

PCMHs, AQCs, ACOs and the evolving Health Care Landscape... *An Insurer's Perspective*

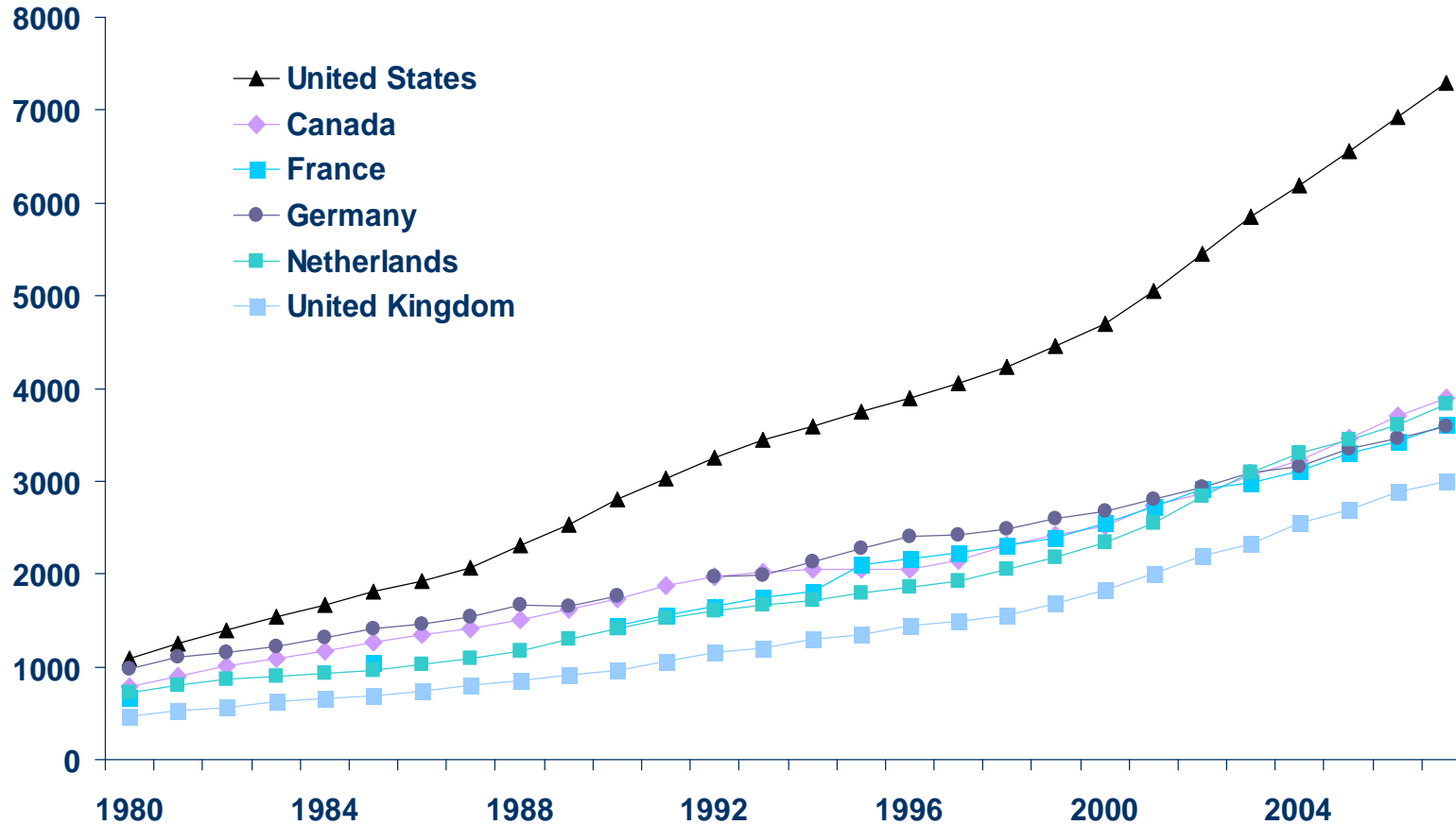
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The Big Question: Can we get this under control?

Average spending on health per capita (\$US PPP)



Data: OECD Health Data 2009 (June 2009).

ACO's begin with Primary Care Oriented Delivery System

- Accountable Care Organizations Begin with a Primary Care Oriented Delivery System
- One key way BCBST is promoting this is through our Patient Centered Medical Homes:
 - Partnership with key primary care physicians across the state
 - Improving outcomes for Chronic patients (Diabetes, Asthma, CAD, CHF, COPD, and Hypertension)
 - Evolving payment model to promote quality, outcomes and value to all stakeholders
 - Leverage medical homes to promote and support EHR adoption across Tennessee
 - Provide access to PCMHs for at least 50% of chronic patients across TN by the end of 2012

BCBST PCMH Key Pillars

- Care Management Fee - BCBST Member /Patient Access
- Care Coordinators - LPN or Equivalent in Practice
- IT Infrastructure Development - Business stipend for IT Support
 - Electronic Health Records
 - Disease Registries
 - E-visits, e-consultations, secure e-mail, telemedicine...
- Performance Management - Shared savings yr 2 and beyond
 - Reducing ambulatory sensitive care
 - Increasing use of evidence-based guidelines for evaluation and treatment
- NCQA PC Medical Home Certification - Level I Required
 - Expect movement to levels II & III

Note: Specialist Consultant Network in Development

BCBST PCMH – Challenges

Practice Challenges

- Identification of Physician and Administrative Champions
- Coordination within practices of differing PCMH models in place
- Data Exchange
- IT limitations
 - Need to build trust
- Practice feeling urgency of needing to partner with somebody
- Competing partnership priorities

BCBST Challenges

- PCMH Growth vs. Operational Resources
- PCMH Reporting Demands
- Limited Internal Resources for Competing Priorities
- Client Relationships (Insurer/Purchaser) Challenge to shared savings models
- BlueCard Operations
- Regional Resource Support and PCMH Alignment
- Acceptance of Performance Bonus/Shared Savings Program
- Short-term ROI vs Long-term ROI
- ASO clients – how to create pool for shared savings models

BCBS Massachusetts AQC Value Proposition

Provider

- *Sustainable competitive advantage based on value as high quality efficient provider*
- *Margin expansion*
- *Increased volume through transparency and plan designs*

Member/Patient

- *Transparency creates educated, engaged consumers*
- *Incentives for choosing the right providers*
- *Incentives for wellness and compliance*



Employer

- *Affordable premium*
- *Predictable cost increases*
- *Improved workforce productivity*

BCBSMA

- *Supports transformation of health care delivery system*
- *Fulfills promise to put our members' health first*
- *Delivery of affordable products*

Key components of the Mass Alternative Contract model

❖ Unique contract model:

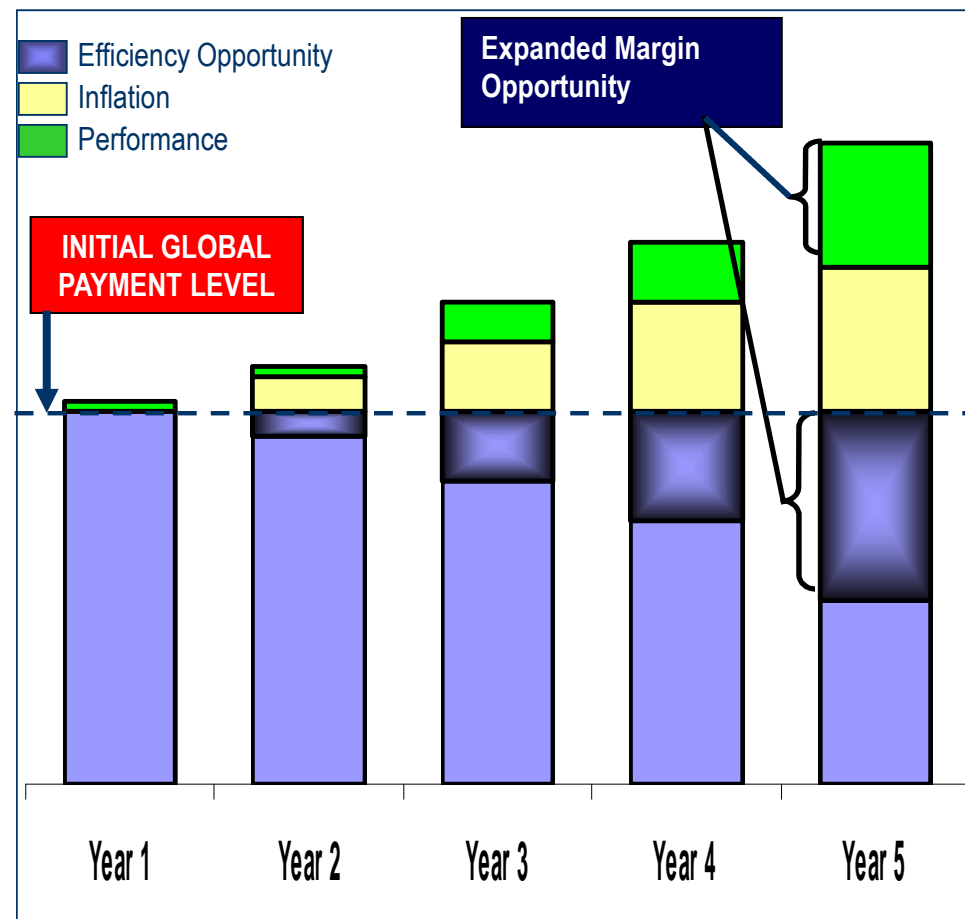
- Physicians & hospital contracted together as a “system” – accountable for cost & quality across full care continuum
- Long-term (5-years)

❖ Controls cost growth:

- Global payment for care across the continuum
 - All medical costs (ambulatory, specialty, IP, OP, ancillary, behavioral health and pharmacy)
 - Includes provider infrastructure costs
 - Includes risk management, high cost claimants
- Annual inflation tied to CPI
- Incentive to eliminate clinically wasteful care (“overuse”)

• Improved quality, safety and outcomes:

- Robust performance measure set creates accountability for quality, safety and outcomes across continuum
- Substantial financial incentives for high performance (up to 10% upside)



How Is this Different from Capitation?

- Includes a significant upside potential based on a sophisticated set of measures that address patient safety, appropriateness of care and patient satisfaction
- Initial payment level is derived from the historical experience of the provider group.
- Payment is adjusted annually in line with inflation
 - Global payment is not reset annually
 - Providers can retain margins derived from reduction of inefficiencies
- Payment is health status adjusted to adequately consider changes in patient morbidity

Defining Performance Measures for the AQC

- Overarching goal: Measures should collectively advance care to the end-state vision of safe, affordable, effective, patient-centered care
- Clinical performance measures will include process, outcomes and patient care experiences; and will encompass inpatient and ambulatory care.
- AQC performance framework based on thresholds (“gates”) with the following attributes:
 - High performance defined in absolute terms (rather than high relative to competitors or the market)
 - Incentives structured to motivate both high performance and continued improvement
 - Use of gates affords “transparency” to providers regarding full scope of BCBSMA performance priorities and expectations

Performance Measures For The BCBS Mass AQC

Hospital Quality and Safety

- Clinical process measures
 - Acute MI
 - Heart Failure care
 - Pneumonia care
 - Surgical care
- Clinical outcomes measures
 - Hospital-acquired infections
 - Complications after major surgery (AMI, PE/DVT, Pneumonia)
 - Obstetric trauma
- Patient Care Experiences
 - Communication quality: physicians
 - Communication quality: nurses
 - Responsiveness
 - Discharge support/planning
- Developmental Measures

Ambulatory Care Quality

- Clinical process measures
 - Depression
 - Diabetes
 - Cardiovascular Disease
 - Cancer Screening
 - Pediatric: Appropriate Testing / Treatment
 - Pediatric: Well Child Visits
- Clinical outcomes measures (triple-weighted)
 - Diabetes (HbA1c, LDL-c and BP control)
 - Hypertension (blood pressure control)
 - Cardiovascular Disease (BP control, LDL-c control)
- Patient Care Experiences
 - Quality of clinical interactions
 - Integration of care
 - Access to care
- Developmental Measures

Global Payment as A Tool for System Reform

- “...Relative to other options, global payment has the greatest potential for encouraging shifts in health care resource use from low-value to high-value services. To counter the possibility of undertreatment, global payment should be implemented in the context of ongoing performance measurement and reporting. Expanding global payment will also encourage provider to become more organized....”
- “...There are obviously important challenges for global payment, including developing credible risk-adjustment mechanisms and finding provider systems willing to accept global risk.”

Source: Mechanic RE, Altman SH. *Health Affairs* 2009

Accountable Care Organizations & The Affordable Care Act of 2010

Insurance Standards, Plans, and Premium Review	State or regional exchanges; private and co-op plans offered; essential health benefits 60%–90% actuarial value, four tiers plus young adults policy; insurers must meet medical loss ratio of 80 percent for individual and small groups, 85 percent for large groups; review of premium reasonableness
Primary Care, Prevention, and Wellness	Primary care 10% bonus for 5 years; Medicaid payment rates to primary care physicians no less than 100% of Medicare rates in 2013 and 2014; annual wellness visit and/or health risk assessment for Medicare beneficiaries; preventive services without cost-sharing; local and employer wellness programs
Innovative Provider Payment Reform	CMS Innovation Center; Medicaid medical home designation; test bundled payment for acute and post-acute care; Value-Based Purchasing
Accountable Care Organizations	Accountable Care Organizations to share savings in Medicare
Controlling Health Spending	Independent Payment Advisory Board recommendations to meet Medicare expenditure target; total system spending non-binding recommendations; productivity improvement update factor
Quality Improvement and Public Reporting	Direct HHS to develop national quality strategy, public reporting
Medicare Private Plan Competition	Level the playing field between Medicare Advantage and traditional Medicare FFS plans
Cost-Conscious Consumers	Introduce a 40% excise tax on high premium health insurance plans beginning in 2018

Note: ACO = accountable care organization;
 PCP = primary care physician;
 AHRQ = Agency for Healthcare Research and Quality.
 HHS = Department of Health and Human Services
 Source: Commonwealth Fund analysis.



BCBST Sees Opportunities in Tennessee

- Regional & National Collaboratives
 - Tennessee Center for Patient Safety
 - TIPQC (Tennessee Initiative for Perinatal Quality Care)
 - TN NSQIP, Pediatric NSQIP (National Surgical Quality Improvement Program)
 - Memphis Region Ambulatory Quality Collaborative
 - Memphis Quality Collaborative
 - Specialty Collaboratives
- Quality Measurement
 - Primary Care & Ambulatory Care
 - Specialty Care
 - Hospital-based Care
- Patient Experience
- Building Trust / New Collaborative Organizations
 - Patient Centered Medical Homes & Neighborhoods
 - Accountable Care Organizations

What Questions Should Employers Ask???

- How do you define care efficiency & value?
 - **Ambulatory care sensitive admission & emergency dept use rates** (e.g. Diabetes complications, CHF complications, pneumonia complications – due to lack of care coordination and follow-up)
 - **Preference sensitive condition admissions** (e.g. Low back pain management, evaluative diagnostics, surgery)
 - **Potentially avoidable complication rates** (e.g. Anemia post-operatively)
- What experts in the field of cost/value/quality are you working with?
 - Prometheus & Dartmouth Atlas
 - THA Delta Group Specialty Specific Efficiency
 - Treo Solutions
 - MedVantage Cost/Quality Scoring
- What is the Role of Transparency / Public Reporting?
- What Should Employers Ask?
 - How can we support these efforts?
 - How can benefit design help?
 - How can we ensure a share of the savings goes to promote primary care best practices (quality & efficiency)?

Questions ???

