Laying a Foundation: Enhanced Personal Health Care
Introduction

Despite being the most costly in the world, our system is not delivering the care that Americans need and deserve. Its shortcomings are the result of some foundational challenges:

- A payment system that rewards volume rather than value or patient health.
- A reactive focus on symptoms rather than proactive health management.
- Fragmentation – care is poorly coordinated and there is often no champion to help patients navigate through the system.
- Limited transparency and information sharing - providers lack the complete picture necessary to manage their patients' health.
- Insufficient resources directed to primary care, contributing to a primary care shortage.
- Treatment decisions that aren’t always based on the best available clinical evidence.
- A system that is not designed around the needs of patients.

It is time to replace this fragmented, reactive system with one that is holistic, proactive, efficient and focused on the health and well-being of each patient. This is known as patient-centered care. We believe everyone should have access to patient-centered care. As the health carrier or administrator for more than 34 million people – 1 in 9 Americans— we are well positioned to be a leader in this transformation.

Enhanced Personal Health Care: Our Patient-Centered Model

The Institute for Medicine defines patient-centered care as “health care that establishes a partnership among practitioners, patients, and their families ... to ensure that decisions respect patients’ needs and preferences, and that patients have the education and support they need to make decisions and participate in their own care.”

Another way to think about this is to envision patient-centered care as the type of care you would want your parent, spouse or child to receive. Enhanced Personal Health Care is our way of supporting patient-centered care.

We have been a leader in promoting the patient-centered care model through the medical home and ACO pilots we implemented across our markets over the last four years. The positive results have been impressive. For instance, practices participating in our New York Patient Centered Medical Home (PCMH) pilot demonstrated 15% lower medical and pharmaceutical costs than control practices. Our Accountable Care Organization (ACO) pilot in New Hampshire had similarly positive results – participating providers’ costs increased at less than half the rate of non-participating practices. Importantly, while controlling costs, in both pilots we saw improvements in quality. For instance, the participating providers had higher compliance with nationally recognized diabetes measures.
The measurable improvements in quality and cost that we saw in these pilots gave us the confidence to build a program around the most successful components of each and expand our efforts. So we are moving from pilot to broad scale implementation and we are starting our broader rollout with primary care. We’ve focused our energy in this area because we know that primary care providers equipped with the right tools and resources can make a dramatic, positive difference in health care quality and costs.

Enhanced Personal Health Care: An Inclusive, Flexible Approach

Enhanced Personal Health Care will reward providers when they deliver high-quality, cost-effective care, and provide clinicians with the tools and support they need to achieve these goals.

We designed our model to be inclusive and flexible:

We partner with any provider organization with a foundation of primary care – from solo physician practices to integrated delivery systems,. The broader our reach, the greater our opportunity to promote positive change.

Ours is not a one-size-fits-all approach. We’re moving past acronyms like PCMHs or ACO and creating a set of solutions that allow us to support and work with primary care providers based on where they are today. We will offer that help regardless of the practices’ current capabilities or how they are organized – and we will help them improve the quality and cost of care they deliver. We will work with independent providers, those in large ACOs, and everyone in between.

From our pilots we know that many changes to the current system are required to make this work. Two of the most important are changing the way we pay for care and providing providers with the tools, resources and information they need to successfully manage population health.

Paying for Value

As noted above, our health care payment system rewards volume rather than value or patient health. This is because we mostly pay for care on a fee-for-service basis. That means we pay for every visit, procedure or test. We don’t pay for the services that can’t be measured by a visit, test or procedure but are designed to improve health.

Physicians and other primary care providers are trapped on a fee-for-service treadmill: to be paid for their time, they must order tests and procedures, or squeeze as many in-person visits into their day as possible. In most cases, payment does not depend on whether the care followed the best evidence available, or whether the patient’s health improved as a result.

The system also underpays for preventive and primary care. Providers are not compensated for effective, proven techniques such as maintaining health registries, following up with patients via e-mail or creating care plans, despite the fact that these interventions have been shown to improve health and save money in the long run.

Value-based payments represent a transformation that puts the quality of care at the forefront of provider payments.

We have seen in our pilot programs that it is possible to simultaneously control costs and improve clinical outcomes with a patient-centered approach.
The table below summarizes the results of some of our pilot programs in patient-centered care. We have strong evidence that strengthening the primary care relationship results in improved quality and cost:

<table>
<thead>
<tr>
<th>Pilot Programs</th>
<th>Colorado</th>
<th>New Hampshire</th>
<th>New York</th>
<th>Dartmouth Hitchcock</th>
<th>Connecticut</th>
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</thead>
<tbody>
<tr>
<td>Program Type</td>
<td>PC Pilot</td>
<td>PC Pilot Yr 2</td>
<td>PC Pilot</td>
<td>PCMH Pilot</td>
<td>ACO Pilot</td>
</tr>
<tr>
<td>Quality Improvement</td>
<td>Improved all diabetes measures</td>
<td>Improved all diabetes measures</td>
<td>Higher compliance with evidence based guidelines</td>
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<tr>
<td>Inpatient Admissions/1K per year</td>
<td>Decrease 3.6%</td>
<td>Decrease 18% vs. 18% increase in control</td>
<td>Decrease 3.6%</td>
<td>12 – 23% lower for PCMH Providers</td>
<td>Decrease 5.81%</td>
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<tr>
<td>ER Visits/1K per year</td>
<td>Decrease 6.1%</td>
<td>Decrease 15% vs. 4% increase in control</td>
<td>Decrease 6.1%</td>
<td>11 – 17% lower for PCMH Providers</td>
<td>Decrease 10.66% - 18% “avoidable”</td>
</tr>
<tr>
<td>Specialist Visits</td>
<td>Decrease 2.0%</td>
<td>Flat vs. to 10% increase control</td>
<td>Decrease 2.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rx Usage</td>
<td>Increase 1.3% in persistent Rx usage</td>
<td>Increase 1.3% in persistent Rx usage</td>
<td></td>
<td>Decrease 2.85% brand Rx usage</td>
<td></td>
</tr>
<tr>
<td>Overall Medical and Rx Cost/ROI</td>
<td>Overall ROI 2.5:1 - 4.5:1</td>
<td></td>
<td>14.5% lower than non-PCMH Providers</td>
<td>3.4% PMPM reduction to projected cost</td>
<td></td>
</tr>
</tbody>
</table>

Per- Member-Per-Month (PMPM) Clinical Coordination Payments

Many providers feel they are caught on a fee-for-service treadmill. To be paid for their time they must schedule as many in-person office visits as possible. This does not provide them with the opportunity to do things like maintain patient registries, reach out to patients between appointments or coordinate care with other providers -- things that they know would improve the health of their patients.

Our Enhanced Personal Health Care model will change this by replacing fee for service increases with fixed per member per month (PMPM) payments that compensate providers for important clinical interventions that occur outside of a patient visit. These payments will also give providers with a predictable cash flow that lets them invest in their practices, whether that means purchasing an electronic health record or hiring care management nurses. These investments in turn support their ability to successfully manage population health.

Our pilots in Colorado have shown that these types of payments, when coupled with a shared accountability for reducing costs, can improve healthcare costs and quality. In two years providers in Colorado were able to reduce ER visits by 15% and inpatient stays by 18% (the control group saw increases in both) while improving performance on diabetes quality measures. Overall, ROI estimates ranged between 2.5:1 and 4.5:1.

By giving providers capabilities to perform crucial care-coordination activities and compensating them for that work, we are driving a change from a reactive to a proactive healthcare system that allows providers to identify at-risk patients and act before those patients end up hospitalized.

Provider Performance Bonus Payments

Under our Enhanced Personal Health Care Model, we will link the PMPM payments to a provider performance bonus plan that rewards providers when they meet quality measures and actual costs for their attributed patients are below projected costs.

Why are we taking this approach? Because if we want value -- improved health at reduced costs -- we must begin paying for and rewarding value. Our pilots with ACOs have shown that these types of payments can promote improvements in quality while reducing costs. Our provider performance arrangement with Dartmouth Hitchcock in New Hampshire provides a great example. In just the first year of this arrangement, Dartmouth Hitchcock was able to reduce the usage of branded drugs, and the frequency of ER visits and inpatient stays while maintaining its high quality of care, resulting in cost savings of over 3%.

We are in good company in using a model that incorporates both PMPM and shared savings. The federal Centers for Medicare and Medicaid is featuring this payment method in several pilot programs deploying payment redesign, including the multi-payer Comprehensive Primary Care (CPC) initiative developed by the Center for Medicare & Medicaid Innovation. We are proud to have been selected by CMS as one of the participating CPC plans in Colorado, New York and Ohio.

Actionable information and supporting tools

We know it is important for us to reward providers when they improve the health of their patients and the affordability of care, but we also know that payments alone don’t create change. Primary care providers will need support from us to reach clinical quality and cost savings goals.
We will offer practices participating in Enhanced Personal Health Care a broad range of tools and support to help address some of the fundamental issues with our healthcare system. These include access to technology-based resources, like our longitudinal health records, as well as access to our human resources – Anthem staff that can assist practices in the transformation to a patient-centered care model and in getting the most out of the new tools and information we provide.

For example, we will support primary care providers by:

- Giving providers the information they need to identify high-risk patients or patients who haven’t received recommended treatment. That will allow providers to close those care “gaps” and proactively manage patients who otherwise might end up in the hospital or emergency room.
- Alerting primary care providers when their patients are admitted to the hospital or visit the emergency room.
- Giving providers the resources they need to effectively manage care for complex patients – like the support of our experienced care management nurses.
- Ensuring provider have access to the medical, prescription drug and laboratory data they need to make treatment recommendations based on a complete picture of each patient’s health.
- Helping providers ensure that their patients get the care they need when they need it, including after hours and on weekends, by supporting web visits and other after-hours care alternatives.
How Patient-Centered Care Works: John and Jane Smith

To understand the impact of a patient-centered care model, imagine an employee we'll call John Smith. John is overweight and regularly has high blood glucose levels and high blood pressure. Typically, John visits his doctor once a year for about 15 minutes. He is on a path to developing Type 2 diabetes and is at high risk for complications that could land him in the emergency room.

Under a patient-centered care model, John’s physician Dr. Doe would likely identify John as a high-risk patient. Dr. Doe would then create a comprehensive care plan, including a referral to Anthem’s diabetes care program. The educator would help John develop and stick to an exercise and diet plan. Dr. Doe’s care team would follow up with John at least once a month to check on his progress and answer any questions. If this support encouraged John to lose 20 pounds and stabilized his glucose levels and blood pressure, he would no longer be at high-risk for avoidable complications, and would have fewer unplanned absences at work due to his poor health.

Then consider John's wife, Jane, a busy working mother of three teenagers. She is in her 50s now, but has not found the time to schedule routine preventative care such as annual mammograms. She sees physician when she’s ill, but her doctor doesn’t have time in these 15-minute visits to talk to Jane about importance of preventative screenings.

Jane is at risk for late detection of chronic or acute conditions, making her less likely to catch disease early and treat it appropriately. She is more likely to receive more invasive, costly treatment if she develops a serious illness like cancer.

Under a patient-centered care model, Jane’s physician would identify recommended evidence-based preventative health screenings for Jane based on her age, health status and family history. Her doctor could reach out to Jane when she is due for screening, and reach out to express concern if Jane does not follow up.

Because of her strong relationship with her primary care physician, Jane would be more likely to realize the importance of having an annual breast exam. A routine mammogram would be more likely to detect a lump. This lump could then be removed, improving her prognosis and ensuring that she is able to remain an active mother and employee.

Jane would then receive ongoing follow-up care that would help avoid complications – and the significantly higher costs of additional cancer treatments and procedures.
Our Partnership with Employers

The delivery system will begin to change when providers are rewarded based on the value rather than the volume of the care they deliver – but that shift must be substantial enough to support a significant transformation on the part of providers. Given our local depth and presence, we have the unique ability to drive positive change in quality and cost when we bring all of our business to the table.

As we continue to move from predominantly volume-based to predominantly value-based arrangements with our provider network, your support and participation helps us build a stronger, more efficient and effective health system for all customers.

Accordingly, our self-funded customers will participate in our value-based contracting arrangement as we expand and accelerate them in 2013 and beyond.

Of course, our migration from volume to value-based contracting will not happen overnight. Rather this change in our payment model will be phased in over the course of years.

We have summarized below what the next few years may look like:

2013

During 2013 self-funded customers will begin to participate directly in value-based payment arrangements. As providers are enrolled in programs that offer PMPM clinical coordination payments self-funded employers will be charged for the PMPM clinical coordination payments paid to providers on behalf of their covered lives.

These payments will vary by market and provider, based on the health status of their patients.

We are undertaking a phased rollout of these programs, and not all providers will be involved January 1, 2013. Nationally, we expect that up to 20% of primary care providers contracted with a WellPoint affiliate will be enrolled in shared savings programs by the end of 2013, though local market participation may vary.

Shared savings payments will not be made until 2014, but will be based on performance during a 12- month measurement period starting in 2013. Depending on the number of your enrollees who receive care from one of the primary care providers participating in our patient-centered shared savings programs, you may begin to experience the benefits of patient-centered care with lower claims costs and better quality outcomes in 2013.

2014 and Beyond

During 2014, employers will start paying their portion of the shared savings payments to providers, based on provider performance in 2013. Employers will also continue to fund the PMPM care coordination payments to participating providers.

As the nationwide rollout of these programs matures, we expect that by 2016, up to 75% of our primary care providers will participate. We expect the cost benefits for employers to grow over time as physicians become more sophisticated in delivering high-quality, cost effective care.
Conclusion

Patient-centered care will provide a tangible benefit to our self-funded customers and their employees by addressing the current system’s shortcomings, lowering health care costs and increasing quality and productivity.

Employees will benefit from improved outcomes, more personal and continuous interaction with their primary care providers, enhanced care management support and information and, ultimately, better health.