

Patient-Centered Care The Next Generation

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Agenda

- **Overview**
- **Opportunity**
- **Product Concept**
- **Ingredients for Success**
- **Medical Management Collaboration**
- **Next Steps**

Systemic Issues

Focus on cost

- Need to lower health plan administrative costs
- Shift of coverage to consumers with increased price sensitivity
- Member increased risk based on personal decisions and aging population.

Provider landscape

- Consolidation and acquisition of Managed Care Physician Organizations
- PPO Networks stable for now, risk of further consolidation of physician organizations, hospitals especially in high leverage specialties (oncology)
- HMO structured around financial model, not treatment model.
- Increased potential for physicians to influence member choice of plan

External market forces

- Major customers want better care management, dissatisfied with health plan DM programs, recognize the value of better chronic care management, e.g., "AICU" and CareMore

Innovative models scale-up

- Speed to market requirement for innovative payment and clinical care models
- Limited internal ability for scalability and sustainability of innovative models

Facts Leading to our Chronic Management Direction

- **2/3 of health care spend is related to members with chronic conditions.**
- **63% of hospital admissions are for chronic members.**
- **78% of prescription drugs are used by chronic members.**
- **Only 10% of Costs are directly related to health care while 40% is driven by member behavior.**
- **50% of Costs are attributed to 5% of the members.**
- **Only 3% of health care spend goes to 50% of the healthy population.**

PMPM Chronic Conditions + Behavioral Health (BH)

1 = \$125

3 = \$534

1+BH = \$296

3+BH = \$1072

Our Philosophy: Support and reward physicians for managing their patients to maximize health and lower costs

Not benefit-dependent

PPO

Incent patient-centered physician care coordination of members with highest needs

ACO/AICU Model Integration

- Better outcomes
- Lower costs
- Biggest \$ impact

PPO ACO/AICU Model

Current System

Fragmentation

Adversarial relationships

Focus on “doing”

One-to-one care

Gatekeeper

Perverse financial incentives

Focus on volume/intensity

ACO/AICU

Integration

Cooperation

Focus on managing a population

Team-based care

System management

Aligned incentives

*Focus on **quality** and efficiency*

Transformation



Source: Brookings-Dartmouth ACO Pilot Project

PPO Integrated ACO/AICU Model

- 1. Collaborative Relationships.** Moving away from traditional managed care contracting as each party is committed to each other's success.
- 2. Long term partnerships with providers.** Three to five year partnerships.
- 3. IT Connectivity.** Health information exchanges are critical to see how the patient's condition is progressing, regardless which physician is managing the care at any point in time.
- 4. Coordination.** Enabling physicians, hospitals and health plans to work together to achieve quality and cost improvement.
- 5. Improved Quality/Shared Savings.** Providers who meet predetermined quality and/or utilization targets qualify to share in the savings.
- 6. No Gatekeeper.** Care is coordinated and patients are followed closely by the ACO providers, yet there are no restrictions to specialists when needed.

How will this strategy work?

Medical Community (co-located or referred)

- Specialists
- Mental health
- Dental / vision services
- Hospitals
- Pharmacy
- Community resources
- Social work
- Home health
- Complex case managers
- Peer programs
- Other ancillary services

Physician Long-Term Planning

- Population Management
- Follow-Up
- Gather Patient Experiences

After the Visit

Pre-Visit Planning

Access

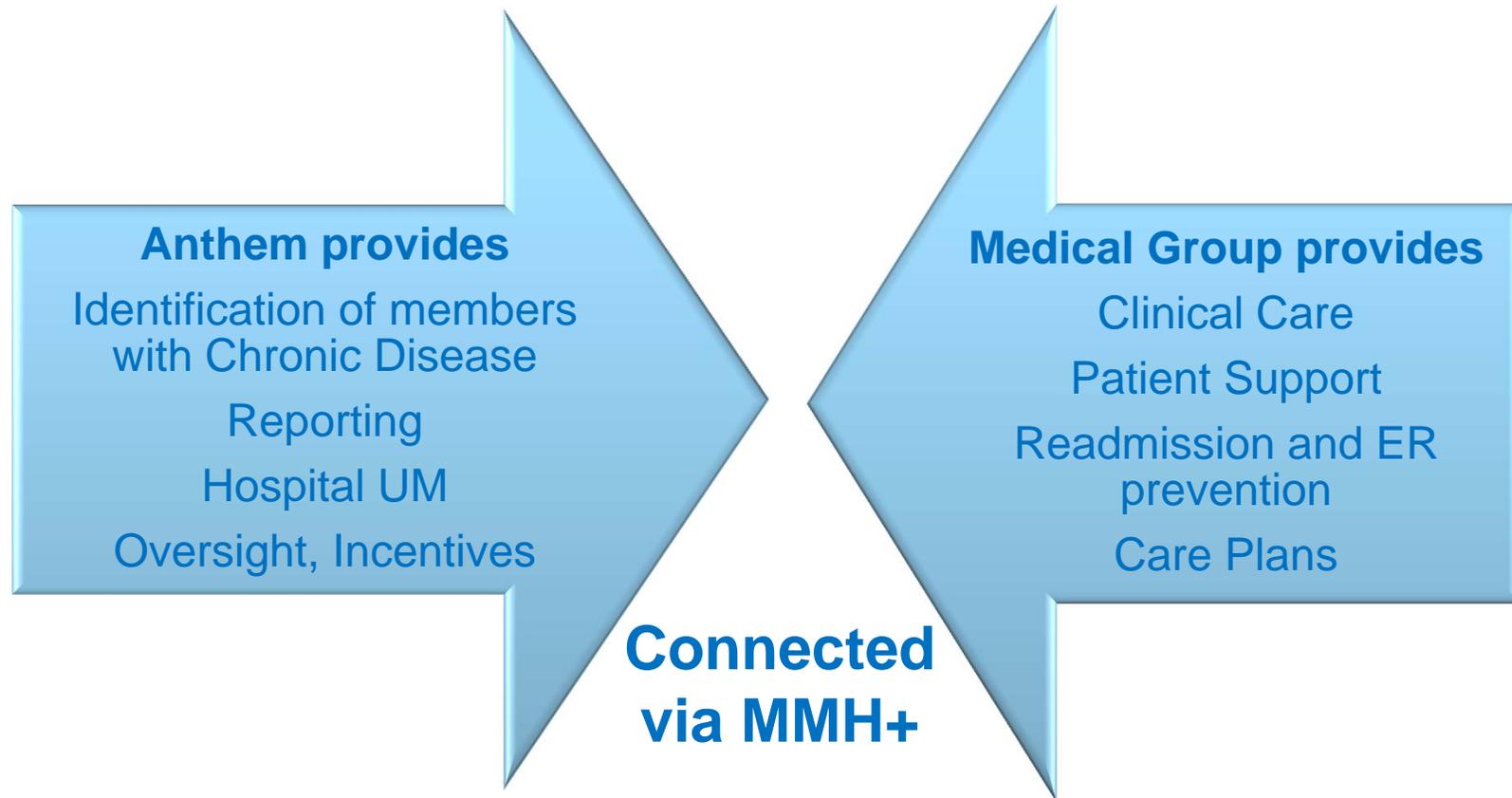
During the Visit



- By visit
- By email
- By phone
- By report

Care Coordination
by team in
physician's office

Clinical Management Model



Hallmarks of Patient-Centered Care

Support for high risk patients

Coordination of care across the delivery system

Facilitated & ensured access

Shared decision making & accountability with patients and caregivers

Promotion of wellness and prevention

Outcomes and compliance with evidence-based guidelines monitored & measured

Simply . . .

- **We will find highest-risk members and identify them to our provider partners.**
- **We will enhance our payment model to promote patient-centered care coordination.**
- **Everyone – client, member, provider and payer – will share in the success.**
- **Stratification of Chronic Members system enhancement. Total of 20 medical groups interested and in discussions with Anthem.**