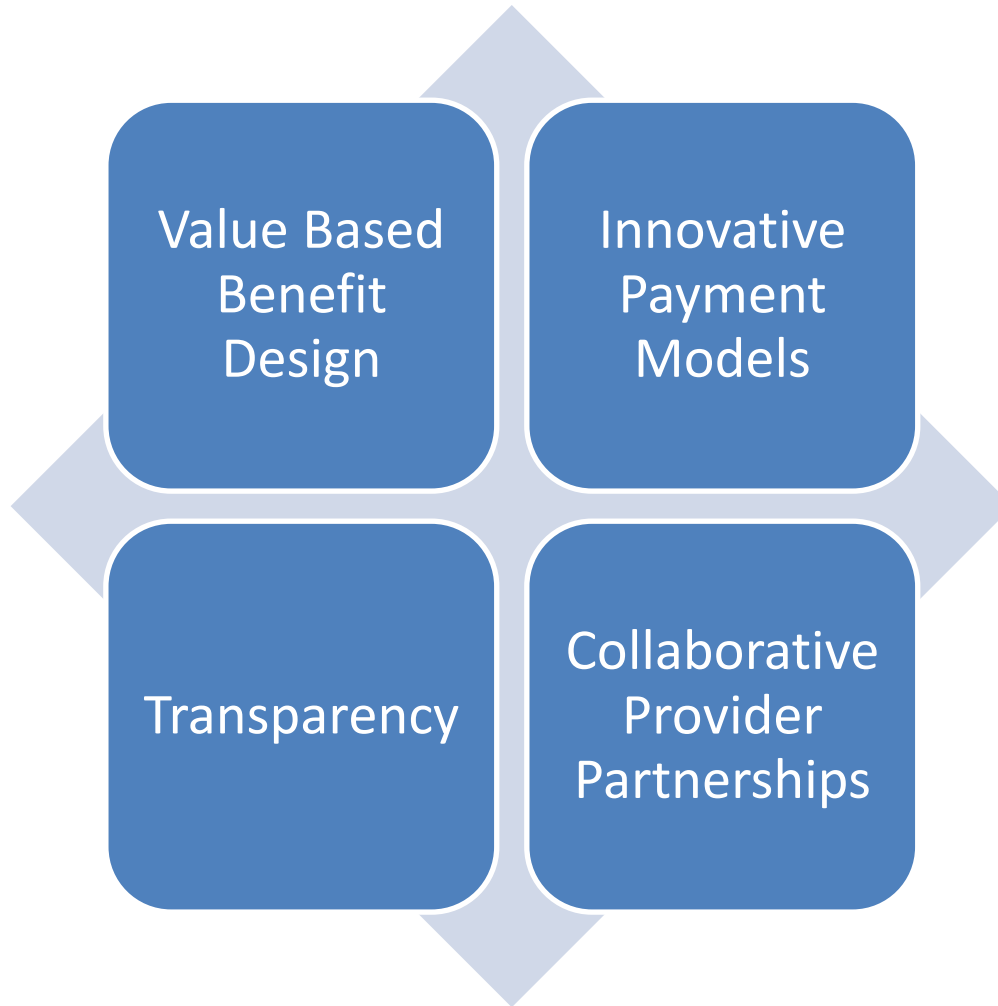




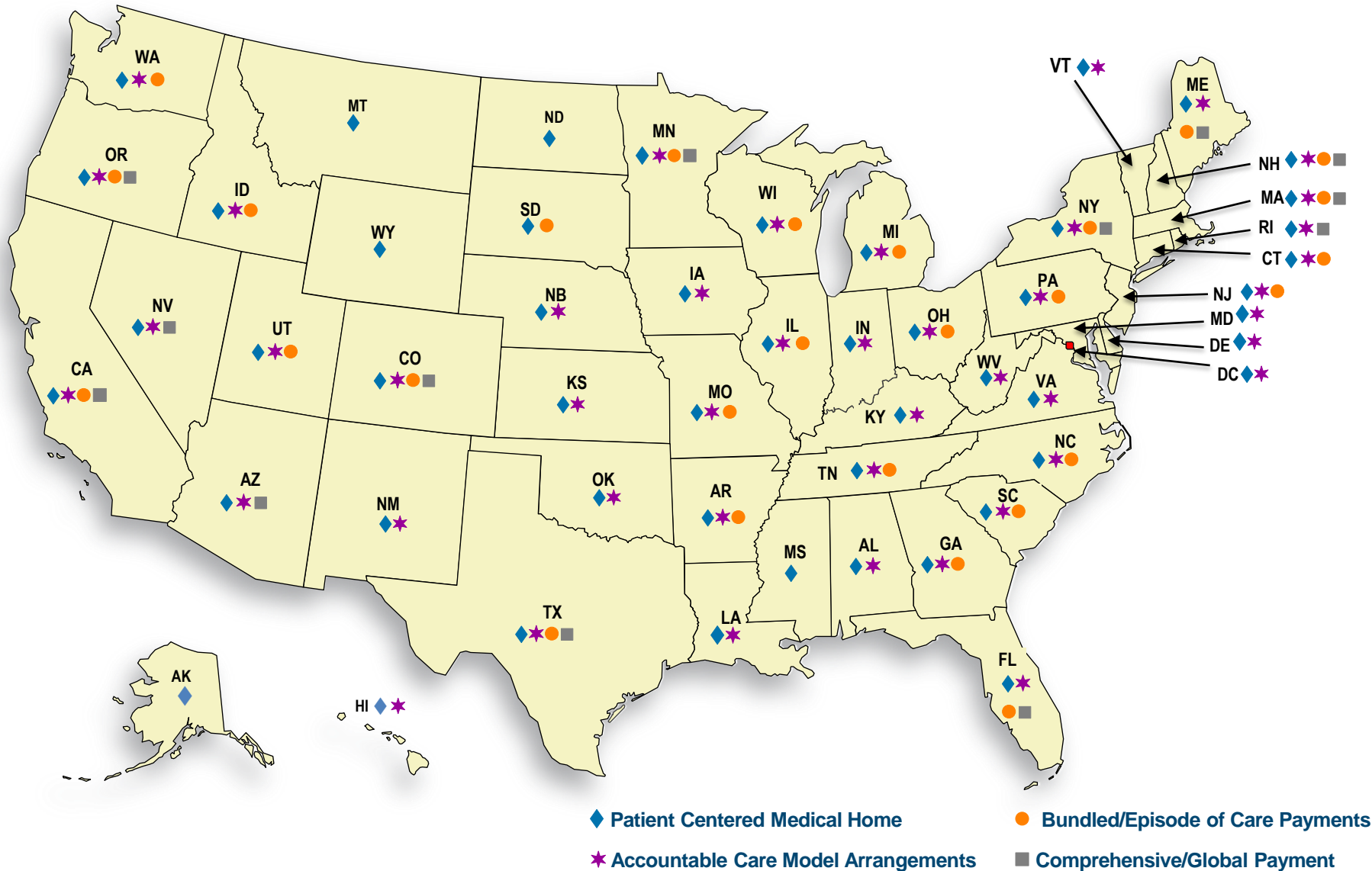
THE PRIVATE INSURANCE MARKET: THE INFLUENCE OF NEW PAYMENT AND DELIVERY MODELS

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Executive Vice President
May 13, 2015

Plans Driving a Move Toward Value



Delivery and Payment Models—Private Sector Initiatives



NOTE: Icons may represent multiple partnerships within the state 3

*The map is current as of January 2015. As new programs are identified the map will be updated accordingly.

Key Technical Assistance

- Population Health Management
 - Providing multiple data and report formats, including:
 - Detailed claims data
 - Analytic reports

- Disease and case management/tools for care improvement and decision making
 - Connecting providers with health plans' disease and case management services by:
 - Embedded nurse case managers
 - Clinical decision-support tools
 - Monthly clinical sessions and collaboration between health plan care management teams and providers

Key Technical Assistance, cont.

- Exchanging health information
 - Two-way flow of information to facilitate case management and clinical decision support
- Managing financial risk
 - Predictive modeling to health access and manage risk; provision of stop-loss coverage or reinsurance

All models have shown Improvement

Quality and Outcomes

- Fewer ER visits; Fewer Readmissions

Improved Patient Satisfaction

- Expanded hours, more timely visits; Use of telehealth

Improved Medical Spend

- Avoided unnecessary costs; Decreased patient OOP

Patient-Centered Medical Home

- \$267 million in avoided costs
- Reductions inpatient hospital admissions 3%-42%
- Decrease in ER visits 6%-74%

Accountable Care Models

- Shared savings amounted to > \$50 Million
- Increase in quality performance
- Reduction in hospital readmissions by 15%-45%

Episode/Bundled Payment

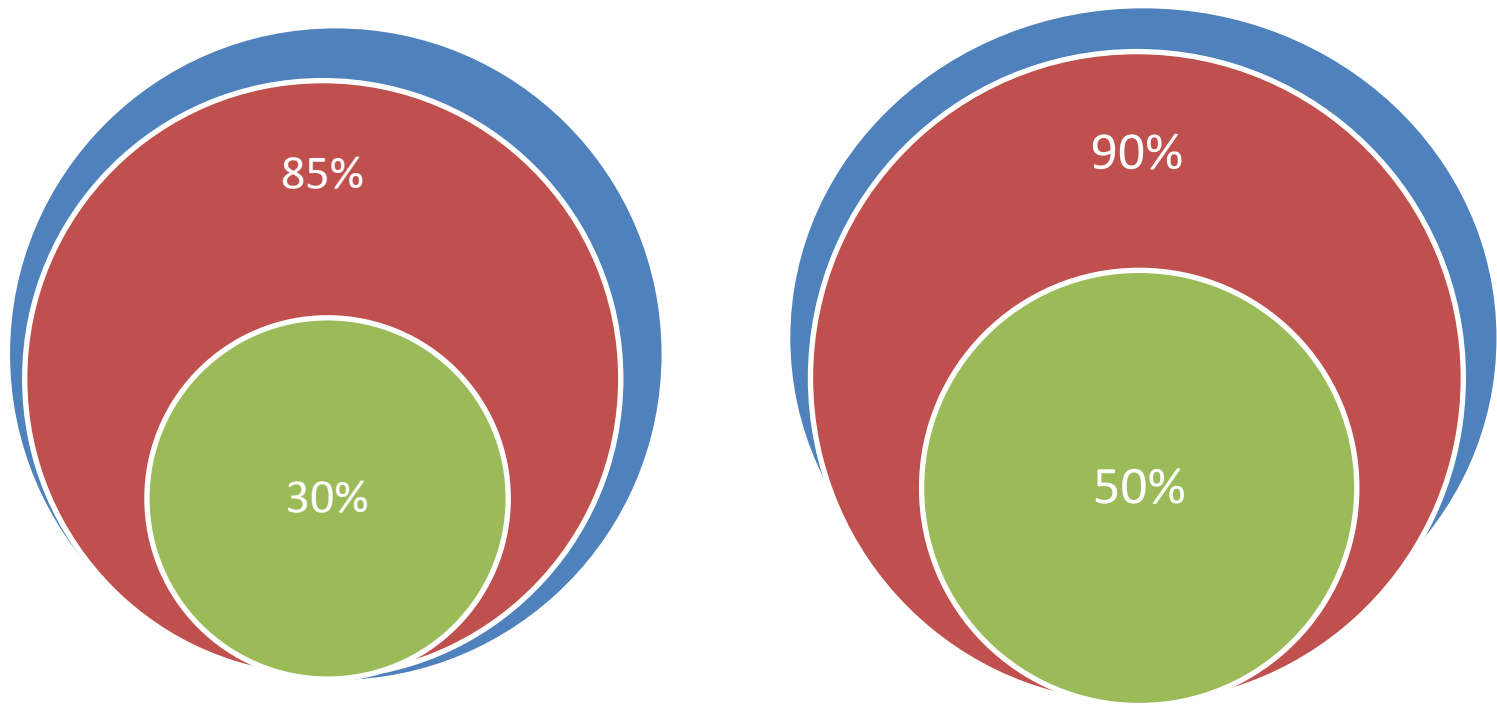
- Consumers savings of 10-30%
- Estimated overall procedural cost reductions of 34%
- Increased screening rates by 72%

Framework for Progression of Payment to Clinicians and Organizations in Payment Reform

	Category 1: Fee for Service – No Link to Quality	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models on Fee-for Service Architecture	Category 4: Population-Based Payment
Description	Payments are based on volume of services and not linked to quality or efficiency	At least a portion of payments vary based on the quality or efficiency of health care delivery	<ul style="list-style-type: none"> Some payment is linked to the effective management of a population or an episode of care Payments still triggered by delivery of services, but, opportunities for shared savings or 2-sided risk 	<ul style="list-style-type: none"> Payment is not directly triggered by service delivery so volume is not linked to payment Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (eg, >1 yr)
Examples				
Medicare	<ul style="list-style-type: none"> Limited in Medicare fee-for-service Majority of Medicare payments now are linked to quality 	<ul style="list-style-type: none"> Hospital value-based purchasing Physician Value-Based Modifier Readmissions/Hospital Acquired Condition Reduction Program 	<ul style="list-style-type: none"> Accountable Care Organizations Medical Homes Bundled Payments 	<ul style="list-style-type: none"> Eligible Pioneer accountable care organizations in years 3 – 5 Some Medicare Advantage plan payments to clinicians and organizations Some Medicare-Medicaid (duals) plan payments to clinicians and organizations
Medicaid	Varies by state	<ul style="list-style-type: none"> Primary Care Case Management Some managed care models 	<ul style="list-style-type: none"> Integrated care models under fee for service Managed fee-for-service models for Medicare-Medicaid beneficiaries Medicaid Health Homes Medicaid shared savings models 	<ul style="list-style-type: none"> Some Medicaid managed care plan payments to clinicians and organizations Some Medicare-Medicaid (duals) plan payments to clinicians and organizations

Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

- All Medicare FFS (Categories 1 – 4)*
- FFS linked to quality (Categories 2 – 4)*
- Alternative payment models (Categories 3-4)*



All Medicare FFS

All Medicare FFS

Changing the Dynamic of Patient Engagement

A large blue triangle is positioned on the left side of the slide. To its right, three rounded rectangular boxes are stacked vertically, each containing text. The boxes are white with a blue border and are partially overlaid by the triangle.

Cost Calculators

Meaningful
Quality Metrics

Health Decision
Assistance

Price Transparency Tools

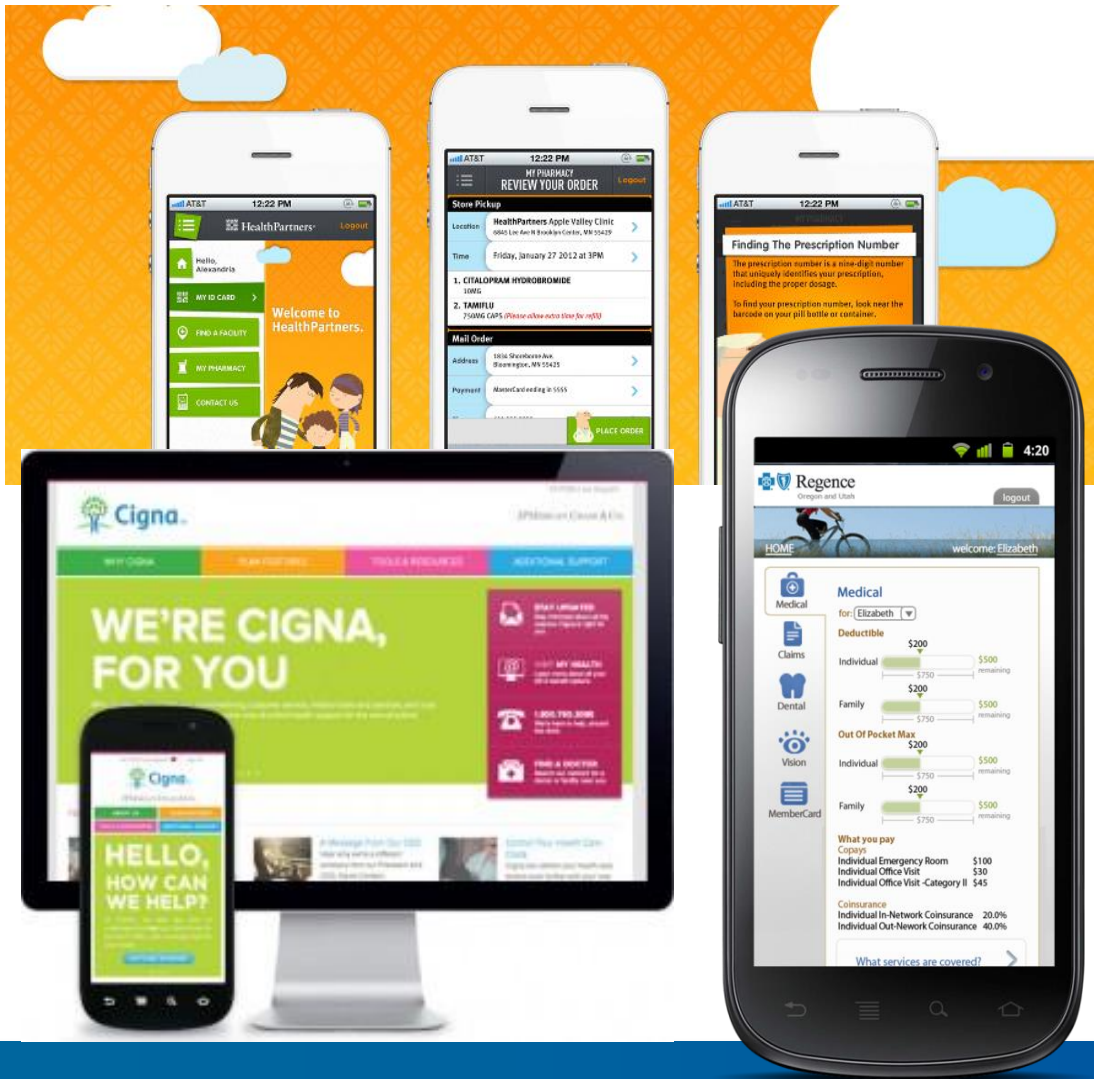
Aid consumer decision-making and provider selection:

- Estimates of frequency used services, including overall cost and the enrollee's share of cost;
- Linkage of price information to quality information where available; and
- Network status of providers

Use of mobile apps:

- Member services apps enable enrollees to submit and look up claims, view ID cards, review deductibles, and check account balances.
- Health care management apps enable members to set up preventive care alerts, access personal health records, order Rx refills, track workouts, food intake, and medications.
- Decision-making apps enable members to search for providers and facilities and compare drug costs.
- Medical support apps enable enrollees to contact an RN and access triage services.

Health Plan Mobile Applications



Provides members with access to information:

- Cost estimates – comparing prices of services; Search for providers and facilities
- Access ID card information; View claims and coverage
- Review claims, deductibles, out-of-pocket spending
- Preventive care alerts; Access to personal health records
- Track medications and order prescription refills
- Track workouts and food intake
- Contact with an RN and/or access to Triage services