Patient-focused Care Programs
Notes/Talking Points for Sales Presentation

Slide #	Notes
1: Front Cover	
2: Health Care Spending Landscape	What is the ISSUE? Rising trend of health care costs in the US is unsustainable • 2.9T is spent in healthcare across the US today, representing 18% of GDP today. Over the next few years this is expected to increase to 20% of GDP. • .30 cents on the dollar is wasted – overuse, duplication of services, and lack of coordination • we're spending more $$$ yet have worse outcomes Here's how we fare compared to other like income countries across the world. • The US spends significantly more on healthcare, yet have poorer outcomes, a higher prevalence of chronic conditions and have a shorter lifespan. *We know that we need to make a change.*
3: Blues Lead the Shift to Value-Based Patient-Focused Care	What needs to CHANGE? Providers have historically been paid more for providing more services. What this resulted in was an abundance of uncoordinated, duplicative and in some case unnecessary care. This payment strategies increased costs and did not improve health outcomes. The landscape is evolving from a FFS to FFV that promotes, better coordinated, patient centric, outcomes based care. The Blues have lead the charge in this effort to transform care by focusing on : **PCP Focus –** • Primary care docs control patient care, they are aware of all of their patients' conditions and are the quarterbacks of patient care. • We long ago made a decision to invest in primary care through QIPS, IPPIP, vertical integration care models, fully integrated care – PCP, SPEC, HOSP – everyone talks to each other. • QIPS and ACO payment models - PCP at center of that – not fragmented care – one story – get all patient caretakers aligned **Specialist integration –** • Specialists responsible for large portion of costs – bringing specialists into our ACOs, VBP specific to specialists- they take care of chronically ill members, very important to overall health

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	Outcome Focused Measurement – • P4P programs typically around process – paid providers for doing something, but have shifted to outcome focused measurements. • Ten (10) years ago we created our own outcome measures. Instead of just process based – did the patient get the A1C, its outcome based - did the patient get the A1C and was the result less than 8. **Medical cost management –** • Gainsharing – look at a provider's historical costs – if they get better – we share the gains with the provider. • Gain sharing measures are split between efficiency and quality: quality standard comes first, then efficiency - can't qualify for efficiency measures/incentives unless quality measures are met.
4: Optimized Care Coordination for Better Health Outcomes	**Our approach to the local market-** • Our adoption of our patient focused care programs is driven by improving the health and wellbeing of our members through the PCP as the first line of defense. • 6 cents on the dollar of healthcare spend is attributed to Primary Care, yet PCPs can help control over 60% of costs! • Not spending more $$$, just reallocating them to the PCP as the quarterback. • Just like your 401k administrator regularly modifies your portfolio to optimize your return, we are reallocating the $$$ we allocate to these programs and shifting more to the PCP where we see the most value. **How do customers budget for 2017?** • No change in budget. Dollars are being shifted to different focus areas, we are not adding new expenses. • Levers we're pulling to enhance value to customers – invest in PCP, reduce specialist • Providers were historically paid a flat increase, through this new approach the providers will receive a smaller fixed increase, and earn the remaining part of the increase. • PaMPM fee is not a new expense, it was previously wrapped in claims expenses and is now being pulled out in a separate bucket.
5:Illustrative Value Based	Walk through EXAMPLE

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Contract Example	
6: Independence Care Delivery Programs: IPPIP and QIPS	Overview of Programs, IPPIP: our ACO Payment Model and QIPS
7: IPPIP Summary: Our ACO Model for Hospitals	IPPIP Overview Integrated Provider Performance Incentive Plan (IPPIP) is our ACO Payment Model and is a hospital/physician rewards program providing a balanced model for high-quality and cost-effective care. **IPPIP* strives to:** • Encourage/incentivize enhanced care coordination across the delivery system • Incorporate measures for improved utilization • Align primary care, specialist, and hospital incentives • Complement health care reform-related initiatives such as Accountable Care Organizations (ACO) **Medical Cost Targets-** • Must improve performance-Health System ABC has a baseline set for $400 PMPM, over the contract period must achieve savings to earn incentive. • The ultimate goal is to have appositive impact to trend. **Quality Measures –** • Ambulatory Quality – Breast Cancer Screenings, Diabetes Care, Cervical- "Getting them done". • HCAPHs- surveys sent out to members after discharge. Did the member understand what to do when discharged to stay healthy? Health Systems are measured on survey responses and unnecessary ER visits, etc.
8: Independence's Blue Distinction Delivery Model - QIPS	PPO QIPS is our local program for BDTC **Rewarding Primary Care practices for delivering coordinated, member-centric, outcomes based care.** • Changing compensation to drive better care • Inflationary increases at risk; PCP schedules held flat – PCPs have to earn increases **PCPs are measured against their peers. Only the highest performers will be rewarded (top 50%)** Quality Measures- • Preventive Care Gaps • Diabetes- Get your A1C

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	Cost Measures- • We measure the total cost of care for the members that are assigned to these PCPs. We asses against the network. The top performers (top 50%)- receive incentive. Utilization Measures- • Discharge follow up measure- follow up with doc within 7 days of discharge. We added because this a consistent ACO best practice. • ER- Reduction of ER visits-low level ear infection, bee sting, dizziness, cut. • Medical Admissions- no surgical admissions (unplanned), diabetic uncontrolled in hospital. Heart condition- not taking meds. **Question about introduction of QIPS to PPO population- Why?** • Providers need data to be successful in the structure of the QIPS incentive program. • Historically HMO members were the only members who had to select a PCP. Therefore, they were the only members we could "assign" to a PCP to share data and measure results. • Now with BDTC attribution methodology we are excited to be able to assign PPO members to PCPs so that data can be shared, and members can be measured.
9: Provider Support Models	Attribution – introduce PPO members into our programs Providers want to deliver better care to their members and want to achieve positive health outcomes. If the provider fails, we all fail. Data plays a key role in the success of these programs. **What makes Independence different/better?** • National carriers don't have same level of local partnership and teamwork. Independence provides 24/7 support for value based programs • We provide a suite of 30+ provider reports for doctors to help them in managing care and drill-down analytics. Within the report there are 100s of metrics that help to track each patient (Members- clinical alerts, PCP visit, admissions etc.). Aetna and Optum provide analytics – but the difference is they push out reports and are done – we take it to the next level and create that personal partnership

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	• Best practices sessions with doctors. PCPs get together to share what works best- new reports and how to use, changes to the program, cost effective settings. • Predictive analytics – developing our own proprietary models; getting patients in the providers' office before they wind up in the ER or the hospital. Best practices, best in class sessions with ACOs; • Face-to-face interaction through meetings and courses. We do courses onsite – e.g., 30 min course on end of life care - end of life directives reduce costs, treatment based on what the patient wants, not the family (amazing that ACOs hadn't thought of this before we brought it to them). Sessions on referral management to explain how referral patterns aren't effective: why are you sending all your echocardiograms to hospital setting? Reviewing patterns for inappropriate trends. Behavior change tied to incentive payments - mixed reactions but because we provide incentives to change what they do.
10: The Proof is in our Results	Review stats
11: Transition Slide from IBX Programs to National Blue Programs	Divider Slide from Local Programs to BDTC
12: Why BDTC? Overview	• Across the country blue plans unite to focus on improving quality, and reducing healthcare spend in each region across the US. • Healthcare is never a "one size fits all" approach. The blues focus on the needs and opportunities in each region to assess opportunities and develop strategies to improve quality and reduce costs. • Each blue has a unique and personal relationship with the communities and providers that they partner with. • Just like IBC, each blue plan takes the time and effort to work with their provider community to meet the overarching goal of better coordinated, member-centric, outcomes based care. Give examples of support other Blue Plans provide as well (e.g., Anthem).
13: Unified Standards offer National Consistency	The BCBSA took a look at all 700 programs across the country, and refined to a network of P4V programs that have met strict criteria. • Coordinated/Holistic Care • Value Based Incentives ties to cost and quality outcomes • National availability • Ability to attribute members and share valuable clinical data

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	• Demonstrated improvements in quality and savings.
14: BDTC National Availability	The refined, high performing network of P4V programs is called Blue Distinction Total Care. • 450 meet our national criteria. • 13M members • Over 118K providers **Attribution Key Dates:** • January 2016 – local members eligible for PPO QIPS • January 2017 – national BDTC programs
15: How BDTC Works	[Review steps in example]
16: BDTC Value	Program Results, $6-9 PMPM National Average Net Savings, etc. >$51B in claims tied to total care programs Quality improvements: • Lower utilization • Better control of chronic conditions • Increased compliance with preventive care • Improved patient experience
17: BDTC Key Dates	[Highlight Milestones for 2017]
18: Back Cover	Accelerating Healthy Graphic Logo