



Illinois
New Mexico
Oklahoma
Texas

Innovative Models for Accountable Care

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Are they new??

What **is** different?

What **needs** to be different?

Will anything **make** a difference?

What is the difference we **want** to make?

Health Care Service Corporation (HCSC)

- More than **13.1 million** members
- Operating Blue Cross and Blue Shield Plans in
 - Illinois
 - Oklahoma
 - New Mexico
 - Texas



New Models: Intensive Outpatient Care Program (IOCP)

Top 10% of patients drive $\geq 60\%$ of costs

How can we control costs without better managing these patients?

Physician-employed Case Manager for Highest-Risk Patients



IOCP



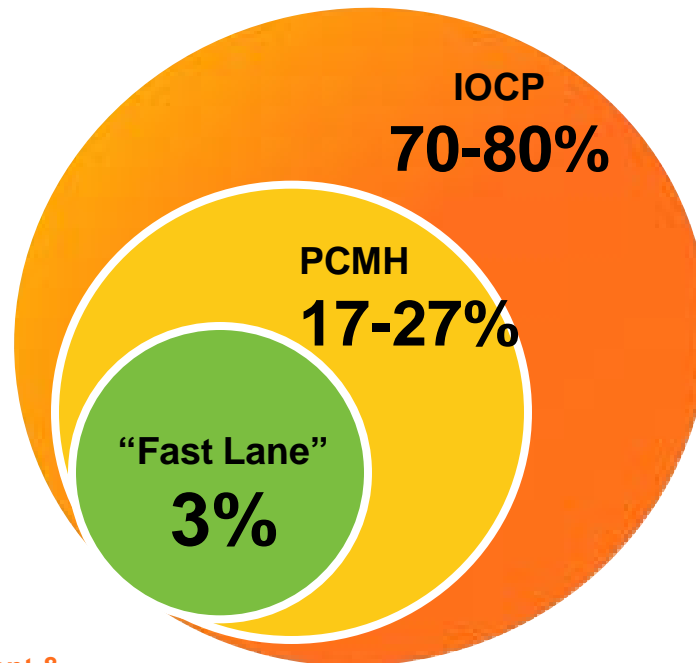
- Multiple chronic diseases (DM, Htn, Arthritis)
 - Poor lifestyle choices (weight, smoking, activity)
 - Incompletely treated depression, anxiety, substance abuse
 - Life stresses >> Coping and support mechanisms
- * How well do our current programs address their needs?

- RN employed in practice; dedicated to high-risk cohort: 1:150-200
- Distinct from, and synergistic with practice re-design (e.g., NCQA criteria) or provider clinical connectivity (MEDdecision, Availity, etc.)
- Offers medical and psychosocial support
- Coordinates and ensures care is connected to their physician
- Can expand beyond traditional primary care specialties

→ 20% NET SAVINGS

Primary Care Total Value Creation

VALUE CREATION:
Start with
Focused Approach to
Highest Cost Patients



	← Persistent & Actionably High Cost →	← At Risk/Early Stage →	← Healthy →
Population	IOCP: High Risk PCMH	At Risk PCMH	Fast Lane
Model Description	Individualized intensive active management of the sickest individuals within the population via dedicated manager support	"IOCP" Lite for early chronics and social/ behavioral engagement for at-risk individuals	Provision of access and low touch convenience services for the healthy
% Members	10-20%	25-35%	55%
% Costs	50-60%	20-25%	20-25%

New Models: ACO Shared Savings Agreement

Who? Advocate Health Care

- 10 hospitals and 2,700 physicians
- 250,000 attributed Blue Cross PPO lives
- 120,000 Blue Cross HMO lives
- \$2 billion annual Blue Cross spend

How?

IF medical cost trend better than network
AND meet patient quality, safety, and
satisfaction metrics, **THEN** share in savings

What?

- Three-year (2011–2013) shared savings PPO agreement with upside and downside risk
- Three-year global risk HMO agreement

Where?



New Models: Transferring Learning from HMO to PPO ACO Shared Savings Agreement

PPO

**Total BCBSIL
Members seeking
care at Advocate**

**Acute
Episodic
Care**
(ex. Surgery)

**Personal
Physician**

“Attributed” members

Total cost of care, including:

- Physician
- Hospital
- Ancillary
- Rx, if applicable

Shared savings model

for beating aggregate
network medical trend

- Guaranteed threshold
- Then shared savings
- Dependent on hitting quality targets

Accountable Models:

How Do We Facilitate Provider Success and Avoid Historic Mistakes in Risk Transfer?

Selection of provider partners	Clinical leadership and infrastructure (including key clinical programs; HIT and analytics)
	History of successful MCO partnerships
	Financial stability
Pace	Graduated increase in risk transfer (IOCP → bundling → partial risk → more risk) based on documented success
Don't mix insurance risk with medical management	Risk-adjustment and size of risk pool
	Stop-loss, reinsurance
Ensure quality	Significant provider financial and contract risk around clearly predefined quality parameters
	Quality floor (e.g., BDC) or ceiling (P4P)
Data and Analytics	Key metrics/dashboard for joint review
Ongoing collaboration	Clearly predefined metrics (dashboard) and joint oversight group/process

Network Management Future State Scenario

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 BlueAdvantage, 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 or us: who can do it better/more efficiently





NO 'Silver Bullets'

NO 'Secret Sauce'

LOTS of work and collaboration

NEW and different relationships

Benefit design **CHANGES**

