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Medical Homes, ACOs and Bundled Payments:

How Does Predictive Modeling Fit in the New Provider Reimbursement Landscape?

H. Scott Sarran, MD, MM

Chief Medical Officer

Blue Cross Blue Shield of Illinois

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Where have we been; Where are we going?

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- Analytics
- Medical management programs
- HIT and Connectivity
- Value-creation with providers and other trend-bending thoughts
- Parting Thoughts

Our mission is to

promote the health and wellness

of our members and communities through accessible, cost-effective, quality health care.

Defeating Wedge Economics

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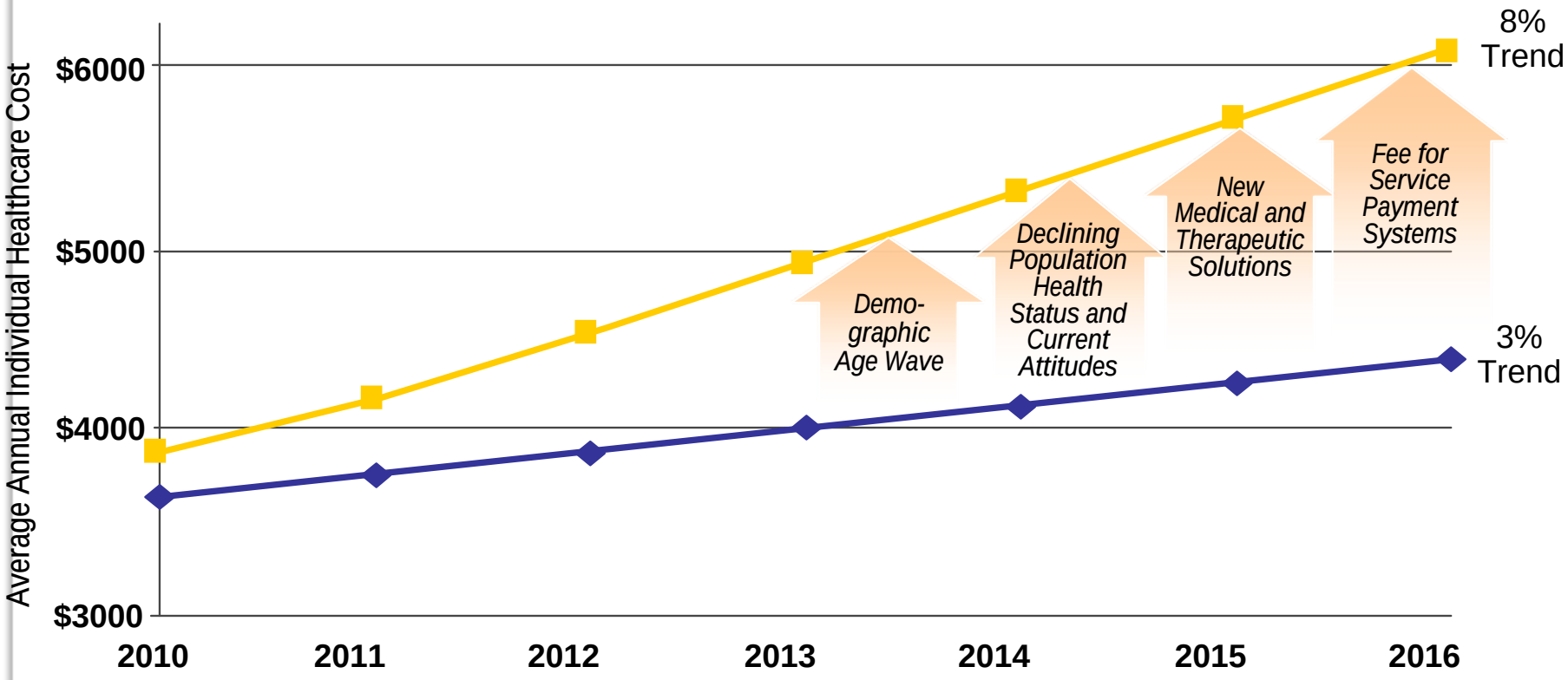

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Predictive Modeling and Member Stratification

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Limitations of Traditional Predictive Modeling

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- Cost, rather than opportunity-focused
  - Claims-based
  - Static

And, most importantly, Disconnected from Providers

Cost Escalation: A Conceptual Overview

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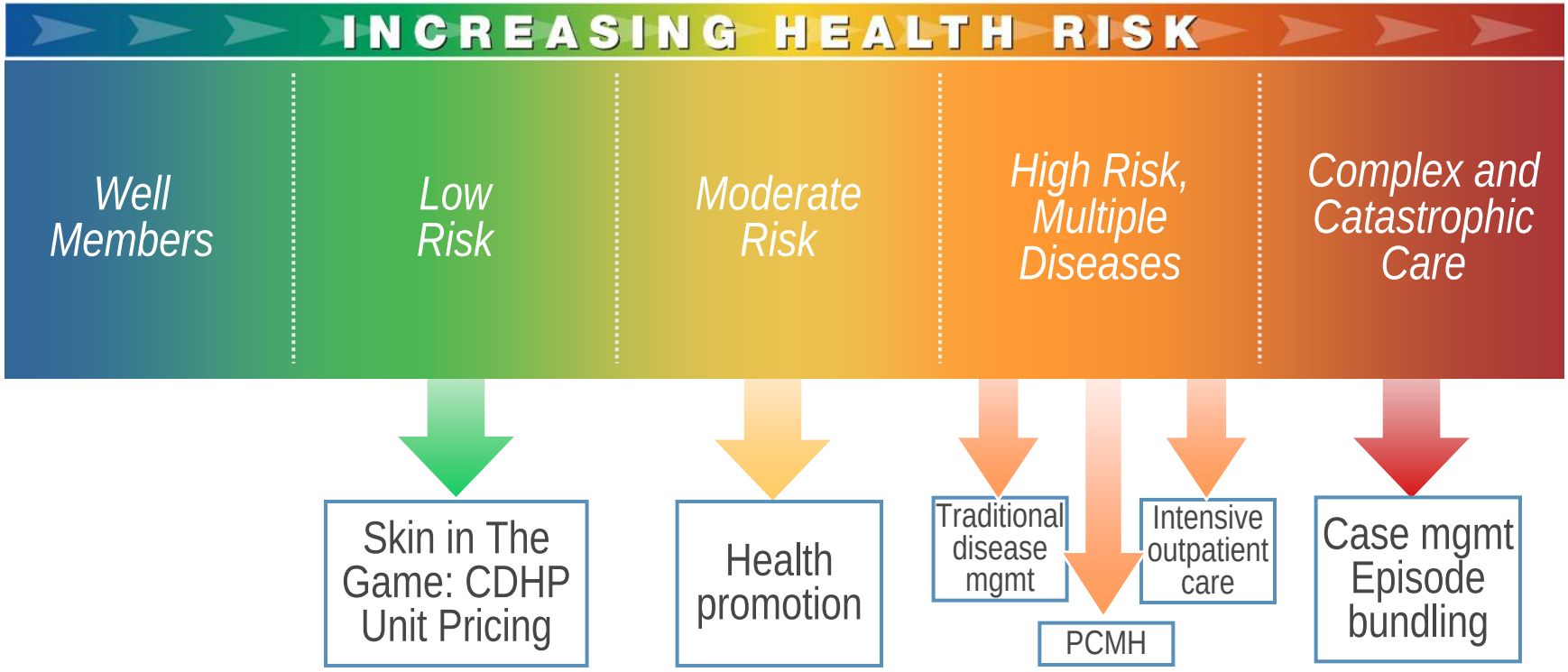
Employer Group

Members	48%	18%	23%	10%	1%
Cost	9%	13%	26%	36%	16%



Whom Do We Want to Engage?

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- Wellness occurs at home and in the workplace
- Chronic care occurs at home (75%) and in the doctor's office
- Acute care occurs in medical settings

Integrated Total Health Management: This is Now a Ticket to the Game

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Employer Data
Biometric Data
Nurseline
PHR
Rx
Admissions Data
Internal
ER
Lab
HRA
Self-Referral Data
External
Campaign Manager
Claims
PHR

Opportunity Score

HIT / PCS / EHR

Customer Outcomes

Operations Process

Opportunity Analysis

Rules Engine

tools and resources

engagement

Note: Mix of real time (auto-routing) and periodic runs; ongoing efforts to reduce data latency

Member Opportunity Score Example

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The **higher the score**, the more opportunity an intervention has for improvement

- **A numeric "score" assigned to each member based on a custom algorithm**, which indicates the opportunity for an intervention to be effective, both financially and clinically.
- Ranges of opportunity scores **replaces traditional predicted future cost only score** as the matrix column
- **Value indicates potential for improvement to member's health** and/or better control over utilization patterns (the higher the score, the more opportunity an intervention has for improvement)
- **At any given time, each member has only one health status and one total opportunity score*** in order to be assigned to one mutually exclusive "bucket"

**We now have separate medical and behavioral opportunity scores: the higher of the two drives primary assignment*

Algorithms and Clinical Intelligence Rules: Essential Features

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- Formalized governance: multidisciplinary process for development and review
- Clearly linked to evidence-based medicine, recognized guideline, or explicit hypothesis
- Ongoing assessment of validity via formalized process

Incorporating Predictive Modeling into

Medical Management Activities

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The Goal

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The goal and challenge of medical management is to proactively **engage members** across the health care continuum

Member Encounters

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- Customer Service
- Preauthorization/Authorizations

- Receipt of claims
- HRA
- Biometrics

Activities that Immediately Generate Medical Management Intervention

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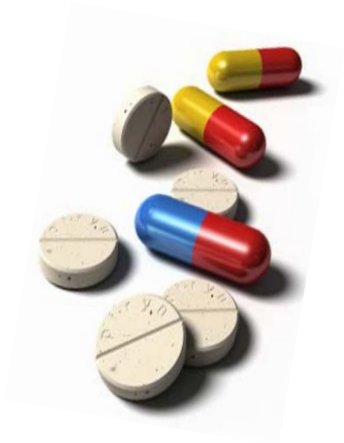
- **Event**-based
- **Medication**-based
- **Benefit**-based



Health Risk Assessment and Biometrics

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Relatively low contribution to total opportunities

BUT …

–HRAs especially helpful:

- Ramp-up of new population
- Behavioral risk factors

–Biometrics especially helpful:

- Metabolic Syndrome

Health Information Technology

Changing How Health Care is Delivered …

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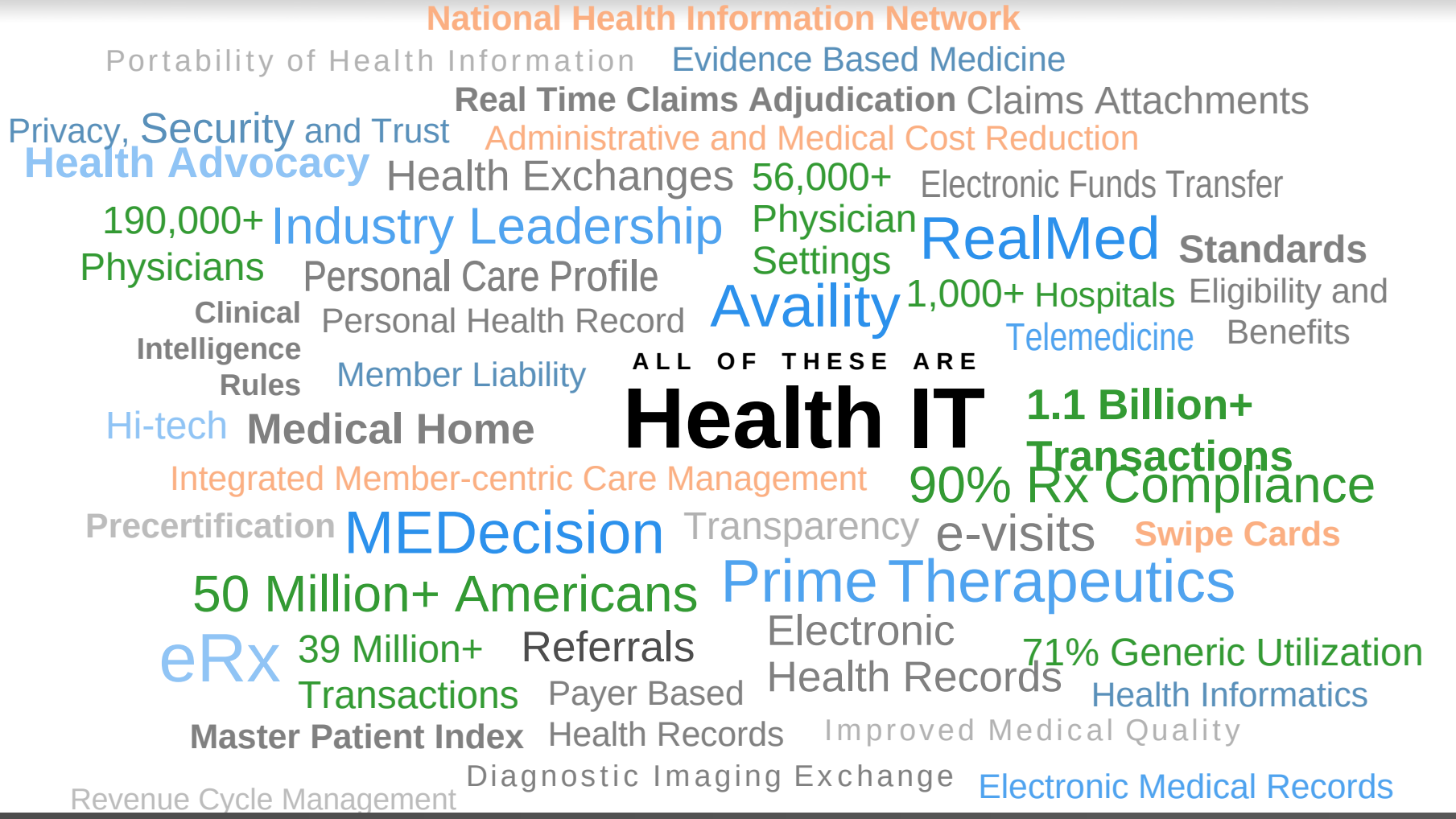

Getting Everyone On The Same Page

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Clinician Decision Support

Availity & Nexalign

(PCS / Care Profile)

EHR

Electronic Health Record

(PHR + EMR + PBHR)

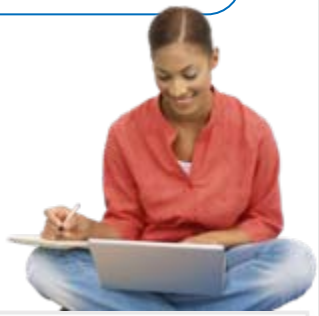
Consumer Decision Support

Personal Health Manager

(Member Care Profille)

Blue Care Connection

CarePlanner Web™ / Alineo



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Health Information Technology
In Real Life

At the Office

2 Patient Examined –

a. Gaps in care addresed

4 Patient Check Out

a. Outstanding balance collected (co-pay, member responsibility estimate, Real Time Claim Adjudication
b. Patient educated, follow-up appointment scheduled
c. Referral if needed

Exam Room

1 Patient Check In

a. Member ID card swiped
b. Eligibility and Benefits retrieved
c. Electronic health record integrated
d. Referral checked
e. Patient responsibility estimated

3 Encounter Documented (EMR)

a. Claim submitted
b. Adjudicated in real-time
c. Prescription submitted to pharmacy (e-Rx)
d. Bi-directional Provider-Health Plan Communication

*Future availability

At the Office

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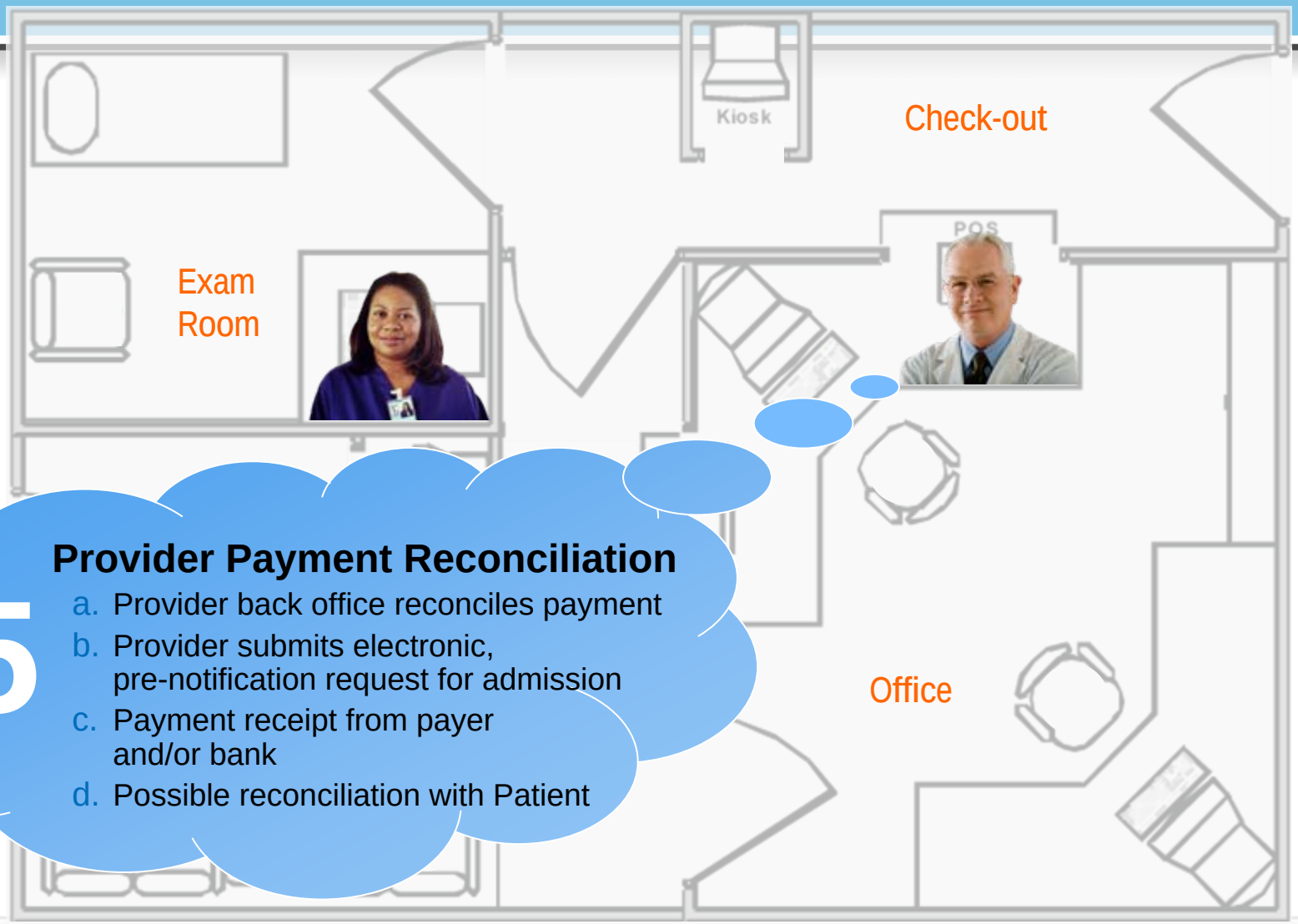

5 Provider Payment Reconciliation

a. Provider back office reconciles payment
b. Provider submits electronic, pre-notification request for admission
c. Payment receipt from payer and/or bank
d. Possible reconciliation with Patient

*Future availability

Three Barriers to Overcome in Health Plan-Provider Clinical Dialog

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- Insufficient clinical credibility:
  - Quality and timeliness of data
- Discontinuous with work (and information) flow
  - Need bi-directional communication to-from provider EMR
- The treadmill of current primary care
  - We must change the payment paradigm

Principles of New Payment Paradigm

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- (Apologies to providers, but…) start by recognizing how perverse the current system is
  - What if we bought other products and services the way we buy health care?
  - What if we bought health care products and services the way we do the rest of our business transactions?

- What do we want to buy?
  - Primary (and chronic disease) care: PCMH, IOCP
  - Hips, knees, heart and lungs: Bundled episodes
  - Population management (minus the insurance risk) please: Global capitation

Payment Reform

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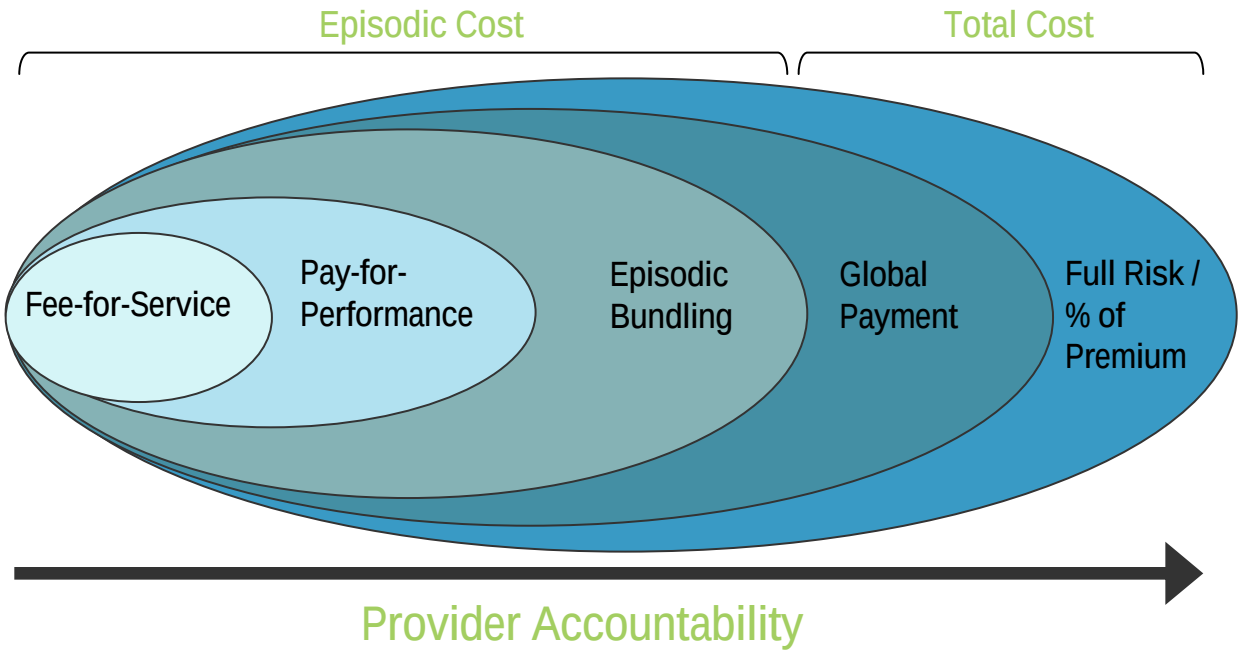
Continuum of Payment Models



Deployment depends on a number of factors:

- provider infrastructure and appetite for risk
- patient condition
- benefit design
- overall cost/quality problem to be solved

Medical Homes and Disease Management: Costs and Activities

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- Adherence
  - Rx
  - Scheduled doctors' visits
- Lifestyle changes
- Appropriate illness care-seeking
- Ordering labs
- Changing Rx
- Evaluate, treat, and/or refer
  - Other medical conditions
  - Metabolic syndrome
  - Depression

Who can deliver these services?

Are you already paying for this in primary care?

Where is it more efficient to deliver these services?

Why Have We Failed to Get What We Need From Primary Care??

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- Historical focus on acute care activities and costs
- Health plans and physicians: distrustful relationships
- Capitalism abhors a vacuum: Consultants and the disease management industry

Payment "Levers" and Impact on Trend

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Professional

	Fee-For-Service	Global Payment
Unit Price	Ø	Ø
Case Mix	Ø	★ ★ ★
Utilization	Ø	★ ★ ★

Facility

	Per Diem	Cost Plus	DRG	Global Pmt
Unit Price	Ø	★ ★ ★	Ø	★ ★
Case Mix	★	★ ★	Ø	★ ★ ★
Utilization	Ø	Ø	★ ★	★ ★ ★

Shortcoming:

- Global - financial viability of the recipient and regulatory issues
- Per Diem and DRG - do not address Outpatient

The Principles of the PCMH Model

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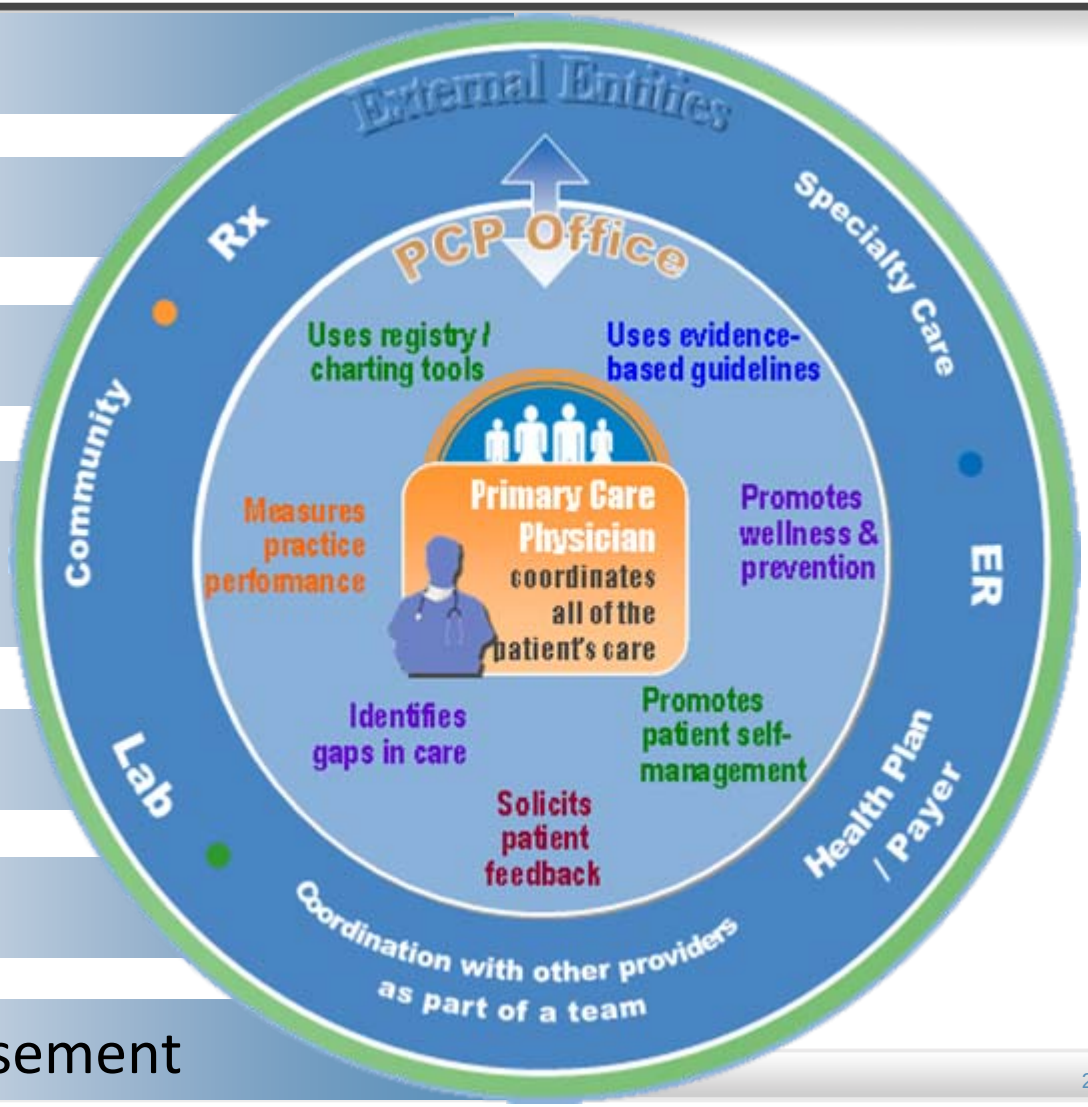
- Personal Physician
- Medical "Team"
- Whole Person
- Coordinated & Integrated Care
- Quality and Safety
- Enhanced Access
- Appropriate Reimbursement



PCMH: Value-Added Activities

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- Care coordination
  - Between physicians
  - Transitions of care
- Gaps & opportunities vs.evidence-based care
- Outreach and population management
- Team-based care
- Easy access for acute and chronic care
- Appropriate Rx
- Appropriate referral to cost-effective
  - Specialists
  - Facilities
- Continuous assessment for behavioral issues

Individualized care plan

Rank value these as compensated under RBRVS-based reimbursement

PCMH and HIT: Physicians and Plans Communicating Clinically

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- Registries
- Gaps in evidence-based care: Real-time!
- Ability to integrate our data with EMR
  - 2-way communication
- Data submission from physicians' office to plan
- Support of contracting and incentives
  - Member attribution logic
  - Clinical outcomes
  - Measurement of access

Real-time integration of health plan, PHR, EMR

Ability to support PCMH practices with desired services

Intensive Outpatient Care Program

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Engaged Employer

HCSC – Valued Partner

Eager Medical Clinics

Committed Member

IOCP

Common patient characteristics:

- Multiple chronic diseases (DM, Htn, Arthritis)
- Poor lifestyle choices (weight, smoking, activity)
- Incompletely treated depression, anxiety, substance abuse
- Life stresses >> Coping and support mechanisms
- Top 10% of patients consistently driving >> 50% of costs

Care Management Nurse Role:

- Distinct from, and synergistic with practice re-design (e.g. NCQA criteria) or provider clinical connectivity (MEDecision, Availity, etc.)
- RN employed in practice; dedicated to high-risk cohort
- 1 RN : 150 - 200 high-risk, high-cost patients
- Offers support
- Coordinates and ensure care is connected to their physician

20% net savings

Medical Home: Putting the Pieces Together

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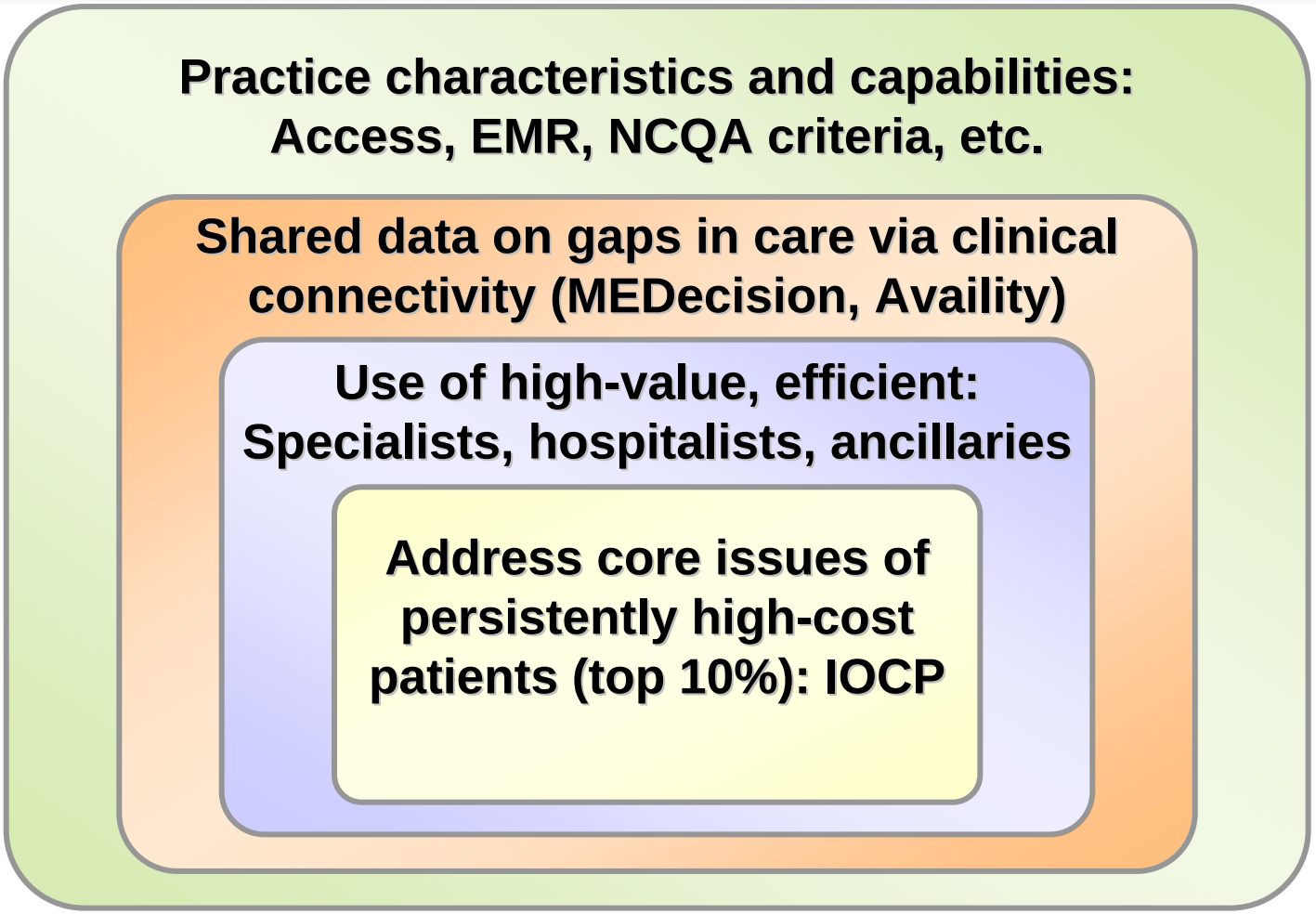

Bundles of Acute Care: Episode Construction and Data/Analytic Support

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- Surgical, medical
- Episode duration
- Services
- Risk adjustment
- P4P, Quality floors
- Claims payment and episode adjudication
- Network Strategy

Managed Care History

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1.0 Granola, good intentions and communities: the first HMOs

2.0 We can make good money at this: For-Profit HMOs and risk transfer

3.0 Who killed MC 2.0 and what took it's place: The rise of broad network PPOs, provider consolidation and vendor profits

4.0 History in process…

Let's Not Make These Mistakes Again

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- Insurance risk vs. clinical-financial accountability
  - Risk adjustment
  - Stop-loss, reinsurance and deep pockets
- Drop the money and walk away vs.:
  - Step-wise progression from P4P → bundling → partial risk → more risk
  - How are they going to make it work?
  - Clinical and administrative infrastructure
  - Ensure application of proven clinical programs
- Assuming quality and service will work vs.:
  - Imbedded P4P and/or quality floors

How will we support all this with data and analytics?
What does the ongoing collaboration look like?

Network Management Future State Scenario

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There will be two overall approaches to providers, with winners & losers, and a gradual, but incomplete shift to future state arrangements

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 Blue Advantage, 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

Provider Infrastructure

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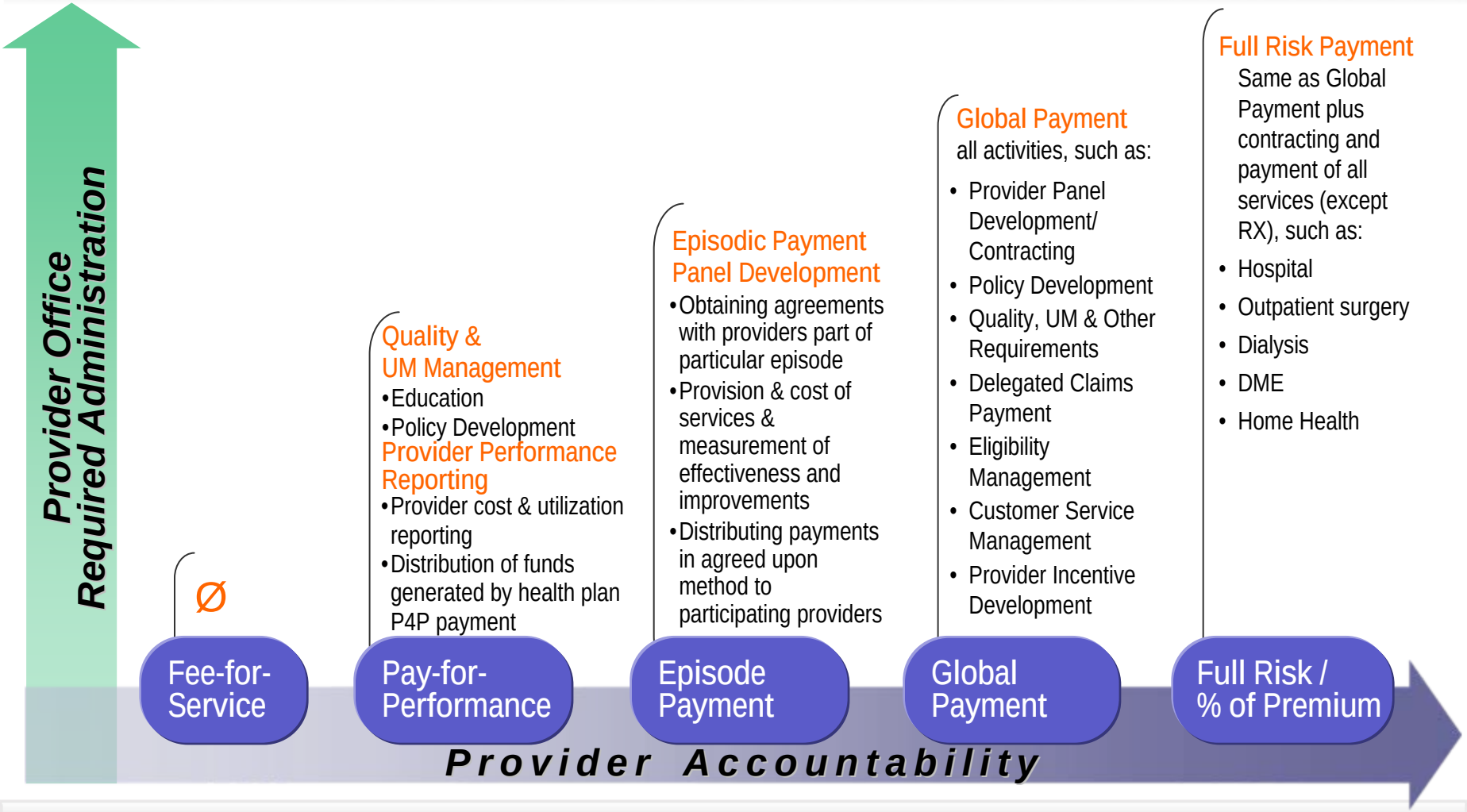

We Will Evolve (or…)

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	From	To
Analytics & data management	• Batched, long cycle times • Insular	• Continuous, concurrent • Integrated with EMRs and PHRs
Clinical programs & population management	• Plan or vendor-run DM & CM	• Accountable providers • Facilitated by bidirectional transfer or useful clinical information

Acute illness management within reasonable parameters of efficiency	• (UM)
	  • Front & back end
	  • Often inherently conflicutal with physicians & patients
		• Provider accountability & execution
		  • Facilitation by networks & HIT

Parting Thoughts

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- Careful shift of population risk to providers
- Analytics for risk-adjustment
  - Payment rates
  - P4P targets
- Analytics as value-add to providers if:
  - Timely
  - Accurate
  - Incorporated info (and data abstracted from) EMS

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Thank you.

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