Care Coordination

Health Insurance Marketplace HealthCare.gov

Innovation In Care Coordination

Scott Streator
SVP, Market & Product Group

Chris Turner
SVP, New Business Integration & Member Care

CareSource

June 9, 2016

Health Insurance Marketplace HealthCare.gov

October 31, 2013

Agenda

- Who is CareSource
- What We Learned
  - Enrollment Snapshot
  - Success Factors
- Care Coordination of Newly Insured
- Innovation in Care Coordination

CareSource®

Health Care with Heart

Non-profit, founded in 1989 in Dayton, OH

Comprehensive, member-centric health and life services

Regionally based-serving multiple states and products

MISSION FOCUSED:

To make a lasting difference in our members' lives by improving their health and well-being.

Product Lines

- Medicaid
- Marketplace
- Duals Demo
- Medicare Advantage

1.52M members

100k

Marketplace Enrollment Growth

Marketplace Coverage

Why We Were an Early Adopter

Commitment to uninsured
&
vulnerable populations

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Enrollment Snapshot

Common Diagnoses

- Hypertension
- Lipid Disorders
- Low Back Pain
- Obesity
- Diabetes

60%
Silver Plan

20%
Prior Medicaid

87%
Receive Subsidies

41.9
Average Age

18% are under age 35

46% Male / Female **54%**

47-63%
Previously Uninsured

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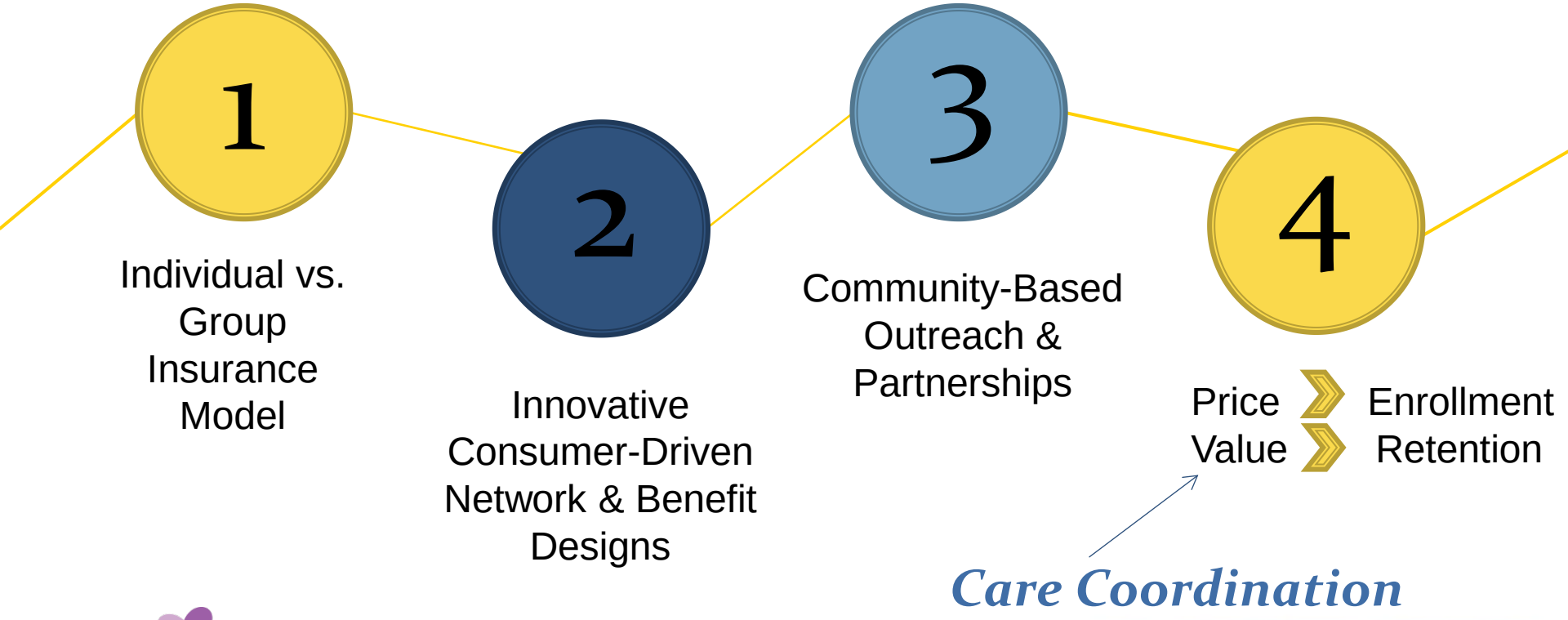
Marketplace Success Factors



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Care Coordination Case Studies

Welcome Call

- Vulnerability Index
- Health Risk Assessment

Identify Members for Care Coordination

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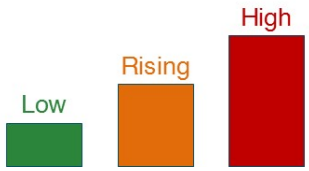
Our Care Model

Population Health Approach

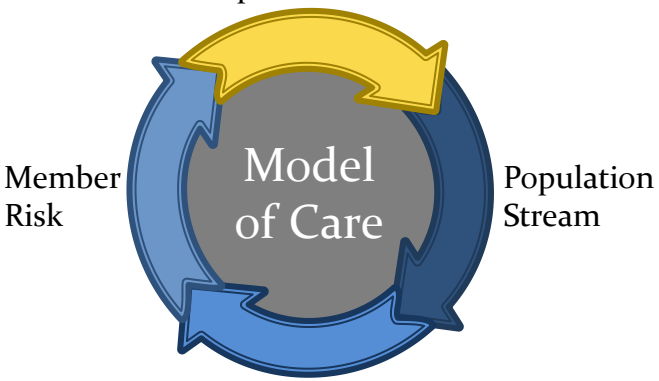
Actionable Insight to Slow Member Progression

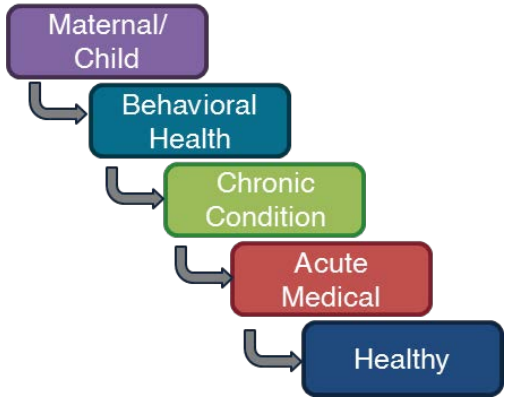
Who manages member's health?

	Self	Health Partner	1:1 Care Coordination
Monitoring	✓		
Low	✓		
Medium	✓	✓	
High	✓	✓	✓
Intensive	✓	✓	✓
Complex	✓	✓	✓



Population Risk





- Life
- Coordination
- Evidence-based

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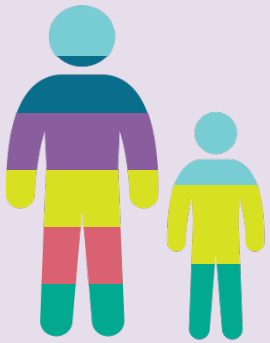
Life Services:
Managing Social Determinants of Health

HEALTH-RELATED SOCIAL NEEDS

HEALTH



Health-related social needs are found where people live, learn, work and socialize; they impact health outcomes.

ECONOMIC STABILITY

- ACCESS TO LONG-TERM EMPLOYMENT
- ACCESS TO FINANCIAL LITERACY
- ACCESS TO ADULT EDUCATION & JOB TRAINING
- INCREASED ASSETS SUCH AS HOME OWNERSHIP

+

HOUSING & NEIGHBOR-HOODS

- ACCESS TO HEALTHY FOODS
- INCREASED QUALITY OF SAFE & AFFORDABLE HOUSING
- IMPROVED ENVIRONMENTAL CONDITIONS

+

EDUCATION

- EARLY CHILDHOOD EDUCATION & DEVELOPMENT
- ACESS TO EXTRACURRICULAR ACTIVITIES & MENTORING
- INCREASE HIGH SCHOOL GRADUATION
- ENROLLMENT IN JOB TRAINING OR POST SECONDARY EDUCATION

+

SOCIAL RELATION-SHIPS

- SOCIAL COHESION
- CIVIC PARTICIPATION
- PERCEPTIONS OF DISCRIMINATION & EQUITY
- INCARCERATION / INSTITUTIONALIZA-TION

+

FOOD & NUTRITION

- REGULAR & CONSISTENT ACCESS TO HEALTHY FOODS
- EDUCATION ON NUTRITION & OVERALL HEALTH IMPACTS
- ADDRESSING FOOD DESSERTS & INEQUALITIES

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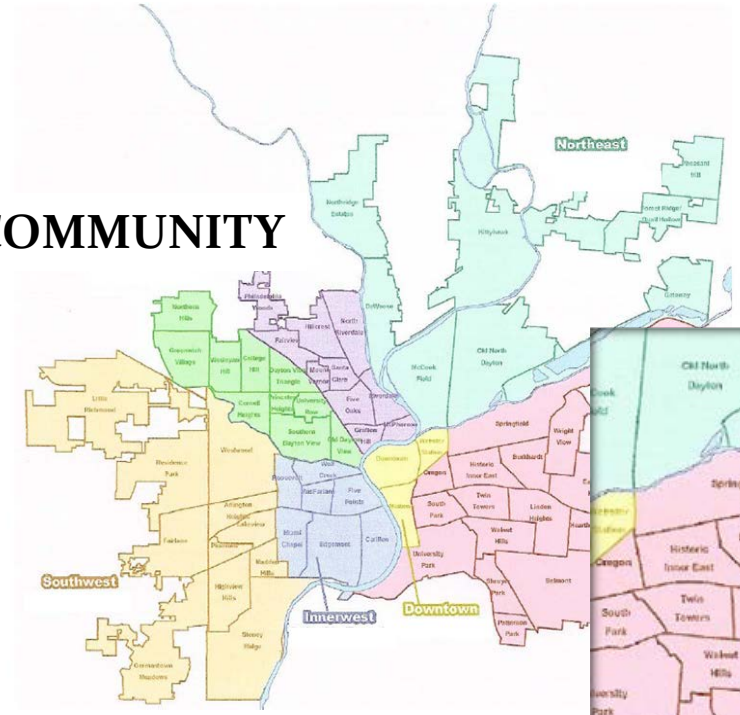
Neighborhood Centered Member Care

REGION

COMMUNITY



NEIGHBORHOOD

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Innovation Supports Improved Outcomes

- Health, Wellness and Care Plans
- Health Risk Assessment
- Member Engagement
- Tailored Interactive Member Experience
- Service Access and Utilization
- Overall Cost Per Member / Month Cost

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Conclusion

- Innovate
- Population Health
- Care for Everyone
- Care is Local
- Relationships
- Rising Risk
- Social Determinants

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Place of Delivery Care Model

A collaborative approach for high-risk patient care

Deborah Stewart, M.D.
Regional Medical Director
Florida Blue
June 9, 2016

Health Insurance Marketplace HealthCare.gov

Innovative Solutions/Customer

GuideWell Emergency Doctors

Free-standing ERs staffed by board-certified emergency physicians billing at urgent care (not ED) fees

CliniSanitas

Culturally relevant, comprehensive care addressing needs of Central and South Americans

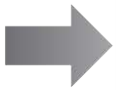
Florida Blue Retail Centers

Retail centers that engage, educate, enroll, provide health assessments and in several locations attached to care providers

Transforming our Medical Management Model

Historically

- Disease-Centric Approach
- Moderate Array of Support Services
- Non-Scalable Care Model
- Post-Event Care Interventions
- Limited Engagement Channels
- Almost Exclusively English-Based
- Average Quality Ratings



Future State

- Member–Centric Approach
- Robust Continuum of Services
- Model Scaled to Support Product/Network Arrangements
- Real Time and Prospective Care Support
- Leveraging Most Effective Engagement Channels for Population
- Culturally Competent to Serve Target Markets
- Competitive Results on all Quality Standards

Progress **80%** **Future State**

Why the POD Model?

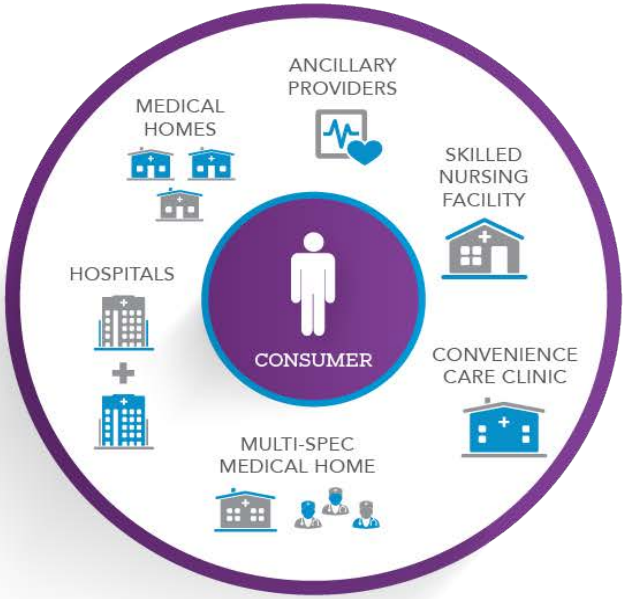
- Improve quality, utilization and cost outcomes for members.
- Coordinates care for high-risk members in the community where they receive their services.
- Builds and improves relationships with members and their medical provider.
- Leverage national best practices.

Current Environment

"Old World"

- Employer-based coverage
- Large open provider networks
- Self directed care management

"Future World"



- Consumer-centric care
- Geo-and product specific networks
- Collaborative care management (ACOs, PCMHs, CCMs)
- Population care management model

How We Make the Greatest Impact

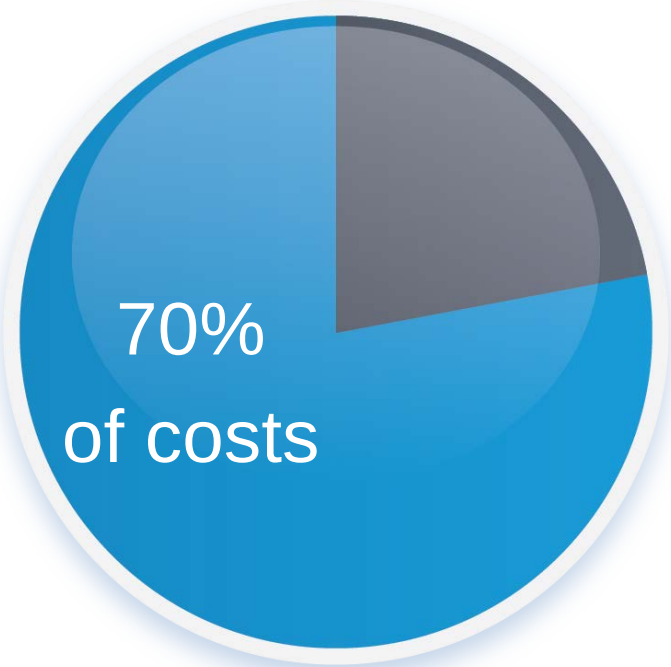
PODs focus on complex-care members who drive 60% to 70% of costs.

This breaks down to:

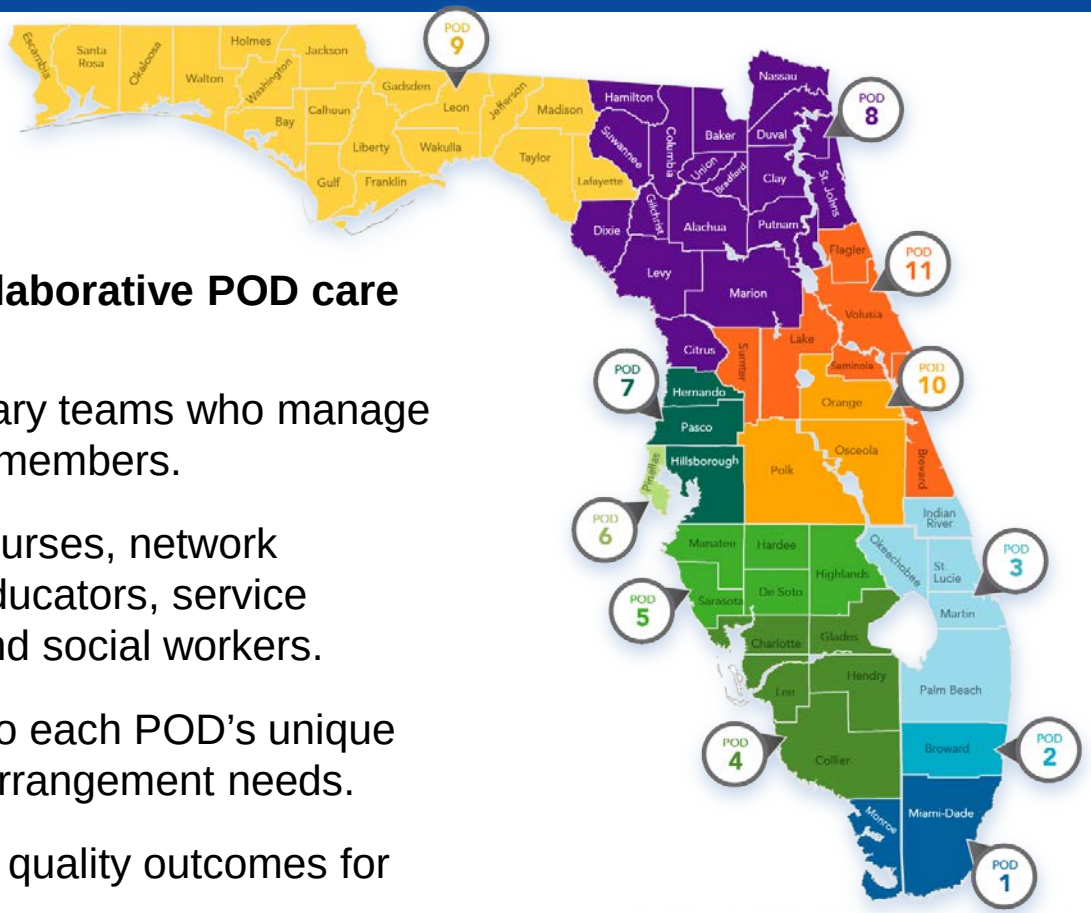
- 1% of the fully insured
- 5% of Affordable Care Act (ACA)/individuals under 65
- 10% of Medicare Advantage members

=

Complex-Care Membership Cost



POD Design and Implementation

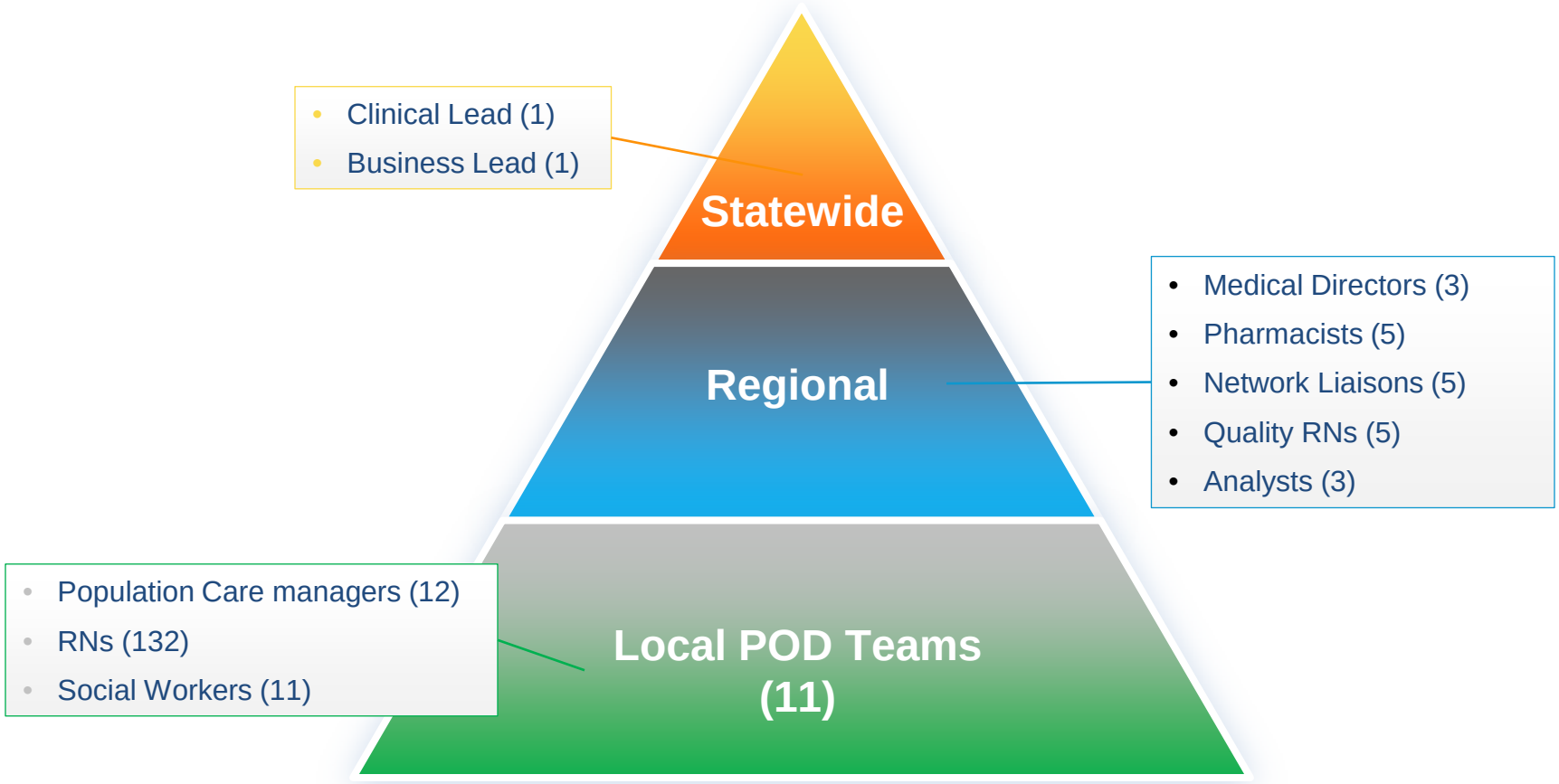


Eleven (11) locally based, collaborative POD care models:

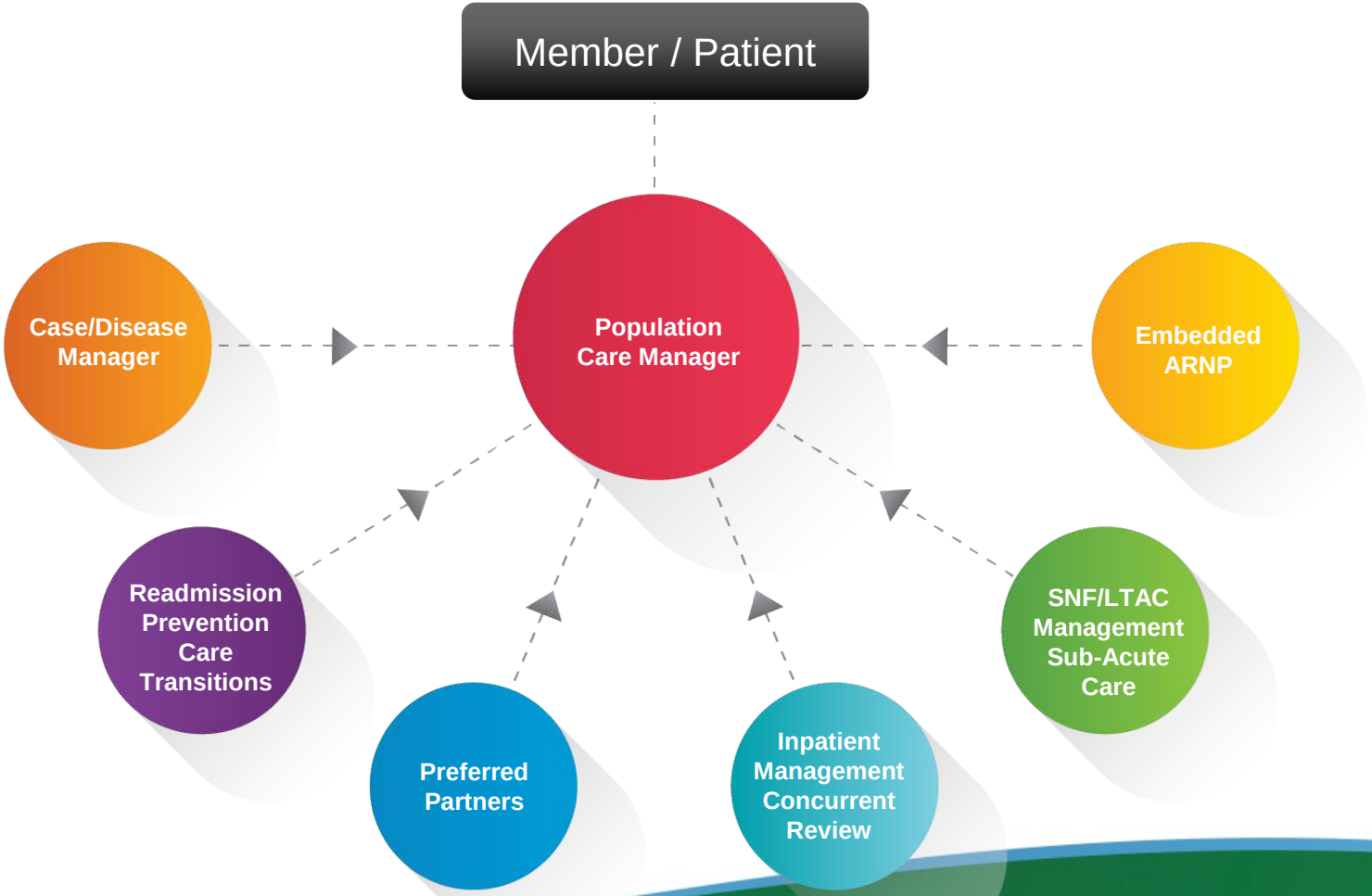
- Geo-specific, inter-disciplinary teams who manage the care needs of high-risk members.
- Florida Blue staff includes nurses, network liaisons, analysts, coding educators, service consultants, pharmacists and social workers.
- Staffing levels customized to each POD's unique membership and provider arrangement needs.
- Accountable for clinical and quality outcomes for target population.

POD Design and Implementation

POD Clinical Support by Vicinity



POD Population Care Manager and Team



POD Model Success Measures

- Admits/1000
- ER Visits/1000
- Per member/per month (PM/PM) cost
- Pharmacy spend
- Stars & HEDIS rates

- Quality results (Stars, HEDIS)
- Trend compared to targets and market
- Per member/per month (PM/PM) cost compared to target and market

- Contracting trend
- Services performed by preferred providers (value based)

- Customer surveys
- Target operational satisfaction metrics

ACA Inpatient Admits, Readmits

Admissions	
Jan. 2015	Jan. 2016
93 admits/1,000	**76** admits/1,000

Readmission Rates	
Jan. 2015	Jan. 2016
11.5%	**10.7%**

PODs fully implemented Sept. 2015

CMS Marketplace Forum
Care Coordination

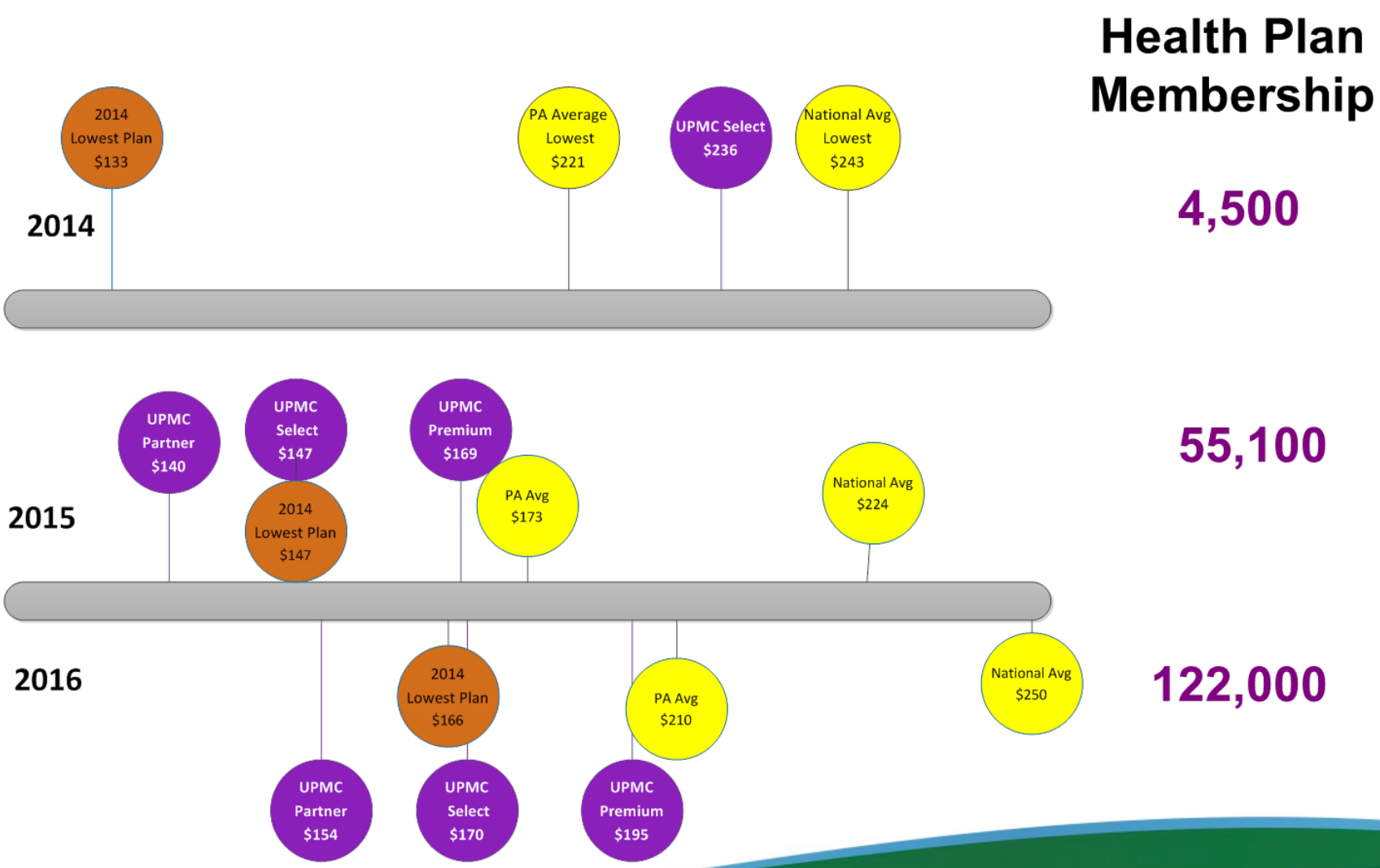
UPMC Health Plan
Adam Pittler, MBA Director Consumer Products
Roseanne Degrazia, Associate VP Clinical Affairs
June 9, 2016

Health Insurance Marketplace HealthCare.gov

UPMC's Integrated Delivery and Financing System Approach

- **UPMC Has Been An IDFS Since 1998** We're committed to improving the health of our members and community, implementing cost-effective solutions, creating innovative product offerings, service excellence, and leveraging our unique structure to partner with community providers, our patients, our members, and our purchasers.
- **Provider-focused, integrated systems are best positioned** to create innovative clinical models that improve care and reduce expenses – the imperative we must embrace in order to thrive in the future.
- **Continued support of physicians coupled with investments** in our systems and infrastructure enables the ongoing success of our integrated delivery and financing model.
- UPMC, through its Integrated Delivery and Financing System, is **partnering with community hospital systems and physicians** to create the highest quality, cost effective care to improve the health of the communities we serve.

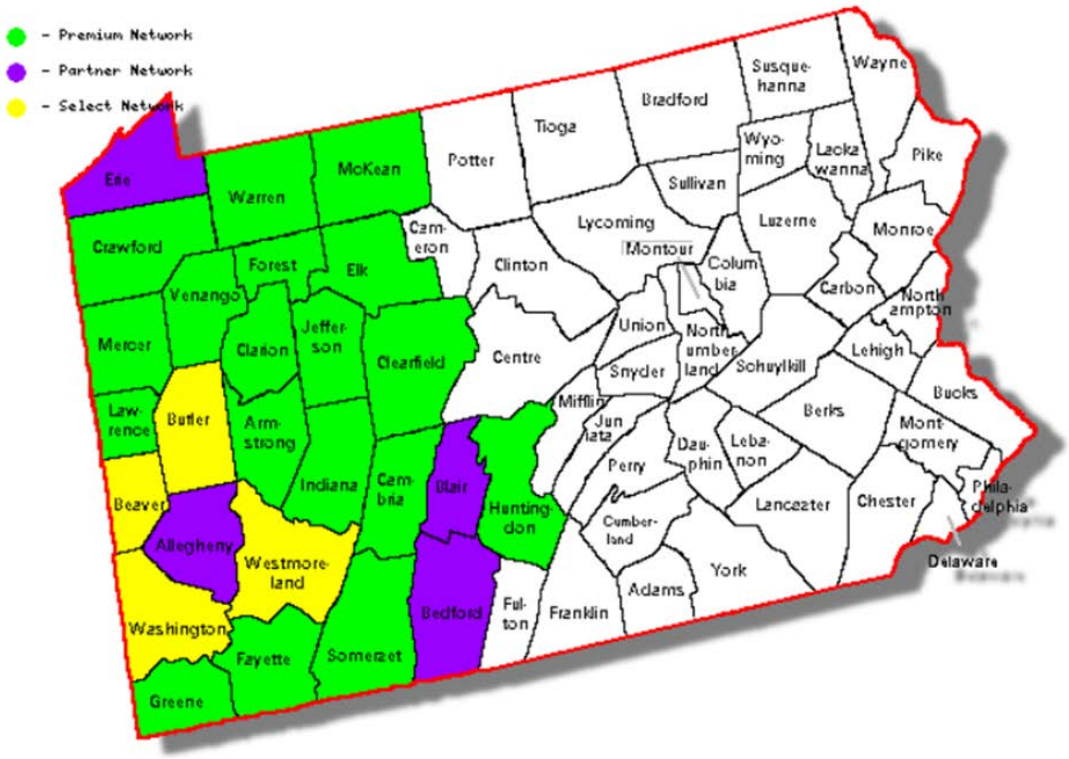
UPMC's Individual Market Experience



UPMC's Individual Market Network Strategy

Develop High Quality/Low Cost network options at the local level

- **Premium Network**
  - Traditional Commercial Network
  - Full 29 County Service Area
- **Select Network**
  - UPMC + Local Community Hospitals
  - 80%+ Shared Savings/PCMH PCPs
- **Partner Network**
  - UPMC Focused
  - Available in counties where UPMC has a hospital presence

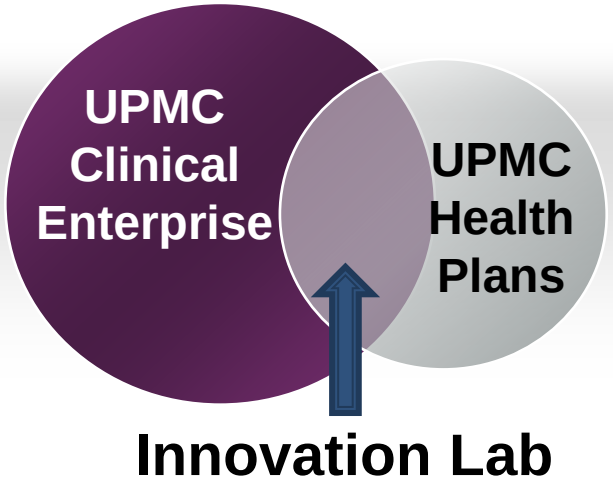


Aligning Plan and Provider Effectiveness

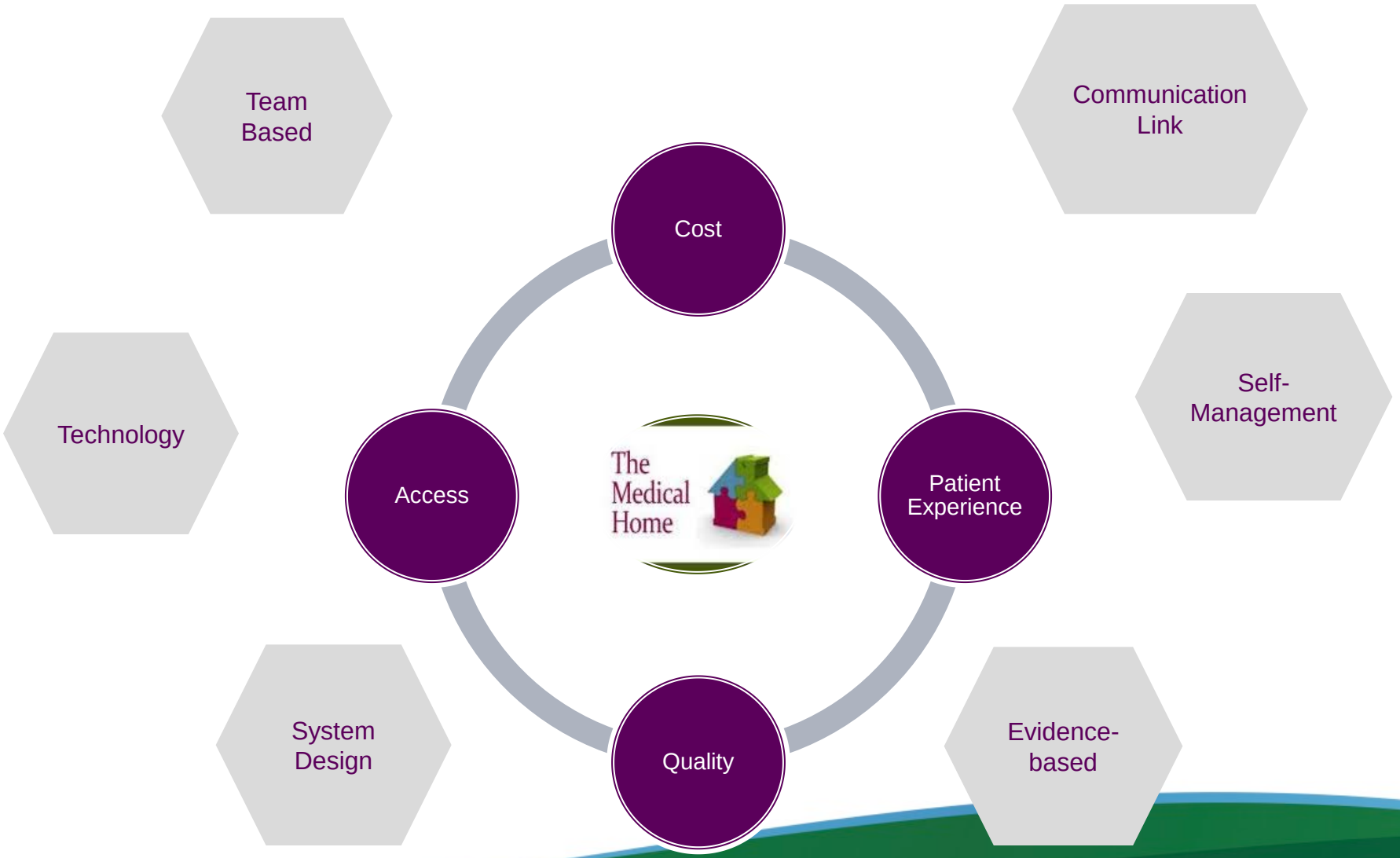
Integrated Delivery and Financing System Innovation Lab

Advantages

- Creates synergistic provider and payer business growth and development strategies
- Combines provider and payer expertise to drive improved outcomes
- Aligns clinical and financial incentives to create value
- Creates administrative efficiencies



UPMC Health Plan Medical Home



UPMC Continues to Focus on People, Process and Technology to Unleash the Power of an Integrated System

Value Network

Right Infrastructure
- People
- Process
- Technology

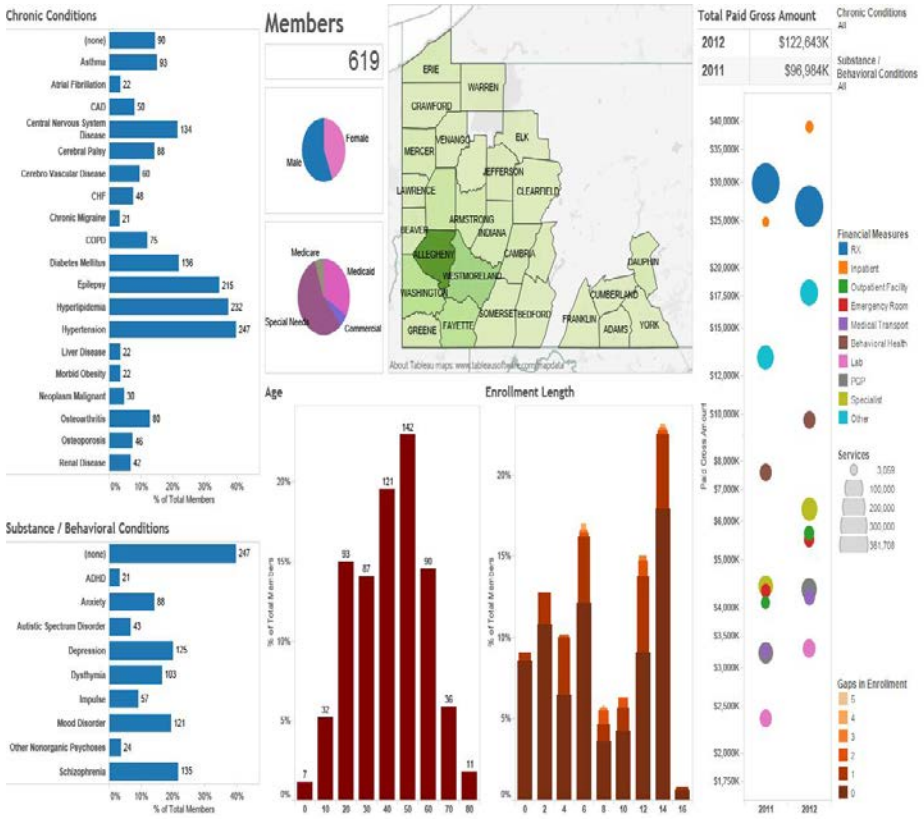
Right Clinical Model
- Standardized Protocols & Registries
- Care Transition Programs
- Patient Centered Services
- Chronic Care Management Models
- Lifestyle Coaching & Education

Right Consumer/Patient Supports
- Consumer Incentives
- Transparency: Cost/Quality
- Shared Decision Support Tools

Right Economic Incentives
- Gainsharing
- Capitation and Bundled Payments
- Care Management Payment
- Performance Payment
- Benefit Designs

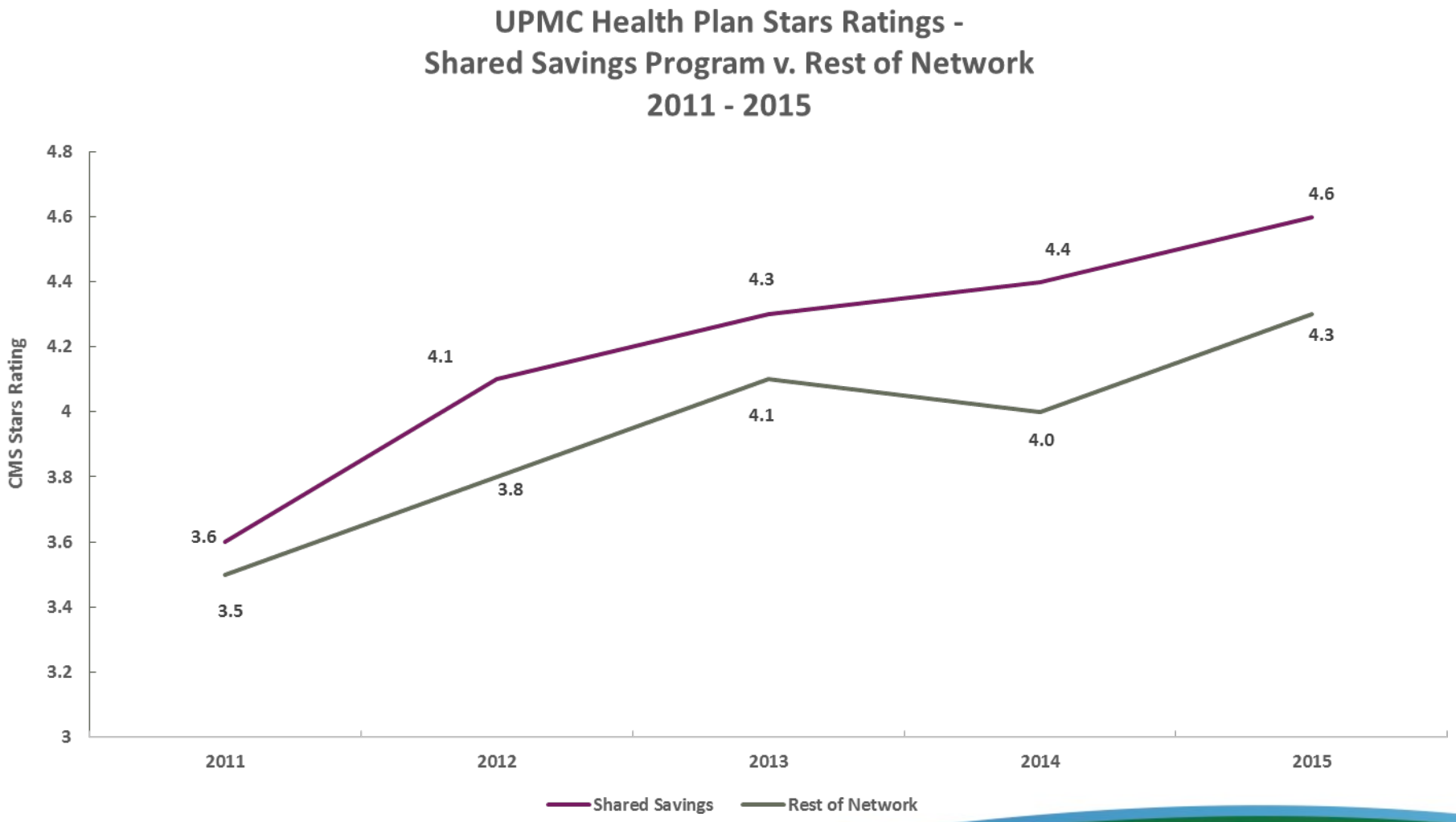
Improved Quality and Cost and Patient Experience

UPMC Health Plan 5th Year of Medical Home Transforming Care Delivery

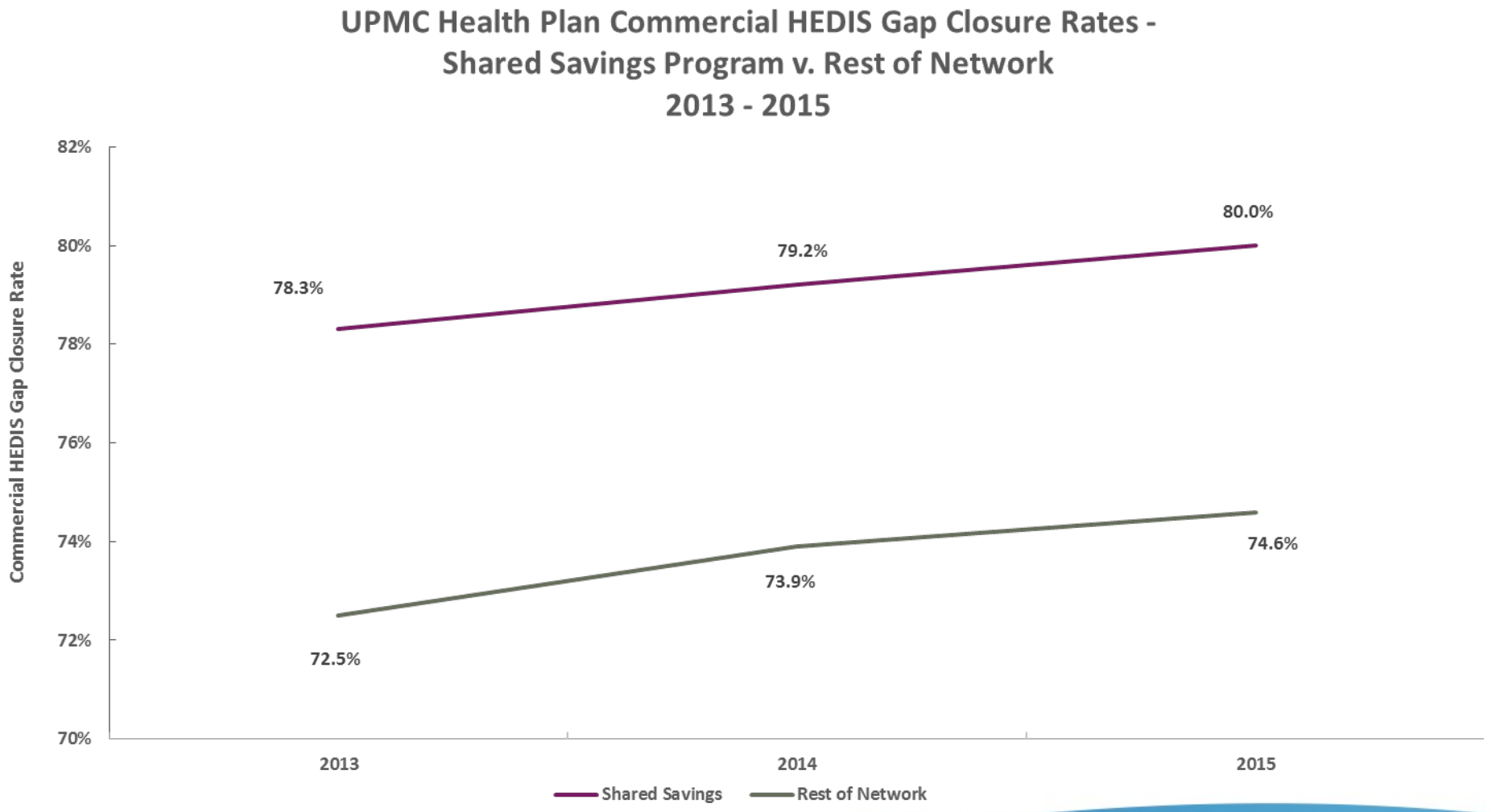


- UPMC Health Plan 422 active sites in Medical Homes
- ~1,000 primary care physicians participating
- Improved care coordination and quality outcomes
- Data and physician report cards drive results
- Integrated primary care and Health Plan coaching teams

Shared Savings Quality Trend – Medicare/SNP: 2011-2015

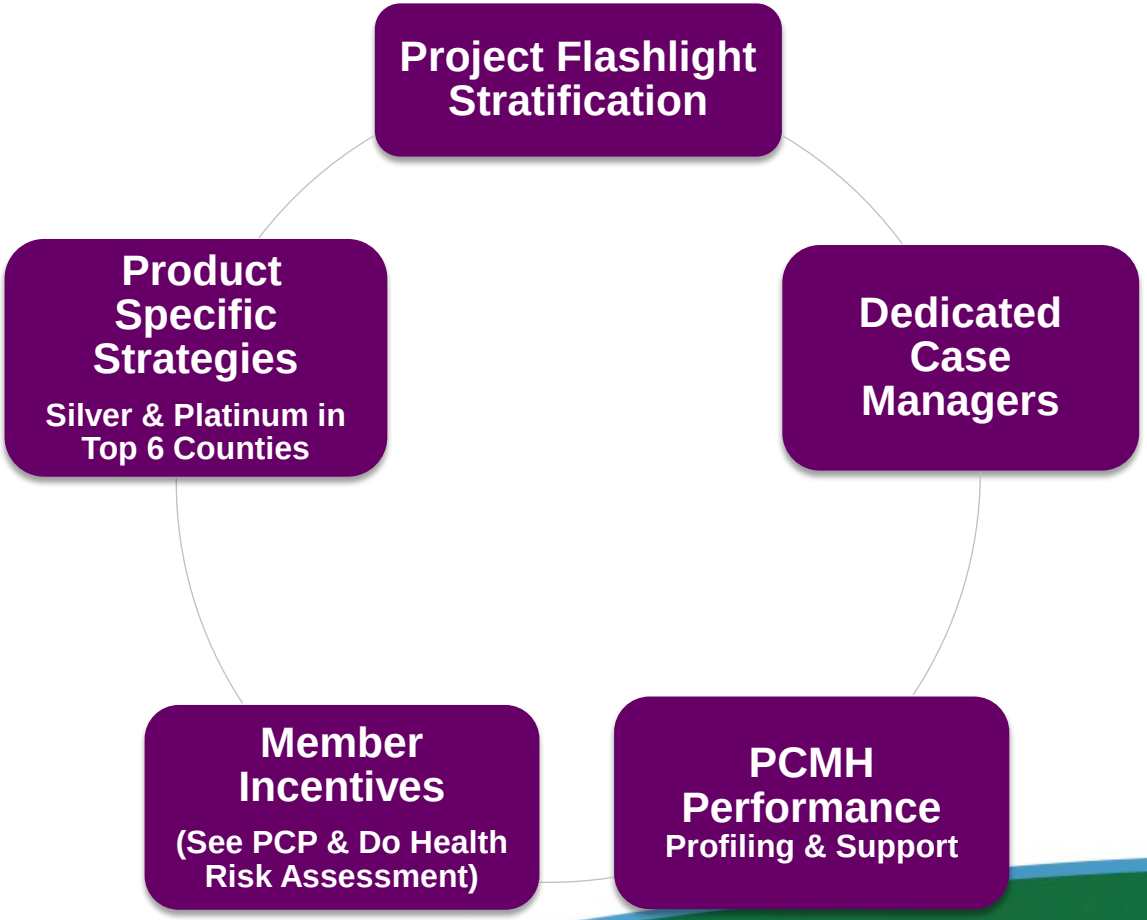


Shared Savings Quality Trend – Commercial: 2013-2015



Marketplace Population Health and Care Management

Improving Strategies for CY16



Proactively Identifying this Population Data sources & Risk Factors – continuous stratification using cost experience

Lifestyle Preferences & Demographics	History of Complex Conditions	Pharmacy Utilization
• Acxiom Marketing Data • Member Demographic Data	Medipac Data Extraction of Inpatient and ER Encounters at UPMC Facilities	Pharmacy weekly claims data
UPMC Doctor's Office Information (EPIC)	MARS Data	Prior Medicare Data

14 medical diagnoses	
Cancer	Hemophilia
Hepatitis C	Sickle Cell
HIV	Multiple Sclerosis
Diabetes	Atrial Fibrillation
CHF	Transplant
CKD	Obesity
COPD	Premature delivery

14 medications	
Anti-rejection drugs	Hemophilia
Depression combination therapy	Hepatitis C
Polypharmacy DUR meds	Inflammatory bowl disease
Long acting injectable antipsychotics	Multiple sclerosis
Chronic Kidney Disease	Oral chemotherapy
HIV	Sickle cell
> 9 medications	17P (maternity)

Proactively Identifying this Population

Individual Market Model Example:

- What creates the initial & early prediction?

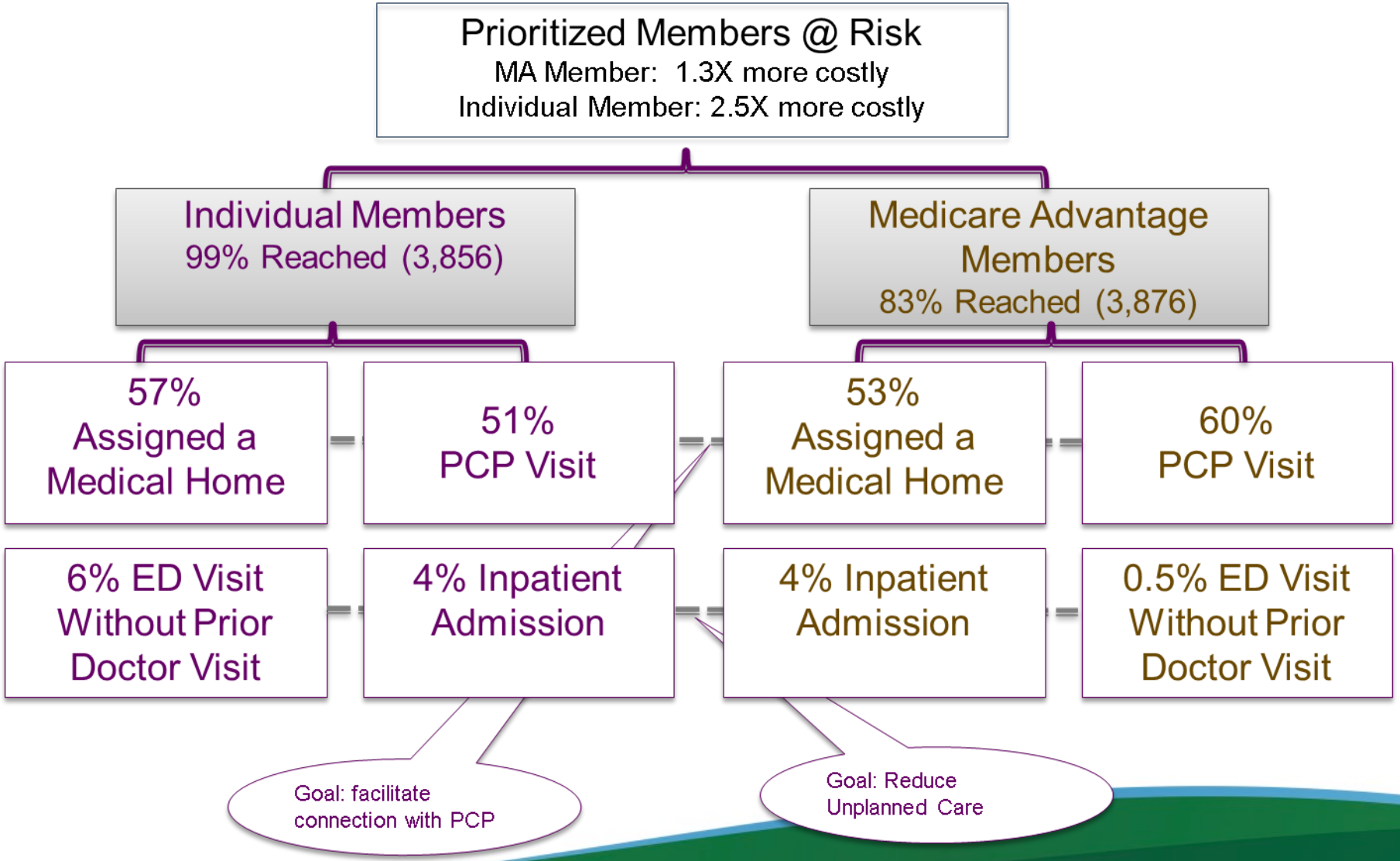
Metal Level	Subsidy	Area Deprivation Index	Product
Geographic Region	Property Type	Length of Residence	Network
Age	Sex	Marital Status	NULL

- Risk Categories / Rules

Predicted TCOC Risk Category	% Exchange Population	Median TCOC PMPM
Low	59.4%	$232.86
Medium	30.9%	$482.55
High	9.6%	$733.97

- Validation
  - Vendor Risk Score Model – Uses claims data to predict future risk.
  - DOHE new Individual Exchange Member model

What happened in CY15 with members identified at risk?



Project Flashlight

December 2015 Initial RISK Review of New Individual & Medicare Advantage Product Enrollees

CY2016 Individual Product enrollee pool

- Currently indicating higher predicted risk mix than CY2015 enrollee pool with net impact (to-date):
  - **3.7% increase in high risk member share**
  - **2.2% increase in medium risk member share**
  - **5.8% decrease in low risk member share**

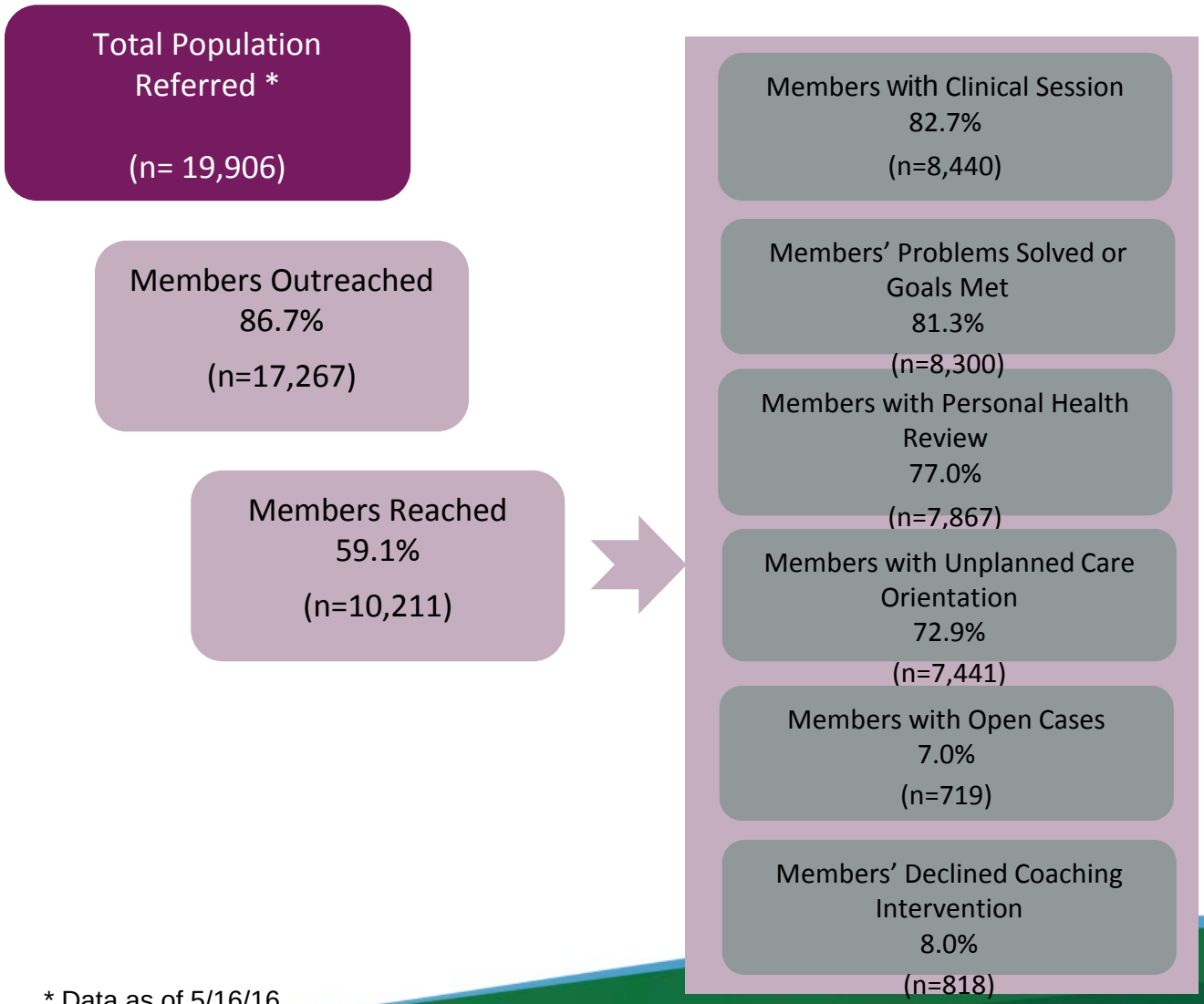
Enrollment Period	Enrollees	High Risk	Medium Risk	Low Risk
CY2015 Final	**60,562**	**9.6%** (n=5,814)	**30.9%** (n=18,714)	**59.4%** (n=35,974)
CY2016 (enrolled-to-date)	**18,864**	**21.3%** (n=3,984)	**40.7%** (n=7,613)	**37.5%** (n=7,011)

CY2016 Medicare Advantage Product enrollee pool – Stable Mix

- Currently indicating similar predicted risk mix as CY2015 enrollee pool.

Enrollment Period	Enrollees	High Risk	Low Risk
CY2015 Final	NULL	**24.9%**	**75.1%**
CY2016 (enrolled-to-date)	**6,819**	**26.7%** (n=1,821)	**73.3%** (n=4,998)

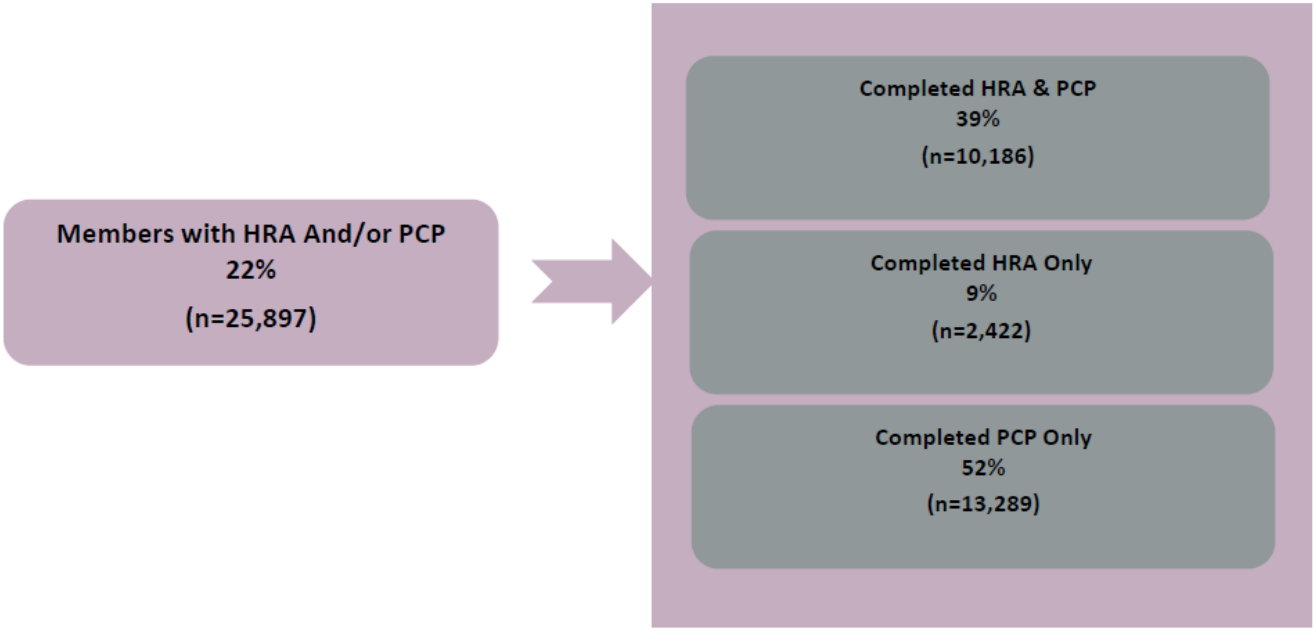
2016 New Member Clinical Outreach – Project Flashlight



* Data as of 5/16/16

ACA UPMC Advantage New Member

- **22%** of total 2016 membership have completed some portion of the incentive



- **45%** of 2016 membership targeted by members services has completed an HAS (8,477)
  - 21% (1,780) referred over to HM based on triggers

Cross Functional Team: New Member Case Referrals

Member Services Welcome call

- 5 Q HRA Individual
- Medicare Getting to Know You Survey including 5 Q Predicative HRA questions
- Selecting a PCP

Clinical Team

- Provide early intervention and care management assistance.
- Assist member in selecting a PCP and schedule PCP appointments
- Provide a direct point of contact between the Provider, Health Plan and member/caregiver(s)
- “Unplanned Care School”
- Facilitate member engagement into health management & wellness programs
  - ✓ *Engage the care coordination team early including the Provider, Case Manager, Social Worker to build relationships*