Population Health Management and Quality Improvement
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Anthem, Blue Cross Blue Shield
Conflict of Interest

Veeneta Lakhani, MBA
Has no real or apparent conflicts of interest to report.
Agenda

• Overview of provider collaboration: payer perspective

• Deep dive into shared savings/shared risk provider collaboration program

• Enablement Solutions: Leveraging analytics, tools and transformation expertise in support of provider success
Learning Objectives

• Understand payer's perspective on value based care transformation

• Deep dive into shared savings: How it works

• How people, process, and technology need to come together to drive results
Anthem: A Health Benefits Leader

BC or BCBS plans in **14 states** and Medicaid presence in **19 states**

Diverse customer base of **38 million** medical members

- **BlueCard** 14%
- **National Accounts** 19%
- **Local Group** 41%
- **Medicaid** 13%
- **Medicare** 4%
- **FEP** 4%
- **Individual** 5%

- BC or BCBS licensed plans (6)
- BC or BCBS licensed plans + Medicaid presence (8)
- Medicaid presence (11)
We are leading the charge to transform the system

**Unsustainable Cost**
- 20% of GDP by 2021
- $700B waste across U.S. system
- 2x cost per capita versus OECD nations

**Variation in Quality**
- 45% care inconsistent with recommended guidelines
- $210B unnecessary services
- 3x variation in hospital days in last 6 months of life

**Lack of Coordination**
- 19.6% Medicare hospital readmissions
- $45B annual costs for avoidable complications
- $91B redundant administrative practices
Framing our role in driving change
Landscape of Anthem Payment Innovation Programs

- **796 Hospitals**
  - In Anthem’s Hospital P4P Program

- **152 ACO Contracts**
  - In operation

- **4.5 Million Members**
  - Attributed to ACOs/PCMHS

- **54,000 Providers**
  - In Enhanced Personal Health Care Contracts

- **$50 billion**
  - In spend tied to ALL value-based payment programs

**Continued Commitment to Value-based Payment**

<table>
<thead>
<tr>
<th>Current Spend</th>
<th>2018 Goal</th>
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<tbody>
<tr>
<td>37% Traditional FFS</td>
<td>50%</td>
</tr>
<tr>
<td>18% FFS payment linked to quality (e.g. P4P)</td>
<td>40%</td>
</tr>
<tr>
<td>45% Shared savings, shared risk, and Population-based payment.</td>
<td>10%</td>
</tr>
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## Payment Innovation
A Spectrum of Solutions

<table>
<thead>
<tr>
<th>Provider Facing: Change the way care is delivered</th>
<th>Member Facing: Steer to high-value providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Global Capitation</strong></td>
<td><strong>Tiered Benefits – Primary</strong></td>
</tr>
<tr>
<td>Providers receive a single payment for managing the health of the patients in their panel</td>
<td>Offer highest level of benefit when member selects high-quality cost-effective primary care</td>
</tr>
<tr>
<td><strong>Shared Savings/Risk:</strong></td>
<td><strong>Reference Based Benefits</strong></td>
</tr>
<tr>
<td>Providers rewarded with shared savings when they meet cost/quality targets</td>
<td>Uses reference pricing to set a “budget” for a given procedure; member accountable for cost above threshold.</td>
</tr>
<tr>
<td><strong>Bundled Payment:</strong></td>
<td><strong>Tiered Benefits - Specialty</strong></td>
</tr>
<tr>
<td>Single payment to a group of providers covering an episode of care (e.g. joint replacement)</td>
<td>Offer highest level of benefit when member selects high-value specialty/inpatient care</td>
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<tr>
<td><strong>Pay for Performance:</strong></td>
<td><strong>Transparency:</strong></td>
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<tr>
<td>Rewards providers with bonus payments for meeting quality/safety objectives</td>
<td>Make quality and cost data accessible to members to guide provider choice</td>
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**Degree of risk**

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Payment Innovation in Action
Enhanced Personal Health Care

Incentive Alignment

Quality Score Card
Calibrates shared savings eligibility

Medical Cost Target
Determines eligibility for shared savings

Attribution:
Algorithm to assign members to PCPs

Clinical Coordination Payments
Support investment in population health management

Provider Care Management Solutions
Population health analytic support

Care Delivery Transformation
Team and resources for performance improvement

Enhanced Personal Health Care
Improving cost and quality
Program year 1

Cost of care
Total Medical allowed PaMPM decreased by $9.51 compared to matched sample control group*; net cost savings of $6.62

Quality
EPHC providers performed better on quality measures providers outside the program across all 5 of our prevention and chronic condition management quality bundles

Member Experience
EPHC members report better access to urgent care, better communication with providers, and higher satisfaction the amount of time they spent with their doctors
Product Partnerships
Local Networks of Value-based Care

High quality, high value product for defined market, built around Anthem’s BDTC providers*.

Aligns providers in new business alliances with products in California.

ACO product partnership built around Aurora Health Care system in Wisconsin.
What is Enablement?
Anthem’s Approach

People + Process + Technology + Culture = Success

- It all starts with physician engagement
- Solutions: It’s not one size fits all
- Scalability requires commitment
- Capabilities must balance short and long term trends
- Power in claims and clinical data together
- It’s an evolution, not a revolution
## Technology and Services

An evolving landscape

<table>
<thead>
<tr>
<th>Population Health Management Services</th>
<th>Population Health Technology Platform</th>
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</thead>
<tbody>
<tr>
<td>▪ Practice Transformation</td>
<td>▪ Data Aggregation</td>
</tr>
<tr>
<td>▪ Care Team Support</td>
<td>▪ Longitudinal Community Record</td>
</tr>
<tr>
<td>▪ Patient Engagement</td>
<td>▪ Attribution</td>
</tr>
<tr>
<td>▪ Referral Management</td>
<td>▪ Clinical Analytics</td>
</tr>
<tr>
<td>▪ Coding Experts</td>
<td>▪ Financial Performance Analytics</td>
</tr>
<tr>
<td>▪ Systems integration support</td>
<td>▪ Bi-directional care management referrals</td>
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Physician Engagement
Approach Care Delivery Transformation

**Step 1**
- Engage practice
  - Welcome Packet
  - Intro Visits
  - Collaborative Learning

**Step 2**
- Provide Practice with Tools of Transformation
  - Reports and Data
  - Practice Advisor
  - Virtual Tool Kit
  - Cost of Care Resources

**Step 3**
- Assess Practice Transformation Capabilities
  - Transformation Action Plan (TAP)
  - Intervention Bundles
  - Collaboratively establish Smart Goals and targeted Learning Plans

**Step 4**
- Provide targeted coaching
  - Teach QI skills, reliable work flows and use of data
  - Teach skills for Care Coordination and Care Management
  - Function as external consultant on roadblocks and obstacles
  - Provide feedback on progress
Enablement: Population Health Management Services
• One Size does not Fit All

<table>
<thead>
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<th>Enablement</th>
<th>Provider</th>
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<tr>
<td><strong>Transformation Support</strong></td>
<td><strong>Care Delivery</strong></td>
</tr>
<tr>
<td>Introduce tools, incentives, and collaborative learning</td>
<td>Diagnosis and treatment</td>
</tr>
<tr>
<td>Reviews performance data and intervention opportunities</td>
<td>Health promotion and patient education</td>
</tr>
<tr>
<td>Collaboratively engage clinical leadership on improvement opportunities</td>
<td>Management of acute and chronic illness</td>
</tr>
<tr>
<td>Shapes and tracks action plans</td>
<td>Disease prevention</td>
</tr>
<tr>
<td>Partner on quality improvement initiatives</td>
<td>Patient outreach</td>
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</tbody>
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| **Care Team Support** | **Care Coordination** |
| Identifies member-level intervention opportunities | Referrals to CM/DM and other resources |
| Ensures seamless coordination with providers – no overlap | Patient follow-up in care planning/adherence |
| Maximize outreachs to patients on behalf of physician | Patient advocacy |
| Deliver complimentary resources and processes | |
| Track patient engagement and outcomes | |
Enablement: Commitment to Scalable Solutions

4.6 million Attributed Members

$22B medical spend

43K PCPs

3,400 monthly care coordination checks to providers

74 million data exchange transactions per month

1,700 provider groups registered on PCMS, accessing application ~3,000x per month

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Population Management

- Alerts, icons, hover overs, drop downs, and drill-through to support population health management
- Supports workflows around care gap closure, utilization management, readmission prevention, and care coordination
- Ability to filter patient population by key conditions, risk factors, gaps in care, and visit history

Performance Management

- Integrated and dynamic financial scorecard to help identify most actionable performance measures
- Offers drill down capability into scorecard, to identify actionable opportunities (e.g. specific providers and/or members) that will improve organization’s financial performance
- In development: cost and utilization trends around impactful types of service
Enablement

- Balance interventions and supporting capabilities across short term and long term trends

**Short-Term**

- **Redirection to High Value Services**
  - Avoidable E/R
  - Generic Rx utilization

- **Remove waste**
  - Avoidable admissions
  - Avoidable duplication

**Long Term**

- **Closing gaps in care**
  - High risk care management and coordination
  - Safe transitions

- **Proactive prevention** via well-visits, immunizations, annual exam

- **Chronic disease management and care planning**

- **Member engagement** focused on self/lifestyle care
Driving Performance through Analytics

**Total cost / population management—Identifying trend drivers**

- Understanding and managing costs and key utilization drivers
- Reducing avoidable ER
- Identifying and managing high-risk patients and gaps in care

**Finding the Most Cost Effective Site of Service / Steerage**

- Lab Services
- Infusion Services
- Ambulatory Surgery
- High Cost Imaging
- Selecting high quality/low cost providers - Blue Precision Specialty Care

**Brand to Generic and Reducing over-use / duplication of services**

- Switching to Generic Equivalents where available
- Avoiding duplication / overuse of tests and procedures
- Care Compacts to coordinate care, reducing duplication
Power of claims and clinical data

Provider Care Management Solutions

- Cost of Care
- Longitudinal Patient Record
- Risk Adjustment
- Care Coordination
- Medical Record Admin
- Client Outcomes Reporting
- Consumer Engagement
- Quality Improvement
- Data Exchange
- Referral Management
- Add-on
- CM
- Lab
- EMR
- HIE
- Claims
- ADT
- Rad
- Member

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We all are evolving: payer, provider and member

**Anthem:**
- Integration across the medical neighborhood
- Products wrapped around value-based payment
- Enhanced enablement and data integration

**Providers:**
- Accountability for increased risk
- Responsibility for care management and coordination activities

**Members:**
- Becoming informed, savvy healthcare consumers
Questions

• Veeneta Lakhani, VP Provider Enablement

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