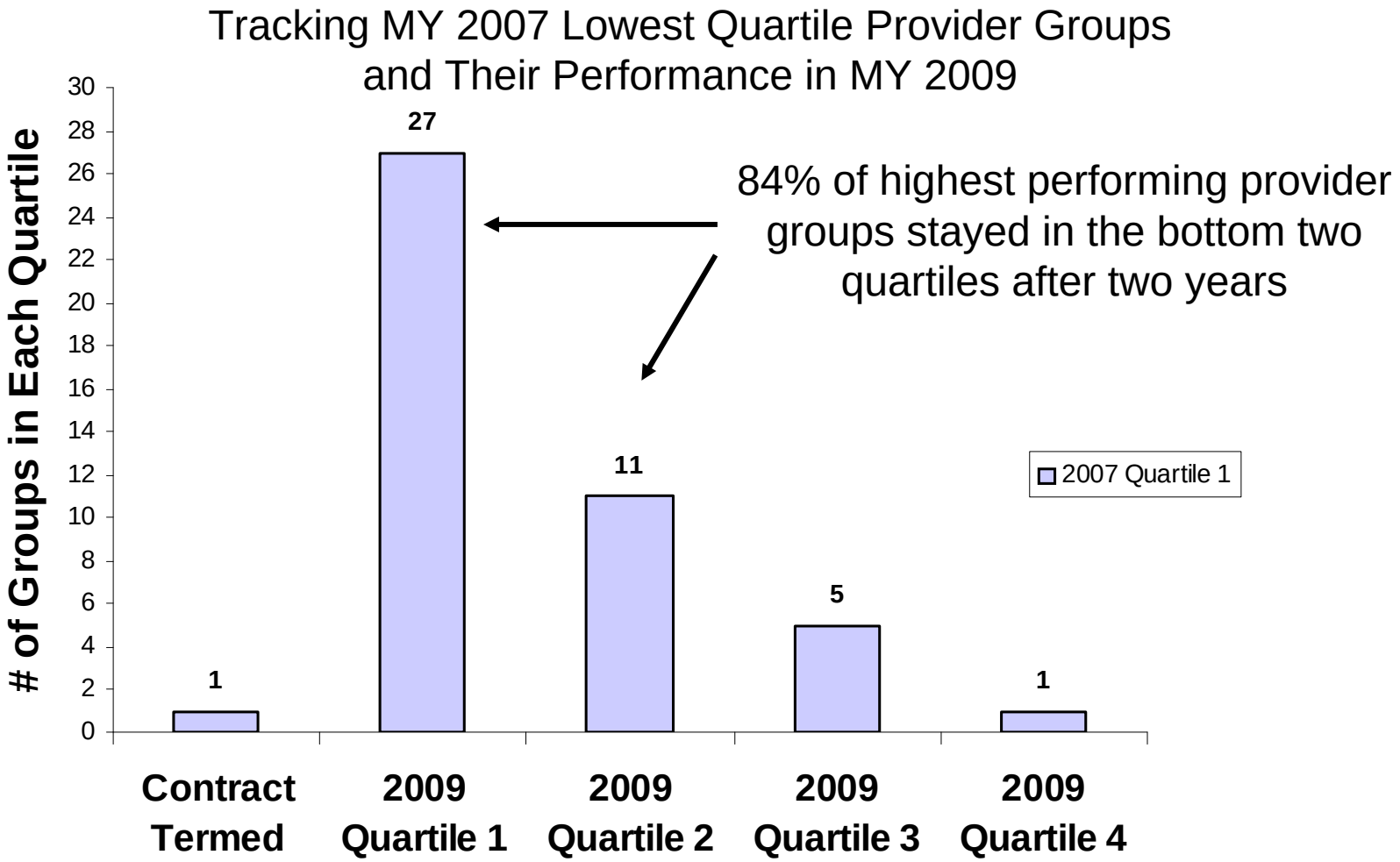
IT Implementation Has Impact on Clinical Quality Scores



Did the Rich Stay Rich?

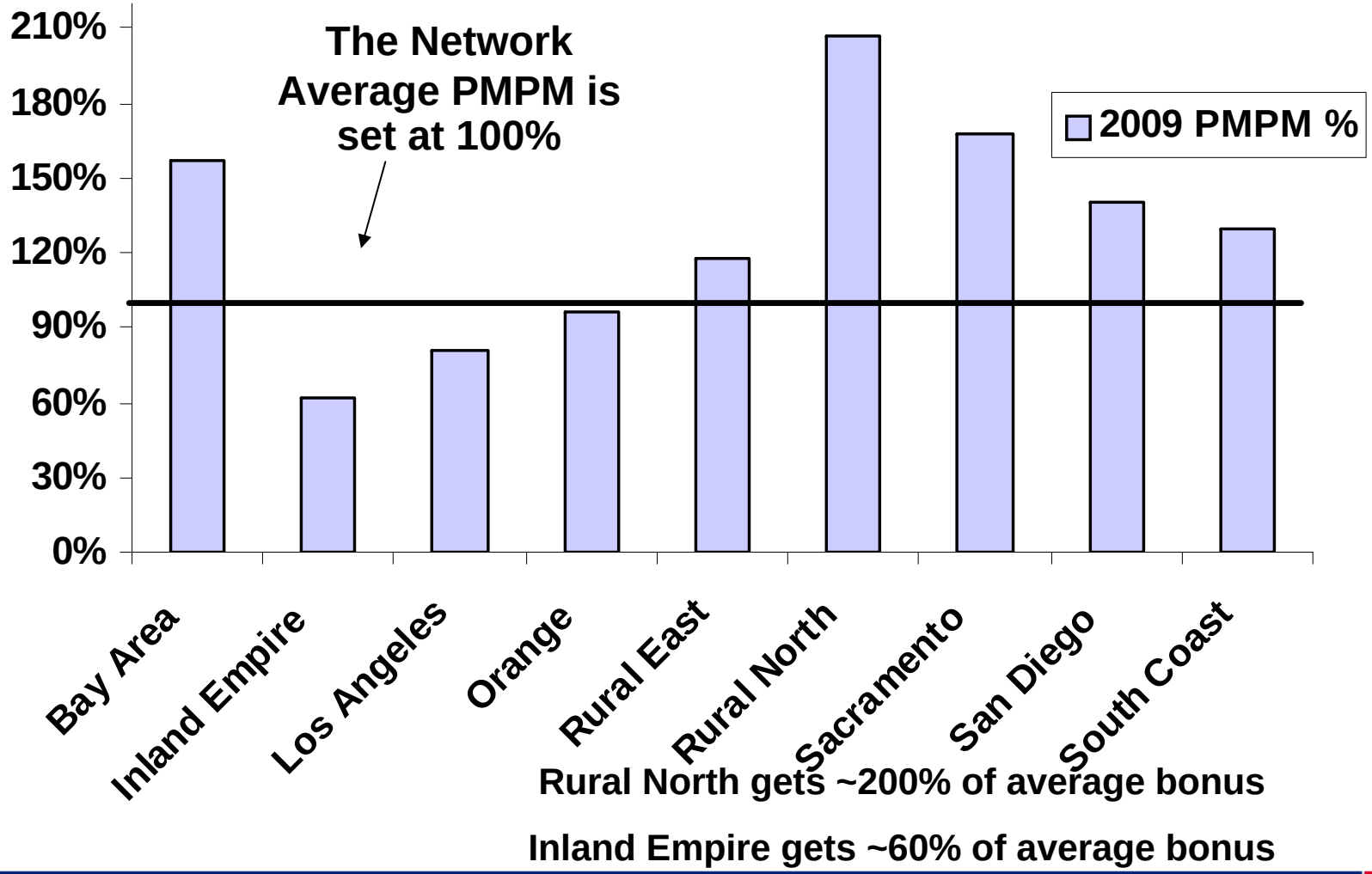


Did the Poor Stay Poor?



Bonus Awards by Region
MY 2009

PMPM Incentive Payout % of Network Average



Rural North gets ~200% of average bonus

Inland Empire gets ~60% of average bonus

Health Disparities and California P4P: A Tale of Two Regions

Demographics	Inland Empire	Bay Area
PCPs/100K Pop.	53	116
PCP + SPC / 100K	119	171
% Pop. MediCal	17%	12%
% Hispanic	43%	21%
Per Capita Income	$21,733	$39,048

Impact of Regional Variation on US News and World Report (2007) HMO Ranking

National Plans in Top 35

North East Region

- WellPoint/Anthem – CT, NH, ME
- HealthNet – CT
- Cigna – NH
- Aetna - CT

National Plans 186-216

California

- WellPoint/Anthem Blue Cross CA
- HealthNet – CA
- Cigna – CA
- Aetna - CA

Healthplan performance largely determined by regional factors (provider network, ethnicity, SES, health literacy, percentage Medicaid)

Conclusions

- Anthem provides disproportionately more dollars to CA bonus pool than other 5 plans
- Persistent and consistent regional variation in performance
- Lowest performing region showing improvement in relative performance – Inland Empire 3rd best increase 08-09 for clinical quality and Composite Diabetes Index
- Prior Incentive program perpetuated disparity in bonus award – now incentive for performance or improvement
- Anthem BC has not improved relative rank nationally
- Breakthrough improvement may require more targeted investment in lower performing regions

Enterprise Hospital P4P

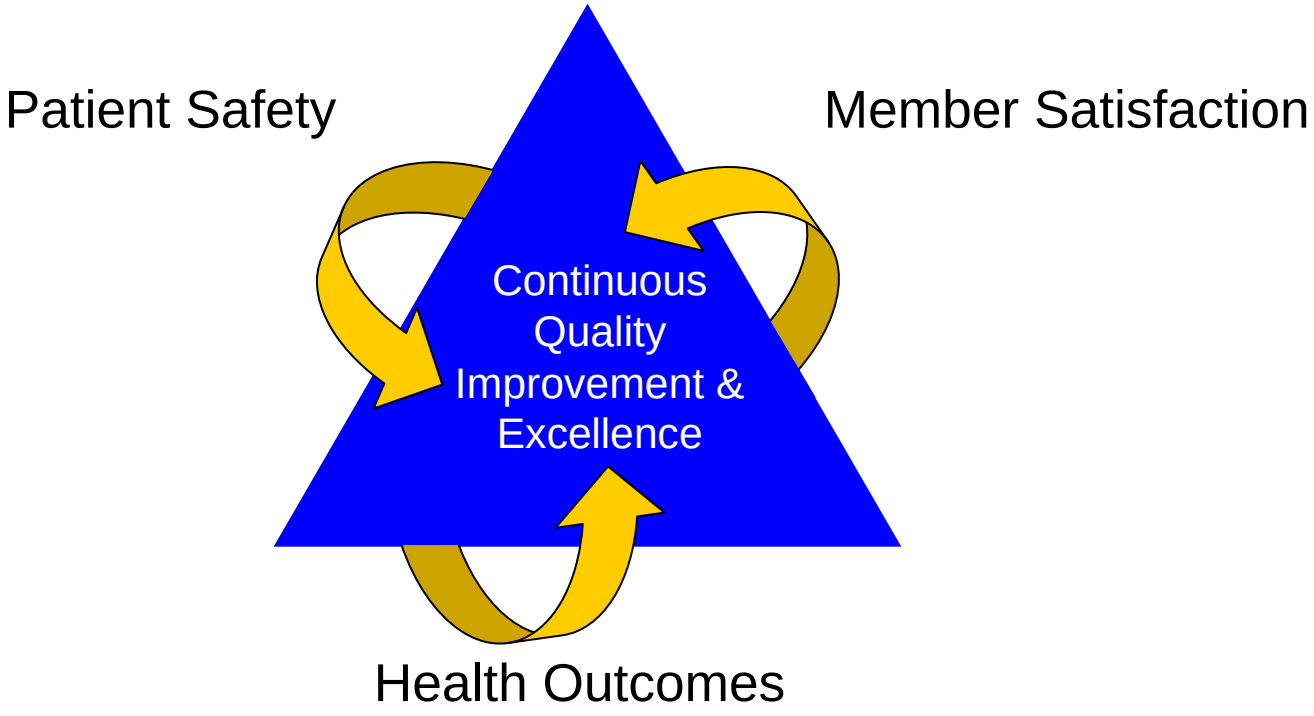
Robert Krebbs

Program Director

Payment Innovation

Q-HIP – The Idea

Q-HIP is a performance based incentive program that financially rewards hospitals for practicing evidence-based medicine and implementing industry recognized best-practices in patient safety, health outcomes and member satisfaction.



Q-HIP Quick Facts

- Based on all-payer data
- Utilizes nationally endorsed measures (NQF, JC, CMS, ACC, STS, etc)
- Feedback provided, with peer comparison reports to participating facilities
- Collaboration with hospitals via National Advisory Panel and annual all-hospital meetings

Q-HIP – Recognition

2006 – Blue Cross and Blue Shield Association (BCBSA) *"Best of Blues Award"*

2007 – BCBSA / Harvard Medical School Department of Health Care Policy *"BlueWorks Award"*

2008 – Joint Commission / National Quality Forum "John M. Eisenberg Award for Patient Safety and Quality"

2009 – Q-HIP becomes the WellPoint standard solution for Hospital P4P

Q-HIP Across the Country

- The original Q-HIP model was piloted in Virginia in 2003 and expanded first into all of WellPoint's east coast markets before becoming the standard enterprise framework for Hospital P4P in 2009, with rollout to all markets by 2010

- There are currently 498 facilities with a pay-for-performance incentive across all 14 of the blue-branded WellPoint markets.

- The standard framework was successfully adapted to accommodate the CHART multi-stakeholder collaborative in California

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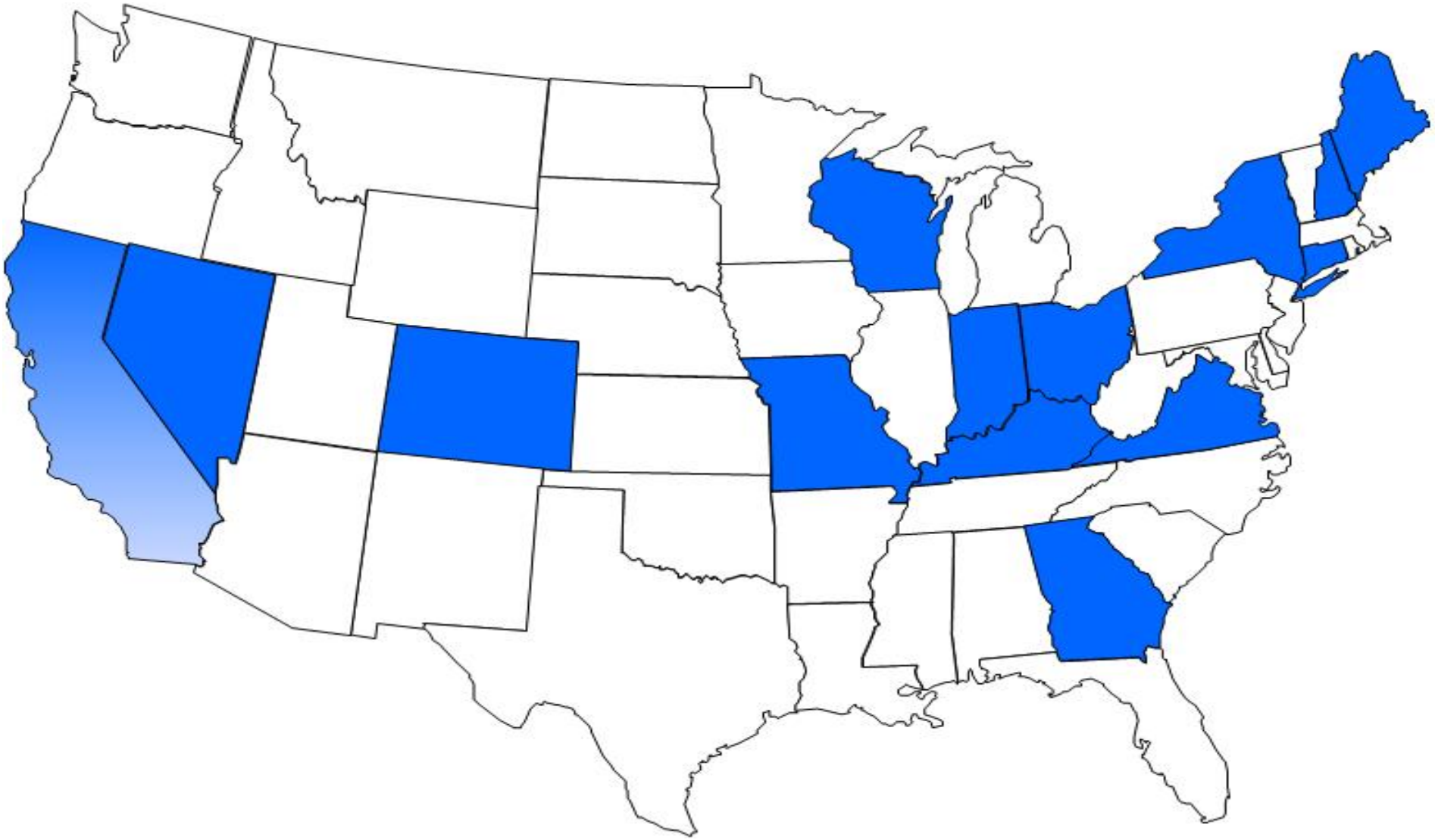
Where's Q-HIP?



Q-HIP Scorecard

Patient Safety Section

- Computerized Physician Order Entry (CPOE) System
- ICU Physician Staffing (IPS) Standards
- NQF Recommended Safe Practices
- IHI 5 Million Lives Campaign – ADE Medication Reconciliation and WHO Surgical Safety Checklist
- CDC/APIC Flu and Pneumonia Vaccine Guidelines
- NQF Perinatal Measures

Member Satisfaction Section

- H-CAHPS Survey Results

Patient Health Outcomes Section

PCI Indicators

- 5 ACC-NCDR/Indicators for PCI

Joint Commission / CMS National Hospital Quality Measures

- Acute Myocardial Infarction (AMI) Indicators
- Heart Failure (HF) Indicators
- Pneumonia (PN) Indicators
- Surgical Care Improvement Project (SCIP)

NSC Indicators

- 4 JC/NQF Nursing Sensitive Care Indicators

CABG Indicators

- 5 STS Coronary Artery Bypass Graft (CABG) Measures

Q-HIP Scorecard Cont.

- Entirely quality-driven – currently no efficiency or resource use related metrics

- A mixture of policy/documentation style metrics and rate-based outcome or result metrics

- Scoring based on individual, versus composite, measures

- Attainment based scoring (hard targets)

Q-HIP Payouts

< Placeholder for market penetration / financial information >

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Lessons Learned

• Lessons learned and the effect on Q-HIP and the ACO Model

- **Attainment / Improvement Scoring**
- **Composites versus Individual Measures**
- **Resource Use / Efficiency Measures**

Hospital Measures – Attainment Pros and Cons

The Pros:

- Q-HIP has traditionally relied on a single scoring methodology based on “attainment”.
- Static targets based on national percentiles (50^{th} – 90^{th})
- Hospitals earn points for hitting one or several targets, with maximum points going to those performing at the highest levels

The Cons:

- Hospitals initially performing at low levels receive no incentive until they reach the minimum threshold (usually national median)
- Hospitals could demonstrate significant improvement year over year and see no change in points earned depending on where the static targets fell

Hospital Measures – ACO Dual Scoring System

Improvement Model:

- The ACO quality scorecard will pilot the incorporation of an improvement scoring system
- The ACO will be able to earn points based on their progress from previous year's baseline rates to the maximum static target
- ACO hospitals performing at low baseline levels will be credited for significant improvement year over year, even if they fall short of the static targets

Dual System:

- The Improvement model isn't compatible with hospitals already performing at excellent levels of quality, so both the Improvement and Attainment models will work together, with ACOs receiving points based on either model

Hospital Measures – Composites

< Placeholder for composite information >

Resource Use / Efficiency

< Placeholder for resource use / efficiency information >

Possible Future Q-HIP Scorecard

Patient Safety Section
(?% of total Q-HIP Score)

- Computerized Physician Order Entry (CPOE) System
- ICU Physician Staffing (IPS) Standards
- Surgical Safety Checklist (WHO Based)
- Other HIT Initiatives

Member Satisfaction Section
(?% of Total Q-HIP Score)

- H-CAHPS Survey Results

Resource / Efficiency Section
(?% of Total Q-HIP Score)

- Imaging Measures
- All Cause Readmission Index

Patient Health Outcomes Section (?% of total Q-HIP Score)

PCI Indicators
- ACC-NCDR/Indicators for PCI

Joint Commission / CMS National Hospital Quality Measures
- Acute Myocardial Infarction (AMI) Composite
- Heart Failure (HF) Composite
- Pneumonia (PN) Composite
- Surgical Care Improvement Project (SCIP) Composite
- Perinatal Care Composite

HAC Indicators
- HAI / HAC Indicators (NHSN, NQF, etc)

CABG Indicators
- STS Star Composite Results

Q-HIP – Effects of the ACO Pilot

Dual Scoring: The 2012 Q-HIP scorecard will adopt a dual scoring system much like that developed for the ACO, giving an opportunity to earn points for attainment and improvement

Resource Use / Efficiency: Q-HIP will move away from pure quality to a hybrid quality/efficiency based scorecard, mirroring many of the measures adopted for the ACO

Composites: The composite measure methodology employed by the ACO scorecard will be monitored closely to determine if it's an appropriate fit for the Q-HIP scorecard

Payment Innovation / ACOs

Skip Walker, MD

Medical Director

Payment Innovation

Payment Innovation Strategy

Moving from Volume Reimbursement to Value

Enhanced Fee for Service	• Physician P4P • Hospital P4P • PCMH
Bundled Services	• Retrospective Model • Prospective Model • Reference Pricing
Population Based Management	• Accountable Care Organization • Enhanced PCMH

Accountable Care Organizations

The Accountable Care Organization (ACO) model is a local health organization that is accountable for 100% of the expenditures and care of a defined population of members. The provision of value by ACOs will require their coordination of care across all continuums of care for the defined population.

Defining WellPoint Principles:

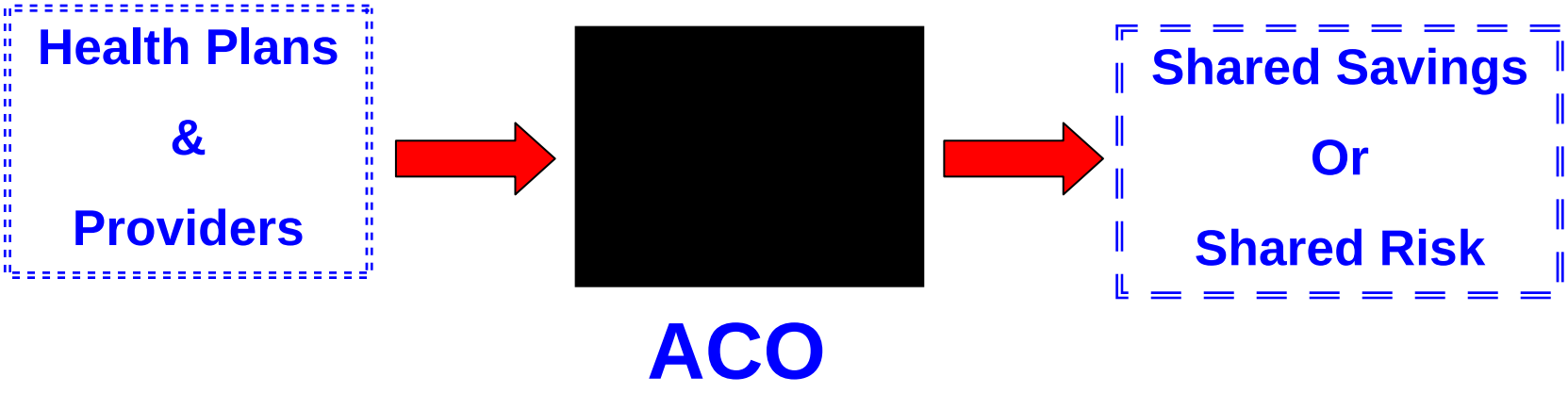
- **5 year relationship**
- **Transitioning to a global payment over the term of the relationship**
- **Development of shared risks over the term of the relationship**

ACO Criteria for Commercial PPO

WellPoint will consider provider organizations which meet the following criteria to operate as an Accountable Care Organization:

- **A minimum population eligible for membership > 15,000 members**
- **Full complement of medical services with the exception of Transplants**
- **Must have a formal legal structure to receive and distribute reimbursement for member services**
- **An adequate network of ACO professionals to provide total care to the defined population**
- **Defined relationships with hospitals and physicians**
- **Demonstrated plan for reducing the cost of medical care**
- **Deploy an IT platform supporting the capture and electronic exchange of clinical information across the Ambulatory, Inpatient and Ancillary (lab, imaging, eRX, etc.) settings for the high volume ACO Professionals**
- **Electronic medical record system allowing for improved coordination of care**
- **A commitment from the senior leadership regarding the ACO initiative**
- **A willingness to enter a 5 year contractual relationship**

Is There an ACO Black Box?



Data Exchanges – Key Component

- **Membership**
  - Electronic Membership File
  - Membership additions/deletions
- **Census**
  - Hospital Census
  - Emergency Census
- **Claims**
  - Two years of historical
  - Monthly claims data file
- **Medical Management**
  - Utilization Management
  - Case Management
  - Disease Management
- **Pharmacy**
  - Claims data files
  - Analytic reports
- **Reporting**
  - Series of analytic reports

Exchanges to the Health Plan

- Bio-metric data
- Smoking status
- Lab
- Functional Status

Anthem ACO Model for 2011

Membership
- Defined by attribution

Provider Network
- Full network with exception of transplants

IT
- IT infrastructure
- Data exchanges

Legal
- Structure to receive / distribute payments
- Management Structure

Financial
- FFS & shared savings
- Care management fee

Medical Management
- Possible delegated medical Management
- Defined processes to promote quality and coordinate care

ETG Attribution Overview

ETG Product: Symmetry/Ingenix Episode Treatment Group Version 7.0.4.4

Purpose: to attribute members to an Accountable Care Organization

Criteria:

- High probability of identifying members with a pre-existing clinical relationship with providers
- Flexibility in filtering the percentage of members attached to a group Tax ID

PPO Population for Anthem

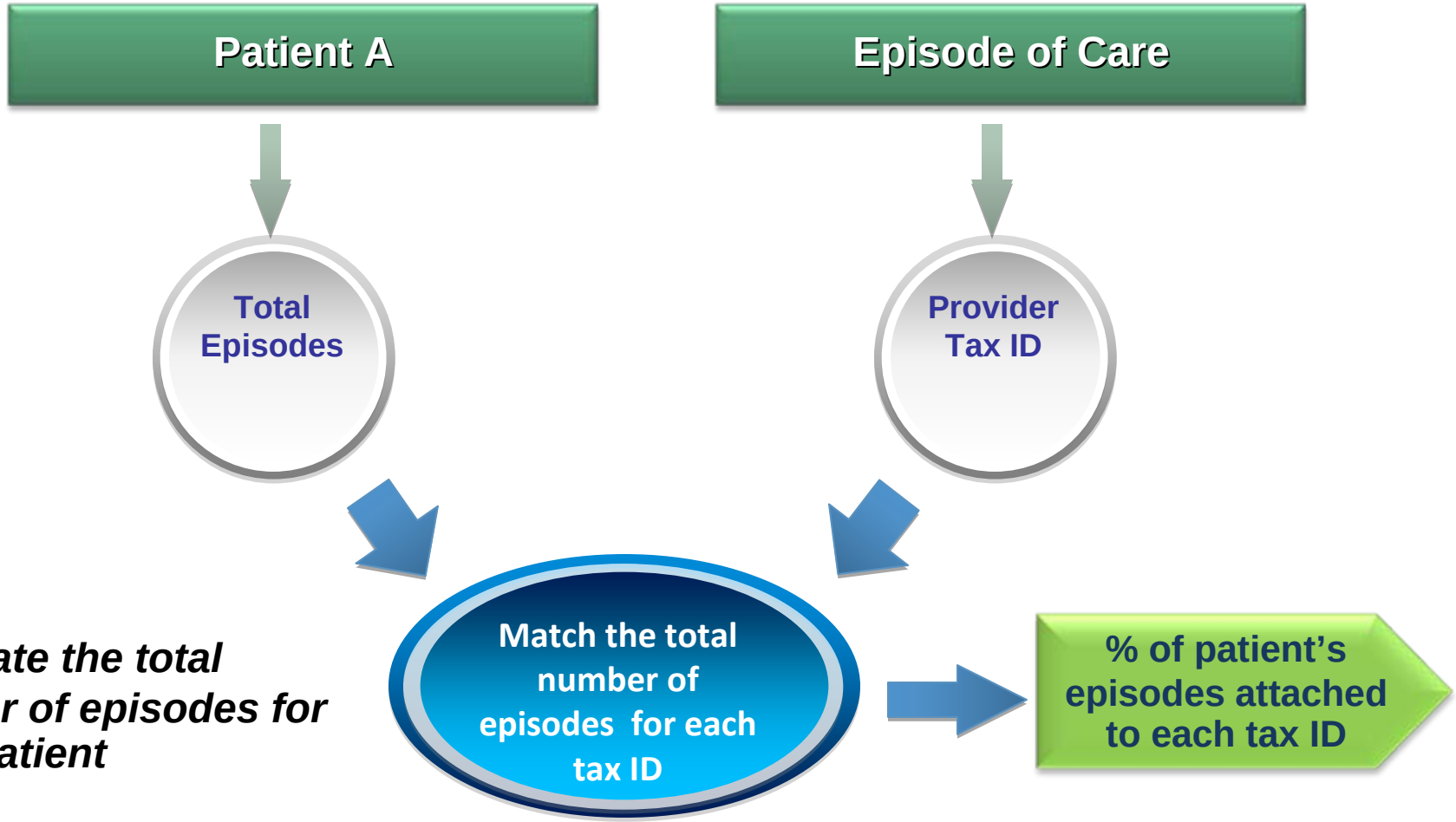
Two years of PPO claims data

- Fully insured PPO lines of business
- Members with both medical and pharmacy claims
- Excluded members with no claims

ETG Exclusions

- Non-episodic Treatments
- Ungroupable Services
- Episodes assigned to Hospitals

Episode Matching Logic



Calculate the total number of episodes for each patient

How Will ACOs be Reimbursed

- This is not Capitation of the 80's
- Options
  - FFS against a Medical Cost Target
  - Full Global Capitation
- Has to include VALUE
  - Quality Gate
  - Efficiency Scorecard
- Shared Savings  Shared Risk

Quality Gate for Shared Savings

- **Required for participation in shared savings**
- **Two components**
  - Physician Quality
  - Hospital Quality
- **All metrics are nationally endorsed metrics**
- **Scoring based on improvement & attainment methodology**
- **Expansion to enhanced metrics in 2012**

Performance Metrics - Physician

- Breast Cancer Screening
- Colorectal Cancer Screening
- Childhood Immunization Status (MMR + VZV)
- Chlamydia Screening in Women
- HbA1C Screening
- LDL Screening
- Nephropathy Monitoring
- Cholesterol Management LDL Screening (Pts with/ Cardiovascular Conditions)
- Use of Imaging Studies for Low Back Pain
- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection
- Avoidance of Antibiotic Treatment of Adults with Acute Bronchitis
- Medication Monitoring (ACE/ARBs, digoxin, diuretics)

Quality Metrics - Hospital

- JC/CMS NHQM – AMI, PN, CHF & SCIP
- ACC Metrics for Cardiology
- STS metrics for Cardiac Surgery
  - Deep Sternal Wound Infection
  - Prolonged Ventilation
  - Operative Mortality for CABG
  - Surgical Re-exploration
  - Pre-operative Beta Blockade
- National Healthcare Surveillance Network –
  - Central line associated bloodstream infections
  - Ventilator associated pneumonia
  - Catheter associated urinary tract infections
- Patient Satisfaction - CAHPS

Expansion to 2012 Metrics

Addition of Clinically Enriched Measures

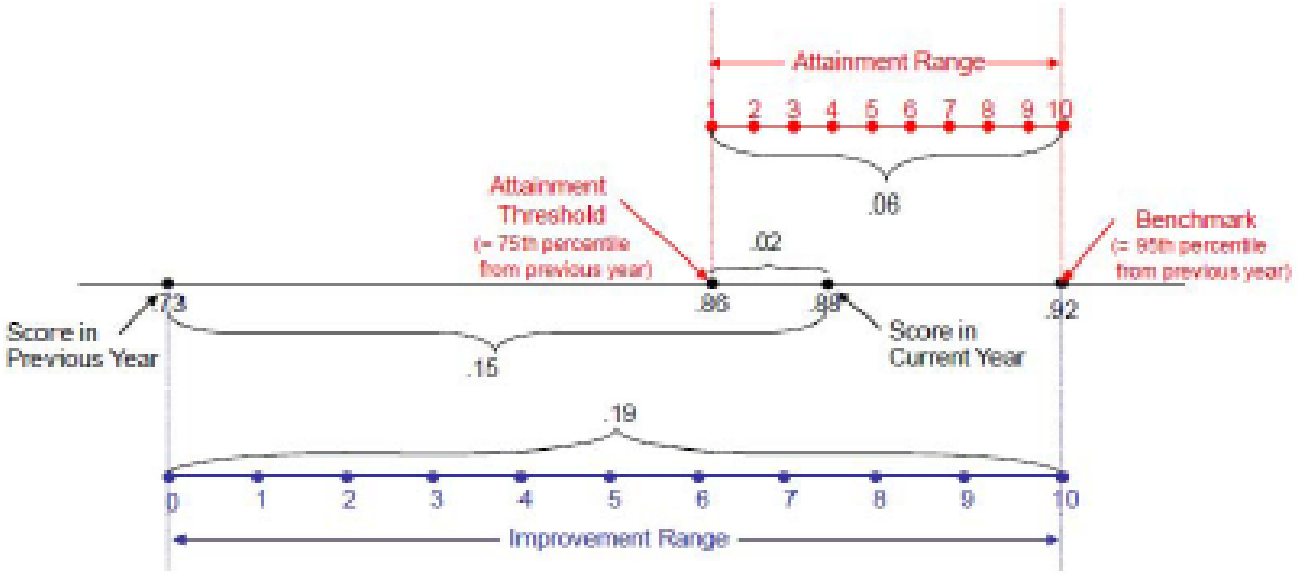
- Lab Results
- Bio-metric Results
- CPT II coding
- Physician Attestation for immunizations

Addition of Patient Experience Measures

- Primary Care
- Chronic Care
- Specialty Care
- Hospital Discharge

Improvement / Attainment Scoring

Earning Quality Points Example
Measure: Nephropathy Monitoring



Attainment Range = .92-.86 = .06
Attainment Scale = .06/9 = .0067
Attainment Value = .88-.86 = .02
Attainment Points = 1+.02/(.0067) ≈ 4

Improvement Range = .92-.73 = .19
Improvement Scale = .19/10 = .019
Improvement Value = .88-.73 = .15
Improvement Points = .15/(.019) ≈ 8

PO earned: 4 points on Attainment and 8 points on Improvement
PO score: maximum of Attainment and improvement points = 8 points

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Draft Efficiency Score Card

Categories	Metrics
Emergency Department	Aggregated total - avoidable visits per 1000
Prescription Medications	Rx pmpy or Rx/1000
	Generic Prescribing rate
Imaging	Spine MRIs per 1000
	Spine CTs per 1000
	Abdominal CTs per 1000
Inpatient	Admits per 1000
	Days per 1000
	HEDIS - all cause readmission rate

Where are the Savings Opportunities 2011

Pharmacy

- Generic Rates
- Rx PMPY

Site of Service

- Outpatient Surgery steerage to ASC

ACO Leakage

- Manage inpatient steerage

Emergency Department

- Avoidable ED visits
- Reduce ED admissions

Inpatient

- Length of Stay
- Admissions
- Readmissions

Imaging

- MRI and CT scans of the Spine
- Abdominal CT scans

Chronic Disease Management

Drawing Conclusions

Brent Higgins, MHA

Program Consultant

Payment Innovation

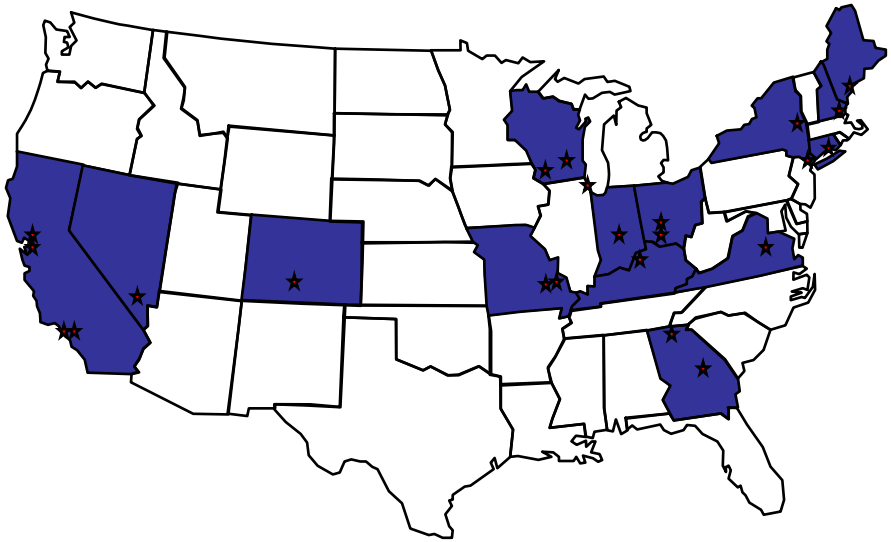
Objective:
Create the best health care value in our industry

How does WellPoint create the best Health Care Value in the industry?

- Use P4P and Payment Innovations to manage unit cost and utilization
  - Move from quality only to a value based reimbursement strategy
- Increase % of revenue stream contingent on performance
- Leverage vast data repositories and analytic capabilities to drive value
  - Enhance data exchanges to providers
  - Actionable data and analytic reporting
- Exploit geography and diverse market demographics
  - Scale programs across the enterprise for operational efficiency
  - Employ best-practice sharing to create best-in-class reimbursement methodologies

Market Dynamics Revisited

How do market dynamics shape the structure and strategy around P4P and other payment innovation initiatives?



Realities

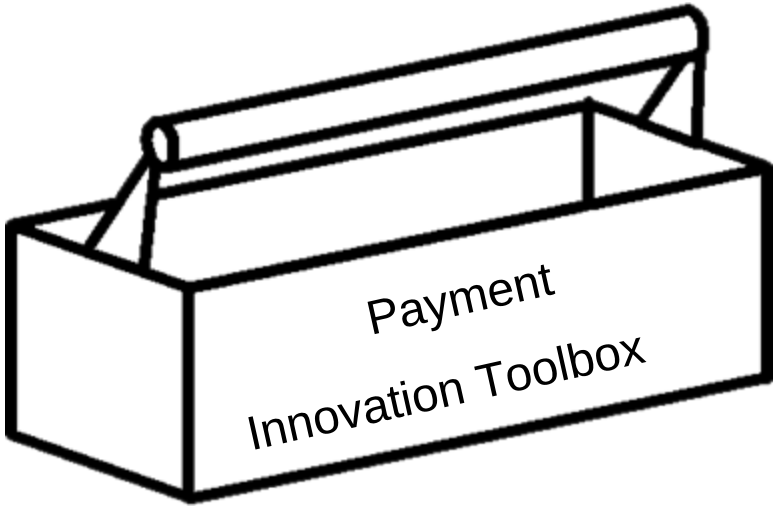
- Diverse market
- Varying provider integration
- Provider engagement in new methodologies
- Micro-Macro tools; healthcare is local

Conclusions

- Not all providers are ready for payment innovation initiatives
- Enhanced P4P will be viable for less integrated provider organizations
- A balanced approach will be the most successful

Shaping the Payment Innovation Toolbox

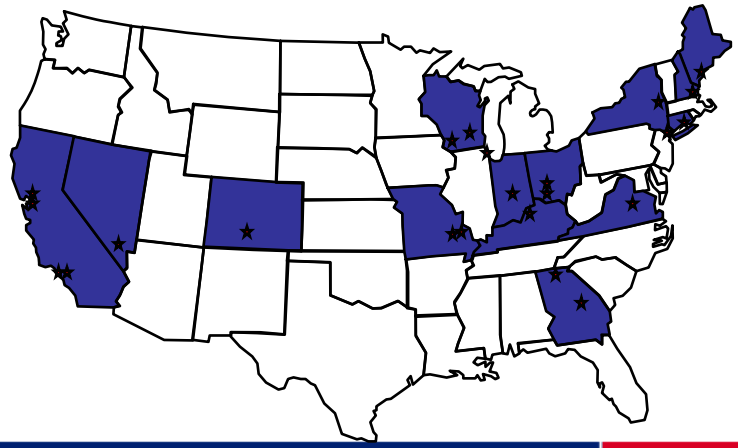
Is there a single solution to address system and market challenges?



Select and apply appropriate tools to meet the needs of hospital and physician partners

- Scalability
- Flexibility
- Consistency

- Continuous improvement refreshes the toolbox
- 14 State enterprise gives WLP a strategic and efficiency advantage
- Capitalize on opportunity to implement best practices



Lessons Learned

How are P4P lessons learned used to create industry leading reimbursement methodologies?

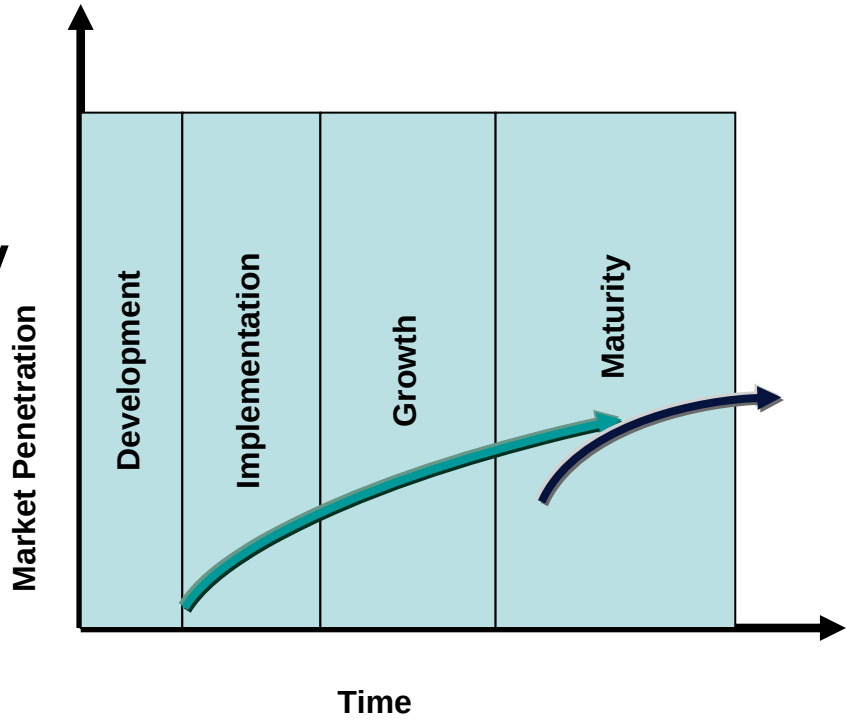
Challenge/Opportunity	Solution/Conclusions
• No new money	• Shared savings; unlimited opportunity
• Excess volume	• Resource use / efficiency metrics
• Value/efficiency opportunities	• Dynamic scorecard and quality gating
• Scoring	• Target attainment / improvement
• Perceived admin burden	• Strategic partnerships, prioritization
• Scope / provider collaboration	• Composite metrics
• Payer paradigm	• Shift from provider payer to a provider partner with enhanced data exchanges

WLP P4P Growth Cycle

What is the long-term value proposition of P4P? How does evolution impact viability?

Conclusions

- **Without evolution, paying for quality only won't remain a viable model**
- **WLP P4P is evolving to reward quality and create value**
  - **Outcomes, EBM, BP, Coordination, efficiency**
- **Composite metrics will cover more areas, making programs more clinically expansive**
- **Increased penetration of scalable models**



Key Takeaways

- Shape industry leading reimbursement methodology through lessons learned in P4P
- Collaborate with providers and leverage key competencies, shifting paradigm
- Create methodologies that reward quality and drive value
- Implement the best tools that support local member and provider needs
- Leverage vast resources and market dynamics

Questions