

Innovation in Provider Contracting



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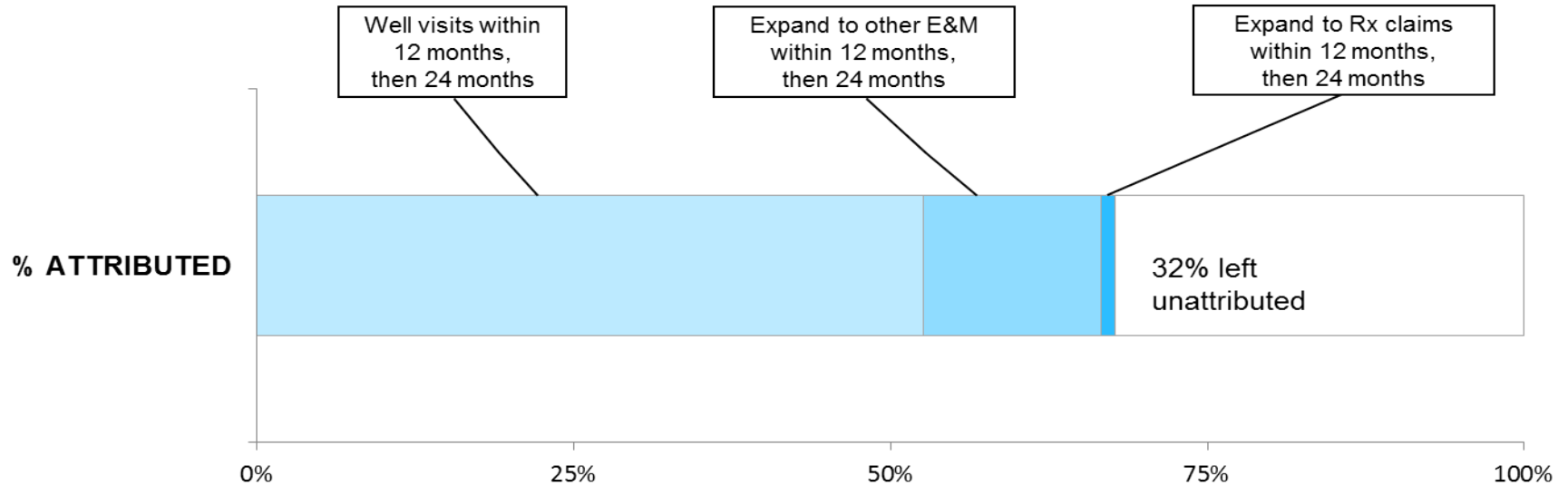
MASSACHUSETTS



Innovation in Payer / Provider Partnerships

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Analytics and Chief Actuary

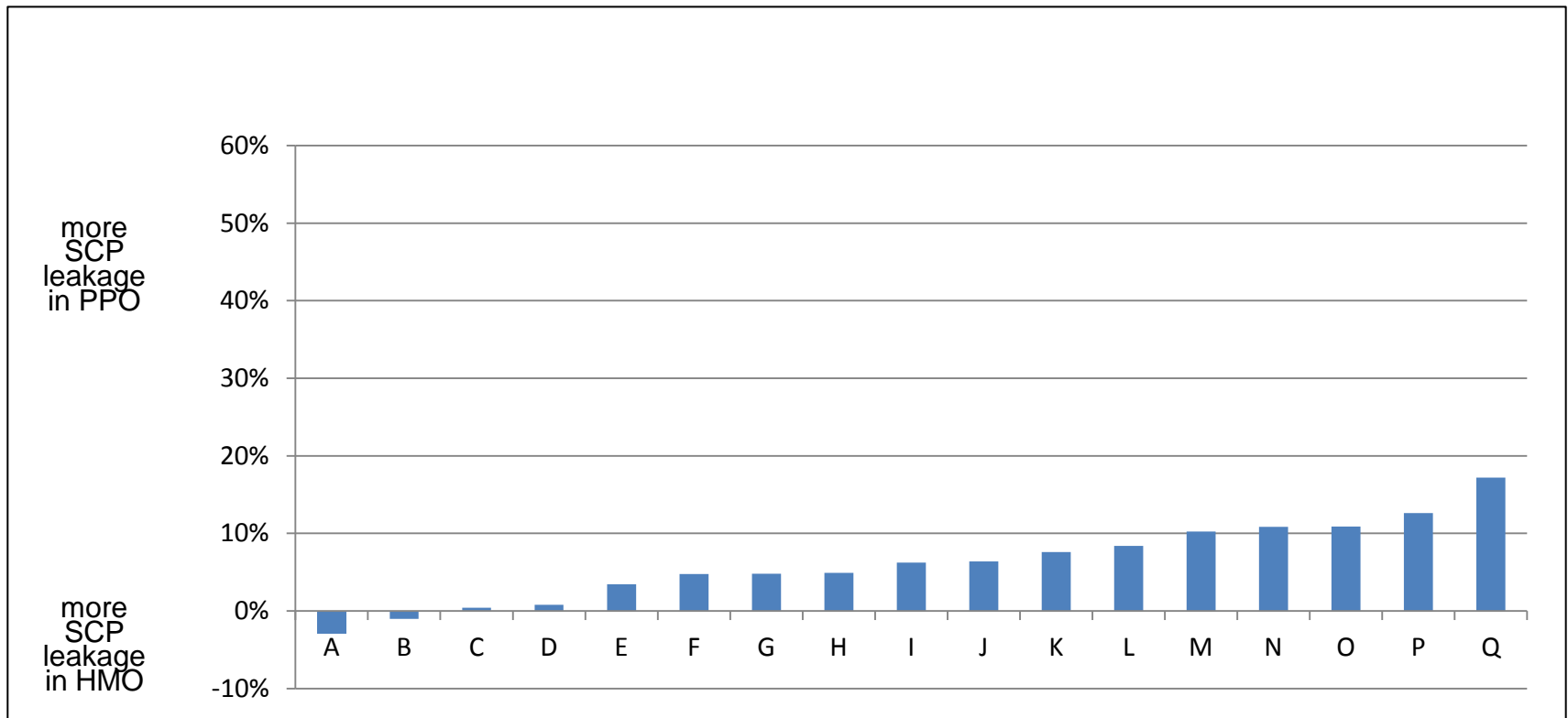
Attribution Methodology



Note: BCBSMA attribution algorithm is based on a hierarchy (e.g., once a member is attributed the logic stops)

- Reflects local, multi-stakeholder workgroup consensus
- BCBSMA tested attribution logic resulting in a 99% accuracy rate. Such test also resulted in limited calls from members regarding the attribution process.
- Indicates that PPO Members have a doctor that they primarily utilize

PPO Members Look to Their PCP for Guidance



- PPO members had their specialist use align with the affiliation of their PCP only 3% less than in HMO
- Illustrating some opportunity for improvement but overall little differences across product lines in patient approaches to accessing care

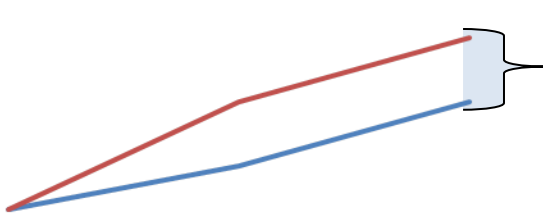
The Model

Core to Value Based Models

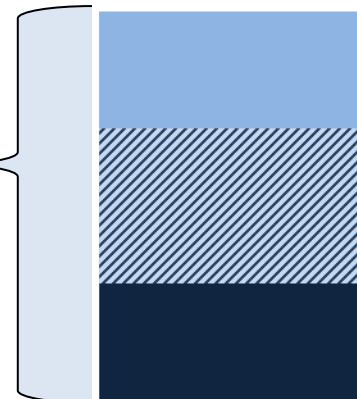


Unique to PPO Model

Savings = provider (risk adjusted) trend better than average



Savings are shared based on quality



30% returned to accounts (minimum ROI)


40% shared (account & provider) based on quality


30% paid to providers

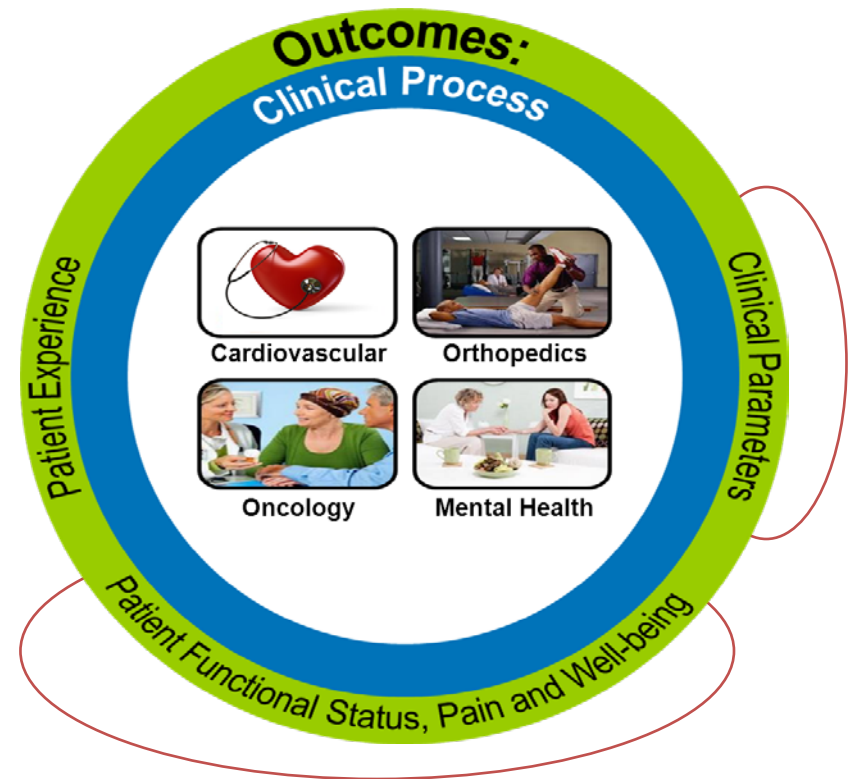
AQC Measure Set for Performance Incentives

	AMBULATORY	HOSPITAL
PROCESS	<ul style="list-style-type: none"> • Preventive screenings • Acute care management • Chronic care management <ul style="list-style-type: none"> • Depression • Diabetes • Cardiovascular disease 	<ul style="list-style-type: none"> • Evidence-based care elements for: <ul style="list-style-type: none"> • Heart attack (AMI) • Heart failure (CHF) • Pneumonia • Surgical infection prevention
OUTCOME	<ul style="list-style-type: none"> • Control of chronic conditions <ul style="list-style-type: none"> • Diabetes • Cardiovascular disease • Hypertension <p>***Triple weighted***</p>	<ul style="list-style-type: none"> • Post-operative complications • Hospital-acquired infections • Obstetrical injury • Mortality (condition –specific)
PATIENT EXPERIENCE	<ul style="list-style-type: none"> • Access, Integration • Communication, Whole-person care 	<ul style="list-style-type: none"> • Discharge quality, Staff responsiveness • Communication (MDs, RNs)
EMERGING	Up to 3 measures on priority topics for which measures lacking	

Expanded Quality Measure Set

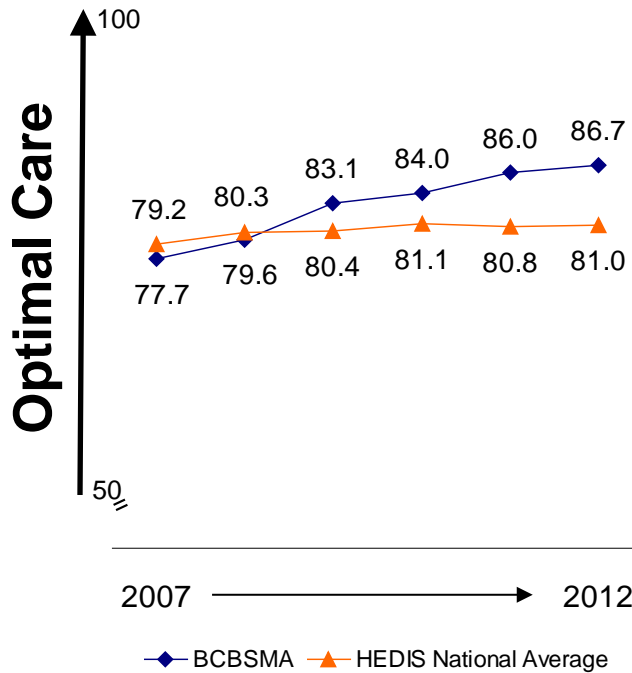
 Ambulatory Measures	
Ambulatory Measure Set	
Clinical Process Measures	
Depression	
Acute Phase Rx	
Continuation Phase Rx	
Diabetes	
HbA1c Testing (2x)	
Eye Exams	
Nephropathy Screening	
Cancer Screening	
Breast Cancer Screening	
Cervical Cancer Screening	
Colorectal Cancer Screening	
Preventive Screening/Treatment	
Chlamydia Screening	
Ages 16 - 20	
Ages 21 - 24	
Adult Respiratory Testing	
Acute Bronchitis	
Pediatric Respiratory Testing	
Upper Respiratory Infection	
Pharyngitis	
Pediatric Well Visits	
< 15 months	
3 - 6 years	
Adolescent Well Care	
Clinical Outcomes Measures	
Diabetes	
HbA1c in Poor Control	
Blood Pressure Control	
Hypertension	
Controlling High Blood Pressure	
Patient Experience - Adult	
Communication Quality	
Knowledge of Patients	
Integration of Care	
Access to Care	
Patient Experience - Pediatric	
Communication Quality	
Knowledge of Patients	
Integration of Care	
Access to Care	

 Hospital Measures	
Hospital Measure Set	
Hospital Clinical Process Measures	
Immunization	
Influenza Immunization	
Stroke	
Venous Thromboembolism (VTE) Prophylaxis	
VTE	
Venous Thromboembolism Prophylaxis	
Intensive Care Unit Venous Thromboembolism Prophylaxis	
Venous Thromboembolism Patients with Anticoagulation Overlap Therapy	
Hospital Outpatient Surgery and Cardiac Care	
Median Time to Transfer to Another Facility for Acute Coronary Intervention (mins)	
Aspirin at Arrival	
Median Time to ECG (mins)	
Hospital Outcome Measures	
Iatrogenic Pneumothorax - Adult	
Post-operative Respiratory Failure	
Peri-operative PE/DVT	
Accidental Puncture or Laceration	
Birth Trauma Injury to Neonate	
OB Trauma - Vag with Instrument	
OB Trauma - Vag without Instrument	
Heart Failure Mortality Rate	
Acute Stroke Mortality Rate	
Hospital Wide Readmission (HWE) 30 Day All Cause Unplanned Readmission	
Hospital Patient Experience (H-CAHPS) Measures	
Communication with Nurses	
Communication with Doctors	
Responsiveness of Staff	
Pain Management	
Communication about Medicines	
Discharge Information	

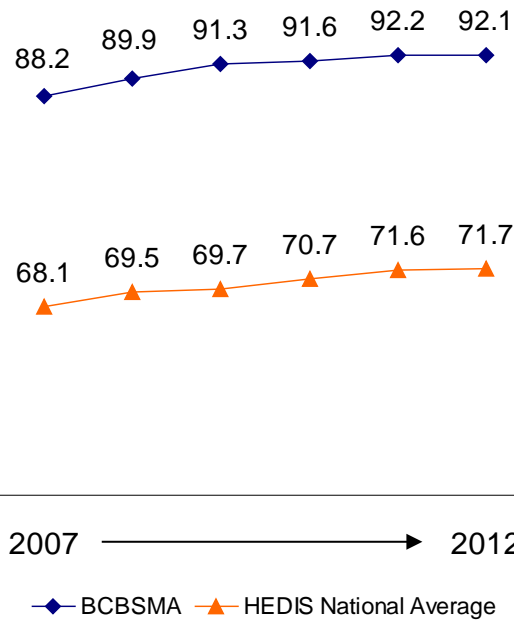


Quality & Health Outcome Results Under the AQC: Improvements by the 2009 Cohort of AQC Groups from 2007-2012

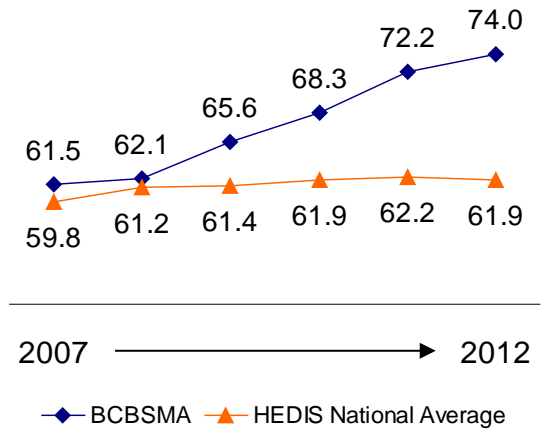
Adult Chronic Care



Pediatric Care



Adult Health Outcomes



These graphs show that the AQC has accelerated progress toward optimal care since it began in 2009. The first two scores are based on the delivery of evidence-based care to adults with chronic illness and to children, including appropriate tests, services, and preventive care. The third score reflects the extent to which providers helped adults with serious chronic illness achieve optimal clinical outcomes. Linking provider payment to outcome measures has been one of the AQC's pioneering achievements.

Delivery System Innovation: Four Themes

There are four domains in which we see AQC Groups innovating to improve quality and outcomes while reducing overall spending.



Staffing Models

Approaches to Patient Engagement



Data Systems & Health Information Technology

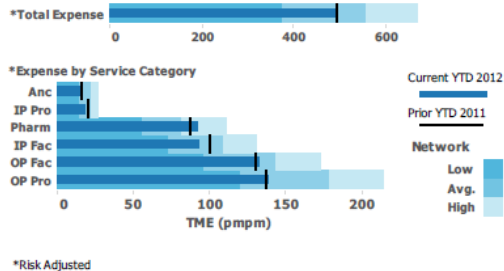
Referral Relationships & Integration Across Settings



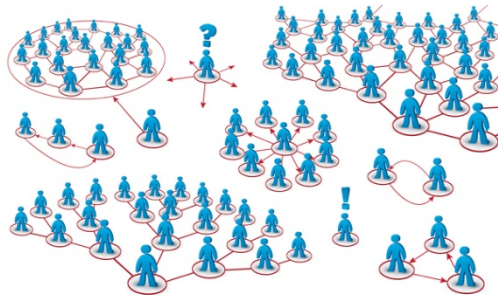
Payer Provider Partnership for Management of Care

Our four-pronged support model designed to help provider groups succeed in the AQC is now expanded across the PPO Population

Data and Actionable Reports



Consultative Support



Best Practice Sharing and Collaboration

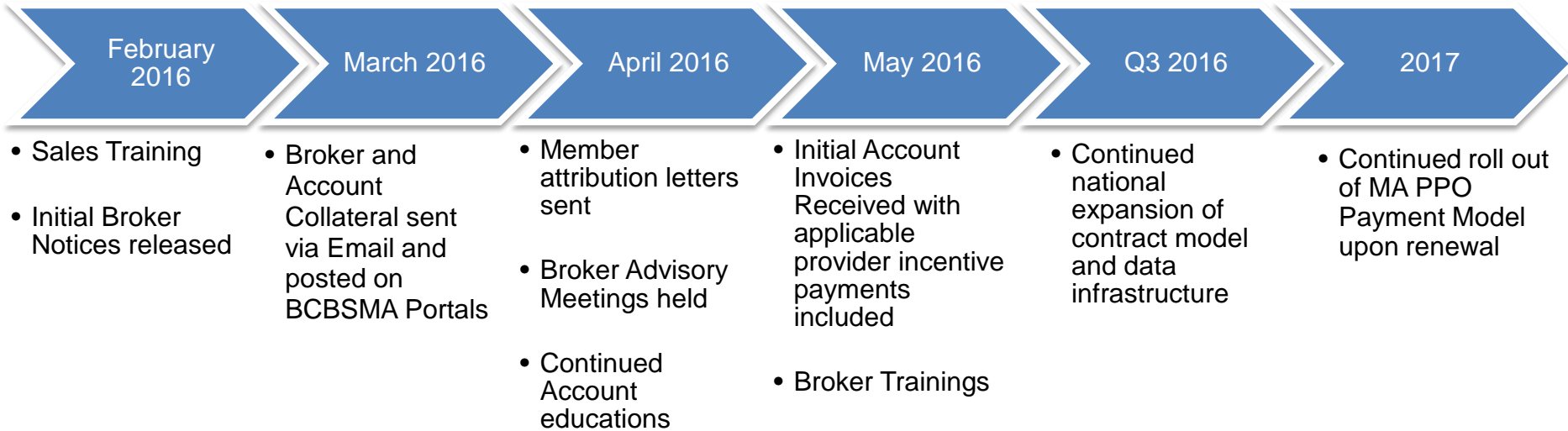


Training and Educational Programming

The AQC has been transformative. It has allowed us to innovate because it enables us to think like a system rather than individuals doctors.

*- Leslie Sebba, MD, Medical Director
Northeast Physician Hospital Organization*

Constituent Roll Out



Frequent and multi-layered communication is key to buy-in

OUR MODEL IN ACTION

Mary has diabetes.

If it goes unchecked, she could cost her employer **more than \$16,000^{1,2}** annually in health care and lost productivity.

Actionable data

BCBSMA provides reports that indicate Mary is not filling her prescription.

Sustained partnerships and support

AQC's Analyst identifies opportunity & informs her doctor prior to her visit

Care coordination by providers

Mary visits her Primary Care Physician.

Total cost accountability

Provider educates Mary on treatment plan & refers to Provider Care Manager

High impact quality incentives

Mary remains adherent to medication and keeps condition under control

¹ American Diabetes Association, People with diabetes incur \$13,700 per year in total expenses on average: <http://care.diabetesjournals.org/content/36/4/1033.full>

² Value in Health Journal, Value in Health study: 20% of diabetics miss 15 hrs of work / month, resulting in \$2300 of lost productivity per person per year <http://www.disabled-world.com/health/diabetes/missing-work.php>



Innovation + Solutions = Results

We're *the* pioneer
in health care
payment reform.

Our model works,
proven by three
major studies.



MASSACHUSETTS

Building a healthier world

Health care transformation through
accountable care



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Health Insurance Marketplace

HealthCare.gov

Agenda

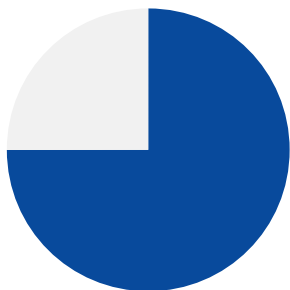
1) *The Aetna approach*

2) Consumers Benefit from value-based contracting

3) Lessons learned

Our commitment – build a healthier world by paying for value not volume

AETNA'S GOAL



75% of spend flowing through VBC models by **2020**

WHERE WE ARE TODAY

40%+ of medical spend through value-based contracts

6.2 million members with value-based care providers

We're changing how health care is delivered

Our accountable care approach is unique:



Includes more **feet-on-the-street enablement** with programs and technology



Supports an **innovative product** – Aetna Whole Health



Not just data, but **advanced analytics and collaboration** for more intense population health



Holds **providers accountable** with more rigorous efficiency and quality measures

By transforming care we can:



Reduce waste:

8-15% savings targeted compared to Aetna broad network plans*



Improve quality:

Focus on targeted quality metrics



Improve member/patient satisfaction:

Establish baseline and increase year-over year

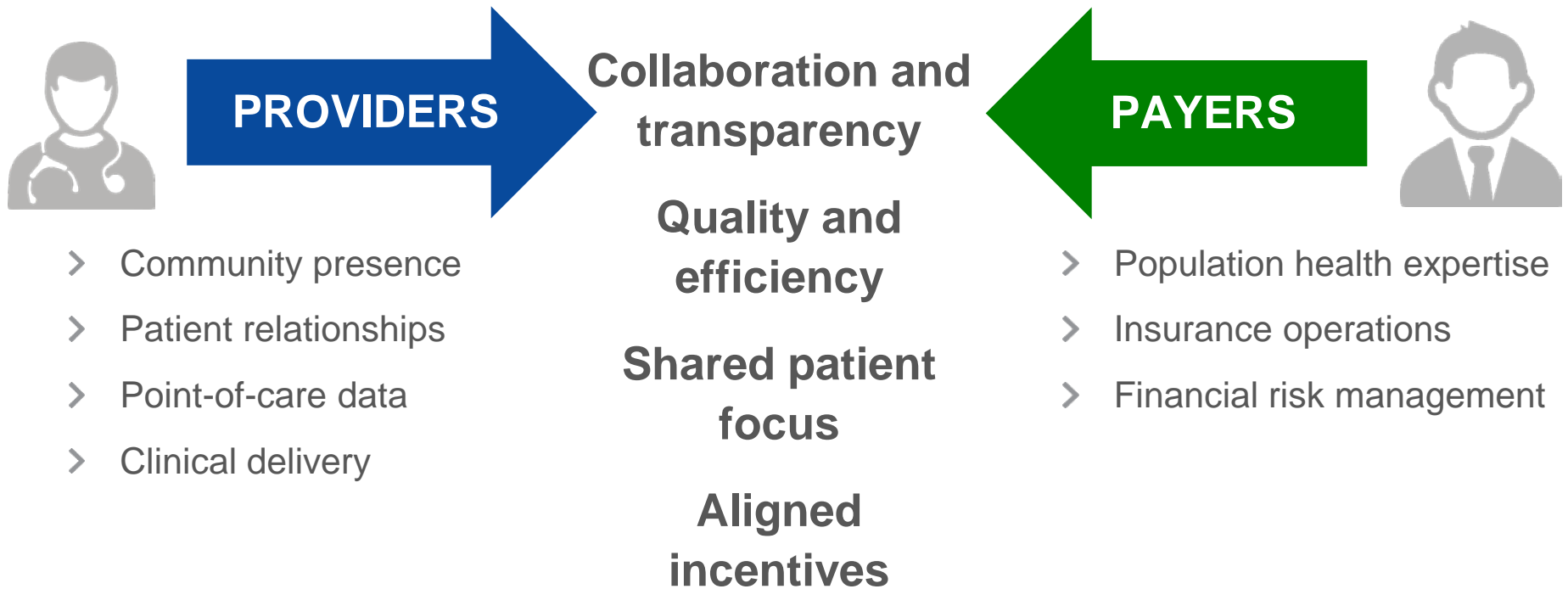


Improve the **overall health and productivity** of members and their families

* Actual results may vary, savings may be less when compared to other value-based or narrow network plans.

The value of payer and provider collaboration

Building on strengths of both players creates a bright future based on shared goals



Agenda

1) The Aetna approach

2) Consumers benefit from value-based contracting

3) Lessons learned

This is a new model, not an old-style HMO

A **win-win-win** for patients, doctors and employers

Old-style HMO (not value-based)

Where many providers are today

Little, if any, health IT or analytics

Limited changes in patient behavior

Provider payment contingent on volume of services

Patient frustration with lack of coordination

New paradigm

Providers that want to transform

Earlier identification of at-risk patients with richer information

Enhanced patient engagement through proactive, doctor-driven outreach

Improved cost and quality effectiveness by aligning financial incentives

A more satisfying experience when providers coordinate care more effectively

Our value based systems are improving the patient experience by helping patients....

Navigate the system

- Proactive outreach to help patients select a primary care doctor to lead their care team
- Smoother care transitions from provider to provider and facility to facility
- A dedicated, toll-free Aetna Whole Health member services number
- Welcome calls and kits to ensure a smooth onboarding process
- New hospital case managers to explain discharge instructions and new medications to patients
- New nurse care coordinators to support doctors and their patients with personalized care plans



Get better access

- Same-day primary care appointments
- Extended weekday and weekend clinic hours
- Reserved appointments for patients with chronic conditions or acute care needs



Manage their health

- A free online health risk assessment
- Online emergency room check-in to reduce waiting times and provide support
- Telemedicine option



Patients are benefiting from improved best practices versus existing approach



Increased generic dispensing of top 4 drug groups



Decreased impactable surgical admits per 1,000



Overall reduction in medical costs versus expected costs for the local area



Baseline period: 1/1/13 – 12/31/13; Performance period: 1/1/14 – 12/31/14. Paid through 3/2015; Results for ACOs effective as of 1/1/2014 and in place for at least one year.

Keeping consumers healthy benefits them – and the economy

Productivity losses related to health problems cost U.S. employers **\$1,685** per employee per year*

TRADITIONAL EXPERIENCE

“I **missed hours of work** driving back and forth to the lab to get my blood drawn.”

“I had a test to see if my cholesterol was high but **never heard anything**. Then I **had a heart attack**.”

“I **can't concentrate on work** because of rheumatoid arthritis flair-ups and multiple joint replacement surgeries.”

ACCOUNTABLE CARE EXPERIENCE

“I went to the lab once when my physician wanted blood drawn. **My specialist had all the information on his computer**.”

“**A whole team watches my cholesterol problem**. A nurse coaches me on my diet. I get educational e-mails, and they get me in for regular checkups.”

“**My doctor's care team made special arrangements** so I get the tests and medications needed to avoid flair-ups. I feel great.”

Agenda

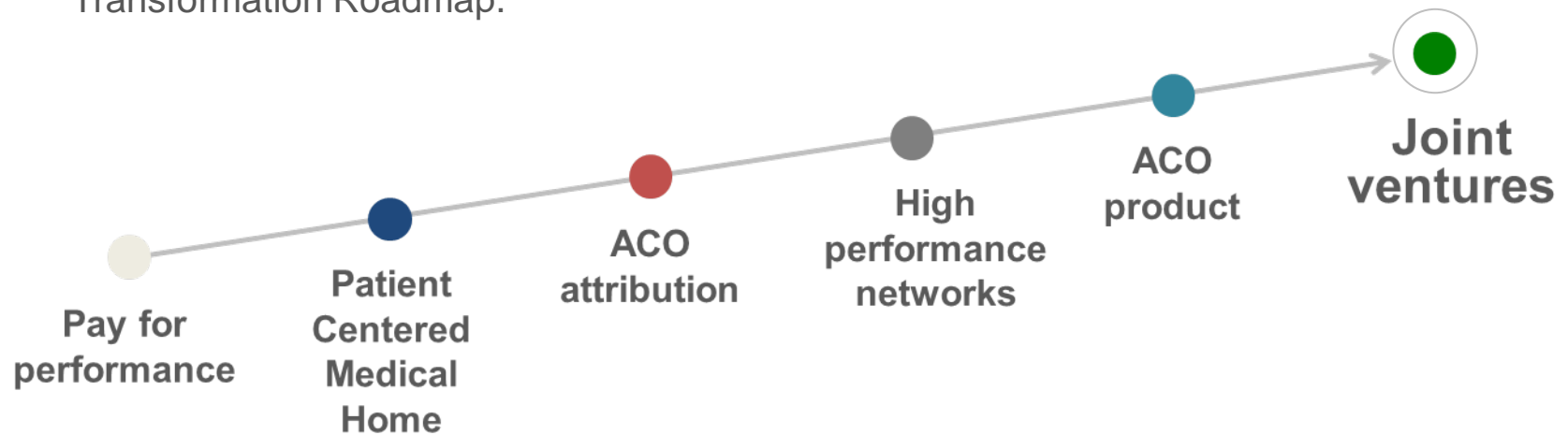
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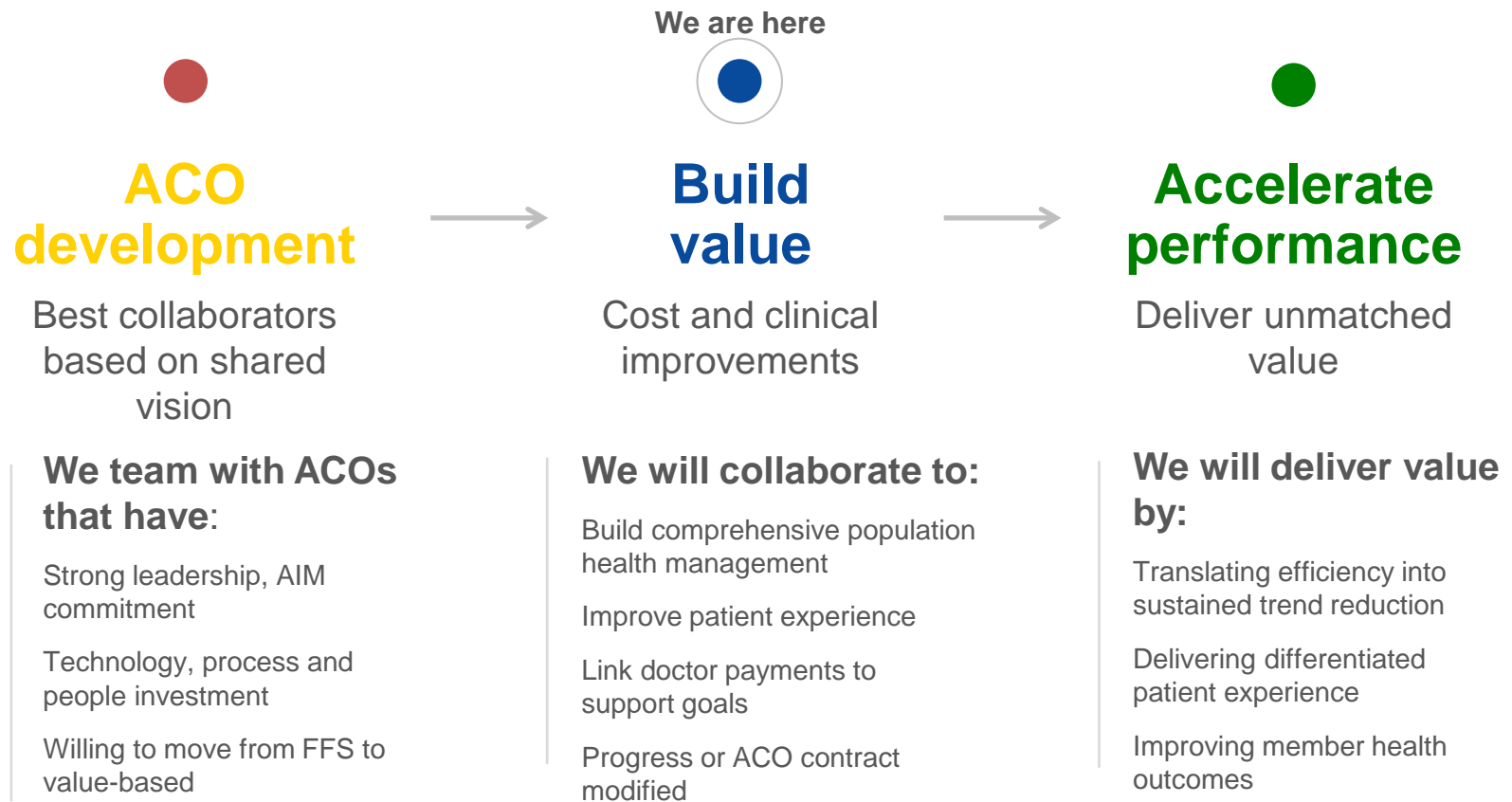
We need to meet providers where they are

- After providers enter the continuum, we help them progress to models with more risk and more reward.
- We guide ACO providers with a comprehensive “Transformation Roadmap.”



Accountable care is a journey – not a destination

PRINCIPAL PHASES:



Population health

Today

Future

MODEL



Provider-centric model

Payer-led care management telephonic model

Member-centric model

Provider-led care management activity at the point of care

PEOPLE



Focus on sick patients only

Lack of comprehensive care coordination

Focus on population health

Robust care coordination across the continuum of care

Patient engagement through digital technology

TECHNOLOGY



Early stages of Clinically Integrated Network (CIN)

Data-driven clinical decision making:

- Standardized evidence based medicine
- Predictive analytics at the ACO level and the primary physician level
- Smart segmentation across the population
- Improved care coordination workflows



Thank you

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