

Curley's "Secret of Life": VBID and Payment Reform

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Curley's "Secret of Life": Just One Thing:





Curly: "Do you know what the secret of life is?"

Mitch: "No, what?"

Curly: "This."

Mitch: "Your finger?"

Curly: "One thing. Just one thing. You stick to that and everything else don't mean s&#."

Mitch: "That's great but, what's the one thing?"

Curly: "That's what you got to figure out."



The Challenge:



- In the US, we pay too much and we benefit too little because of:
 - How we pay for health care
 - The way health care is organized and delivered
 - A disconnect between medical science and actual practice
- Significant variation exists in quality and efficiency with little evidence of improved outcomes
- Traditional reimbursement systems, including fee-for-service (FFS):
 - Reward overuse and misuse
 - Are indifferent to high quality care
- Consumers have limited information on value to distinguish among physicians and hospitals
- The Solution: **To build a path to affordable and high quality medical care (not in theory, or in idealized models, but in actual communities!)**

The New Yorker On Health Care Costs:



“Discussions of health care in the U.S. usually focus on insurance companies, but, whatever their problems, they’re not the main driver of health-care inflation: providers are. Hospital stays, MRI exams, drugs, and doctor’s visits are simply more expensive here than they are elsewhere, and the fee-for-service structure insures that we use more of them, too.”

Source: James Surowiecki New Yorker 5/2/11

http://www.newyorker.com/talk/financial/2011/05/02/110502ta_talk_surowiecki#ixzz1M3RHiaHz



September 5, 2012, 8:30 a.m. ET

New UnitedHealth Group Report: High-Quality Care Can Be 14 Percent More Affordable on Average, but with Significant Local Variations

VARIATION IN COSTS

By Philip Ellis, Lewis G. Sandy, Aaron J. Larson, and Simon L. Stevens

Wide Variation In Episode Costs Within A Commercially Insured Population Highlights Potential To Improve The Efficiency Of Care

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Foundation, Inc.

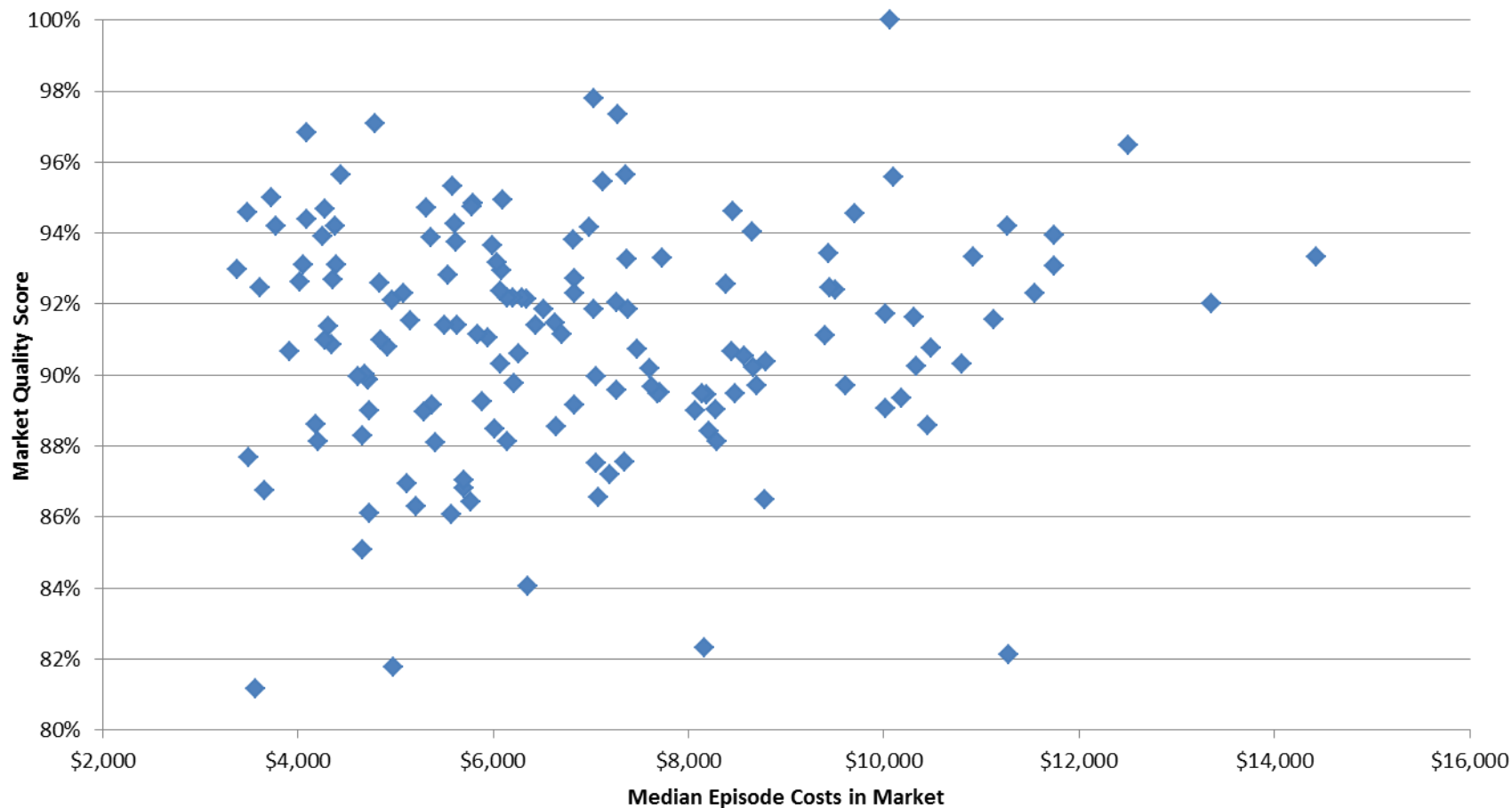
ABSTRACT Reforming payment methods to move away from fee-for-service reimbursement is widely seen as a crucial step toward controlling health care costs. Although there is a good deal of evidence about variability in costs under Medicare, little has been published about the variability of costs for care that is financed by private insurance. We examined both quality and actual medical costs for episodes of care provided by nearly 250,000 US physicians serving commercially insured patients nationwide. Overall, episode costs for a set of major medical procedures varied about

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Variation Across Markets in Episode Costs and Care Quality for Cardiac Catheterization (Diagnostic)



Note: Data includes only physicians designated as providing higher-quality care.

UnitedHealth Group – A Diversified Health and Well-Being Company

UNH

Publicly Traded Registrant (NYSE)

UnitedHealthcare

Health care coverage and benefits businesses, unified under a master brand

- Employer and Individual
- Community and State
- Medicare and Retirement



Helping people live healthier lives

- Diverse benefits business
- Ensuring 38 million individuals get the best care
- Positioned well for post health care reform

Optum

Information and technology-enabled health services platform, encompassing:

- Technology solutions
- Intelligence and decision support tools
- Health management and interventions
- Administrative and financial services
- Pharmacy solutions



*Helping to make the health care system
work better for everyone*

- Independent businesses providing services to:
 - 6,200 hospital facilities
 - 66,000+ pharmacies
- 246,000 health care professionals or groups
- Nearly 60 million individuals



UnitedHealth Group and Innovations In Payment/Delivery Reform:

- Decades of Experience in Quality-Based Specialty Networks (Transplant, Congenital Heart Disease, others)
- Multiple Patient-Centered Medical Home Pilots, varying designs/geographies, collaborative approach
- Robust Accountable Care Platform: Focused, Flexible, Aligned
- Migrating payment from FFS to Value-Based Contracting: Rewarding Value Creation vs. Volume/Intensity
- Payment innovation: Gainsharing models, Oncology Bundled Payment, Episode Based payments
- Large scale physician performance assessment/improvement/transparency
- Advanced consumer engagement & activation programs/capabilities



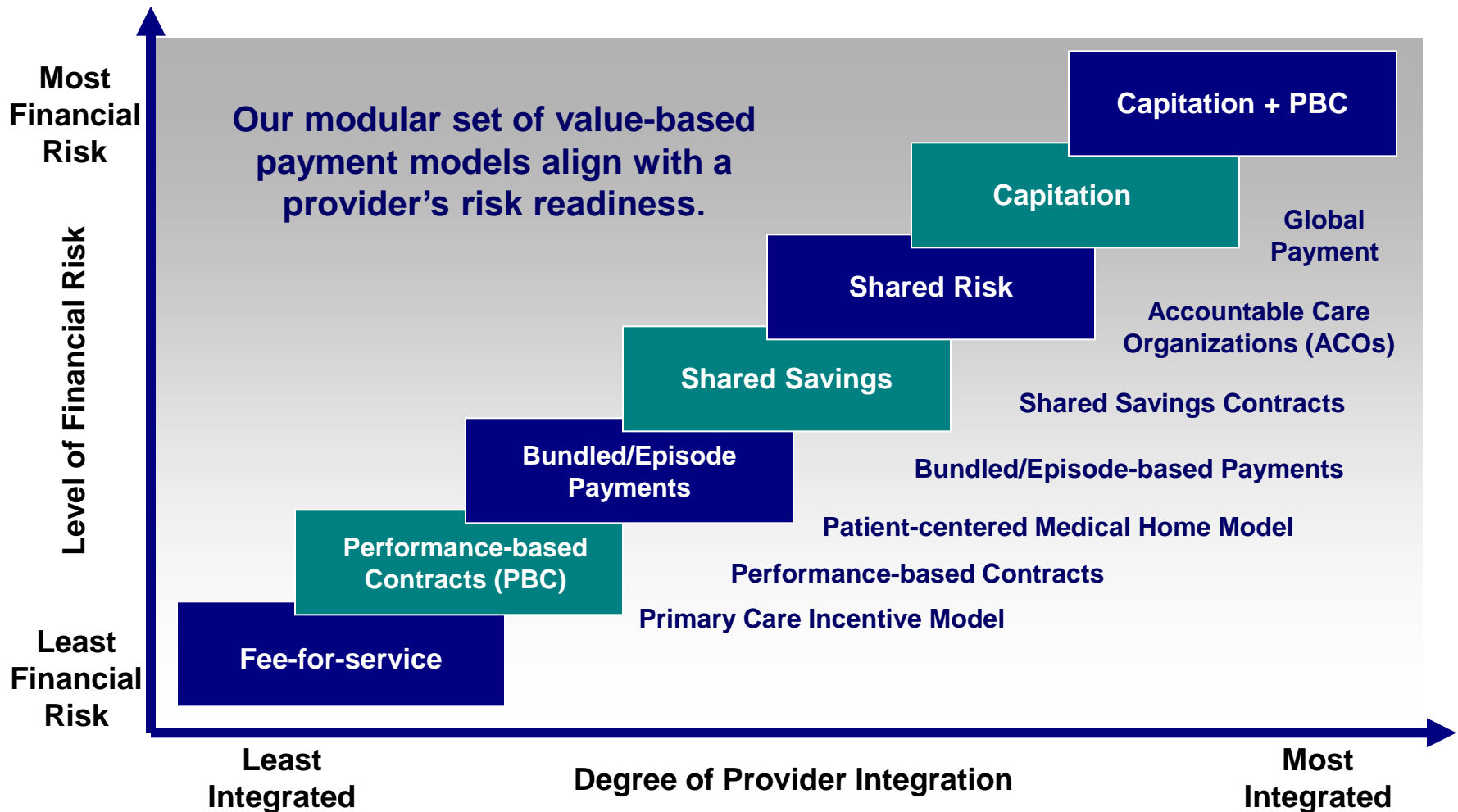
Value-based Compensation

Key Components & Objectives

- Payment linked to improved outcomes
- Financial risk and reward leveraged to achieve best practice and affordability
- Payer and provider incentives aligned to drive enhanced coordination among providers for population health management
- Increased accountability to promote efficient and high quality care



No “One Size Fits All”—A Continuum of Approaches



Value-based Compensation

Overview - Common Models

- **Primary Care Incentive Programs:** Designed to increase payment to primary care physicians in exchange for improvements on quality and efficiency measures.
- **Performance-based Contracting:** Pay for performance incentive programs that reward providers for performance against quality and cost of care measures in conjunction with fee-for-service.
- **Episode/Bundled Payments:** Provider receives a lump sum for all health services delivered for a single episode of care and/or over a specified time period - integrates risk and creates a continuum of care.
- **Shared Savings/Shared Risk:** Payer and provider share upside and downside risk against an agreed-upon budget after meeting quality and experience thresholds.
- **Capitation:** Provider is responsible for the quality, cost and experience outcomes of specific population of patients and receives payments for a specific time period (rather than fee-for-service) – promotes efficient and high quality care and coordination among providers for population health management.

Value-based Compensation Models Go Hand In Hand With Practice Transformation

- **Patient-centered Medical Home (PCMH):** Promotes comprehensive primary care for a population of patients, facilitating partnerships between individual patients and their personal physicians. Incorporates shared savings payments in conjunction with fee-for-service.
- **Accountable Care Organizations (ACOs):** Integrated provider organizations take accountability for care of a specific, defined population. Reimbursement generally incorporates capitation or shared savings/risk based on quality, cost and patient experience.



Accountable Care Platform

Value-based Payment Model Deployment



Primary Care Incentive Models

- Bonus-based incentive programs for primary care practices designed to improve quality and cost-efficiency
- Medicare and Medicaid programs focus on HEDIS star rating improvement and state specific measures
- Programs will be launched in **15 states** across all lines of business in 2012
- Commercial program live with over **600** groups in Rhode Island, Tampa, Phoenix, Orlando and Houston.



Performance-based Contracts

- Incorporates performance-based, value-driven adjustments into physician, ancillary and hospital contracts
- Performance measures drive improvements in quality and efficiency
- Currently in place with over **400 hospitals** and **23,000 physicians** nationally
- Targeted program expansion in 2012 and beyond

Over \$17 billion dollars of our total network health care spend, across all lines of business, is tied to our Accountable Care Platform.

Shared Savings/Risk

- Shared Savings agreements in place with over **9,500 physicians** that are ready for population health management and meet relevant criteria
- Quality measure performance required to share in savings (including star ratings)
- Component of **ACO** and **PCMH** models for commercial, Medicare and Medicaid

Episode/Bundled Payments

- We have administered bundled COE transplant facility contracts for many years (over **160** bundled agreements)
- Chemotherapy episode pilots underway in **5 states** with over **120 physicians** (TX, GA, OH, TN, FL)
- Exploring bundled payment methodology in conjunction with our ortho **specialty network**

Capitation

- We have a variety of capitation arrangements in place with more than **40,000 physicians** across our commercial, Medicare and Medicaid networks
- Exploring model enhancements to incorporate performance-based contracting
- Limited expansion near term

Accountable Care Platform

Managing Population Risk



Requirements for United's ACO Partnerships

- Physician leadership with clear governance
- Robust end-to-end clinical programs
- Ability to coordinate care across all care settings
- Effective HIT
- Disciplined financial accounting and systems
- Mechanisms to appropriately distribute funds
- Ability to manage and willingness to accept risk
- Tools for patient activation and engagement



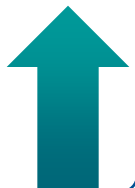
**← Key Success Factors
Critical to Achieving the
Triple Aim**



***Our ACO partners are
accountable for managing
patients across the care
continuum - these are not
simply pay for performance
agreements!***

How United Supports ACOs

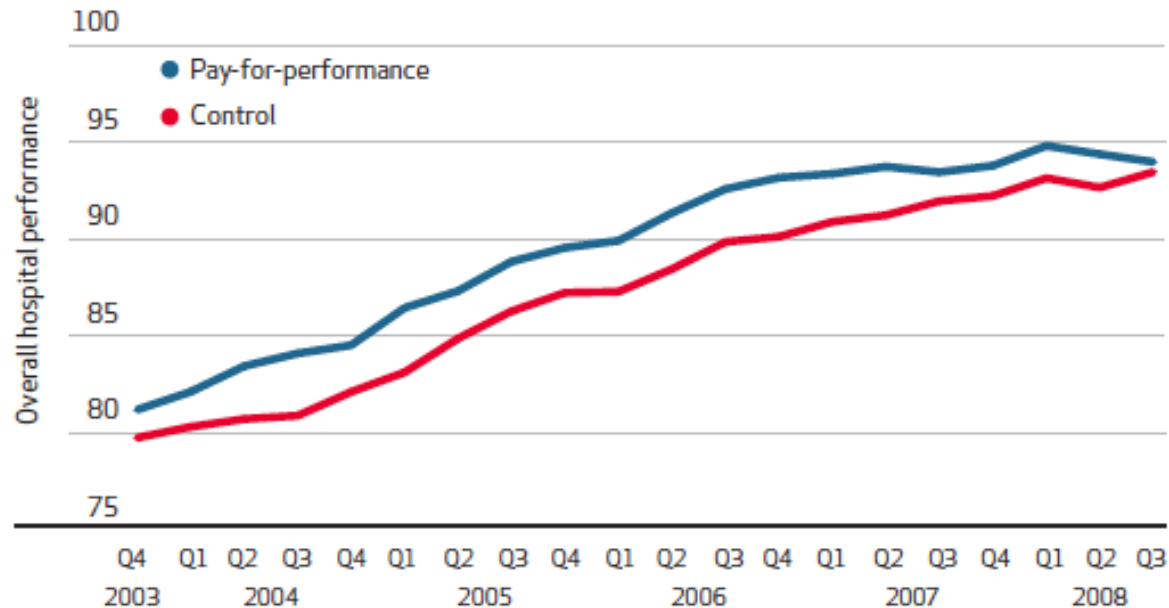
- Membership
- Contracting evolution based on provider risk readiness
- Comprehensive performance measurement and reporting
- Member empowerment strategies
- Clinical consultation
- Robust suite of tools offered by Optum
- Mechanism to administer incentive programs
- Physician/patient portals and transparency tools
- Option to apply model to provider's employee lives



Remember, It Takes More Than Incentives to Achieve Success

EXHIBIT 2

Average Overall Performance in Pay-for-Performance and Control Hospitals, Fiscal Years 2004-08



SOURCE Rachel M. Werner, Jonathan T. Kolstad, Elizabeth A. Stuart, and Daniel Polsky, "The Effect of Pay-for-Performance in Hospitals: Lessons for Quality Improvement," *Health Affairs* 30, no. 4 (2011): 690-8. Data from Hospital Compare: survey of patients' hospital experiences [internet]. Department of Health and Human Services. **NOTES** Performance is averaged across the three conditions: acute myocardial infarction, heart failure, and pneumonia. The values shown are average composite performance scores.



It Take Strategic Alignment:

- The shift toward increased collaboration, outcome-based payment and new benefit design is transforming how we pay for health care and how health care is delivered.
- We are taking an industry leading approach to this transformation by leveraging years of experience with value-based contracting models.
- Our strategy transitions care providers to a value-based environment in which they are accountable for cost, quality and experience outcomes.



Payment Reform Strategy

Delivery System Strategy

Aligned Clinical & Product Strategy

- Alignment across our Network, Product and Clinical innovations allows us to increase value for customers and consumers.
- Our value-based strategy charts the path to superior performance, making health care more affordable and helping people live healthier lives.

Affordability and Quality: Integrating Payment with Clinical Outcomes

Value Based Payment

- Performance-Based Payment
- Episode-Based Payment
- Risk Sharing



Consumer Engagement

- Health Kiosks, Biometric Screenings
- Health Risk Assessment
- Consumer Health Apps
- Innovative Product Designs for all Lines of Business



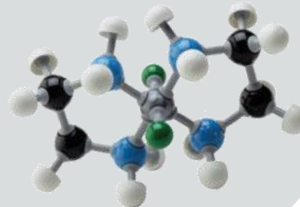
Transparency

- Published Prices by Code and Procedure
- UnitedHealth Premium Designation
- Measuring and Displaying Quality Results Based on Adherence to Evidence-Based Clinical Guidelines



Clinical Integration

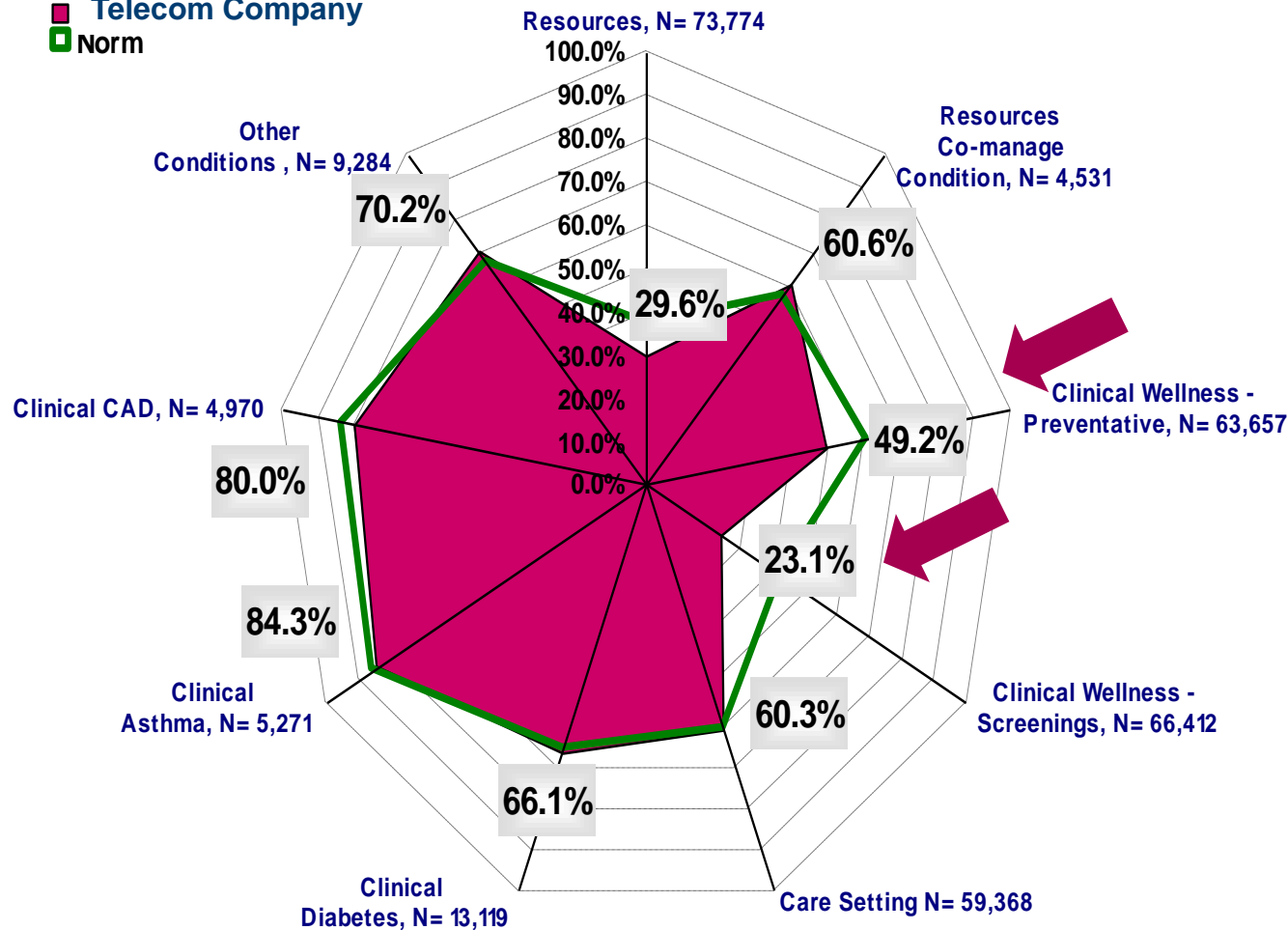
- Primary Care Medical Home
- Accountable Care Organizations
- Electronic Medical Records
- E-Prescribing



Consumer Activation Indexing

Example Telecommunications Company

■ Telecom Company
■ Norm



Insights:

- ❑ Overall Index (CAI) 54%
- ❑ Clinical Wellness activity below normative levels
- ❑ Not taking advantage of 100% paid Wellness Screening Programs
- ❑ Compliance with EBM for CAD is below norm



Personal Action Plan



eSync Delivers a Holistic Member View and Real-Time Insights

Care Managers proactively identify and prioritize opportunities in four major areas:



eSync SM Value Interface

Welcome, **Tiffany Ingram**
Your Total Points Confirmed This Week: **0**

Members Links Configuration

Member Search Add Member Edit Member View Opportunities View Program History Care Plan Tracker

Member Info Programs Providers Medications Contacts Fulfillment Available Programs Referral Labs Condition SAI Secure Message

Anderson, Fred Subscriber ID[873676351-2] Alternate ID[564879213] Total Points Confirmed: **1115**
Total Points Identified: **1677**



DOB: 05/20/1970 (40 years old) Gender: Male Primary Language: English Predictive Model Score: 5.23 Restricted Member: No
Primary Nurse: Tiffany Ingram Preferred Outreach Time: Morning Primary Preferred Communication: Phone Secondary Preferred Communication: Mobile Texting

Opportunities [Add Opportunities] [Update Opportunity] [Select All] [HA Summary] Your Identified Program Points: **1527**


Right **Provider**

RIGHT PROVIDER										
		<input type="checkbox"/>	Opportunity Date	Opportunity Name	Status	Program	Topic	Points	Created By	Assigned To
[edit]		<input type="checkbox"/>	9/1/2009	Premium/HiQPiQ Provider Shift: • Internal Medicine Physician	Identified (9/1/2009)	Diabetes		250	Brenna, Courtney	Brenna, Courtney


Right **Care**

RIGHT CARE										
		<input type="checkbox"/>	Opportunity Date	Opportunity Name	Status	Program	Topic	Points	Created By	Assigned To
[edit]		<input type="checkbox"/>	1/14/2011	Blood Glucose Managed To Target 	Confirmed (1/21/2011)	Diabetes		250	Ingram, Tiffany	Ingram, Tiffany

Right **Medication**

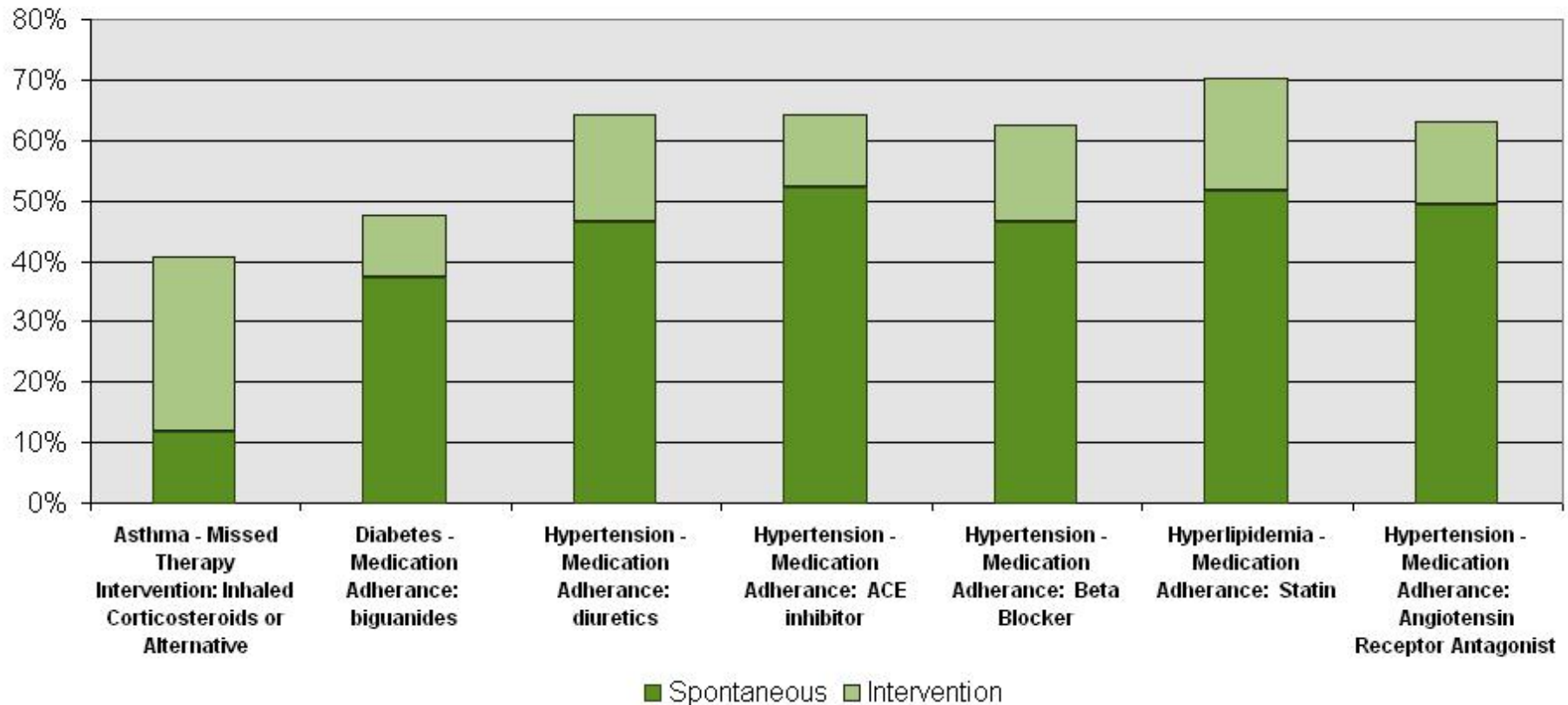
RIGHT MEDICATION										
		<input type="checkbox"/>	Opportunity Date	Opportunity Name	Status	Program	Topic	Points	Created By	Assigned To
[edit]		<input type="checkbox"/>	9/1/2009	ACE Inhibitor/ARB medication added	Identified (9/1/2009)	Diabetes		160	Brenna, Courtney	Brenna, Courtney

Right **Lifestyle**

RIGHT LIFESTYLE										
		<input type="checkbox"/>	Opportunity Date	Opportunity Name	Status	Program	Topic	Points	Created By	Assigned To
[edit]		<input type="checkbox"/>	1/6/2011	Increased minutes per week of physical activity 	Identified (1/6/2011)	Wellness Coaching		250	Altermatt, Heather	Altermatt, Heather

Synchronization of the Health System Improves Goal Achievement 20%

Closure Rates by EBM Rule: Spontaneous and Intervention Attributed



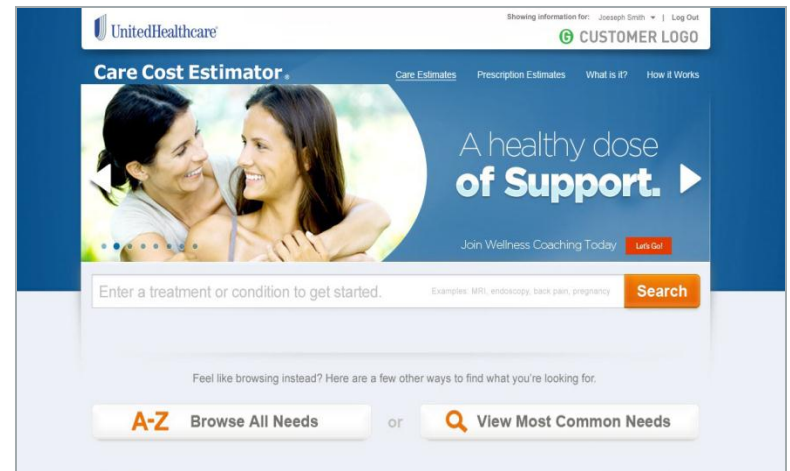
Note: 132 Rules were utilized in this analysis. Gap closure rates vary by rule. We believe this is a conservative estimate for gap closure and savings because the additional rules were not included in the gap closure and savings analyses.

Innovation that informs: Health Care Cost Estimator

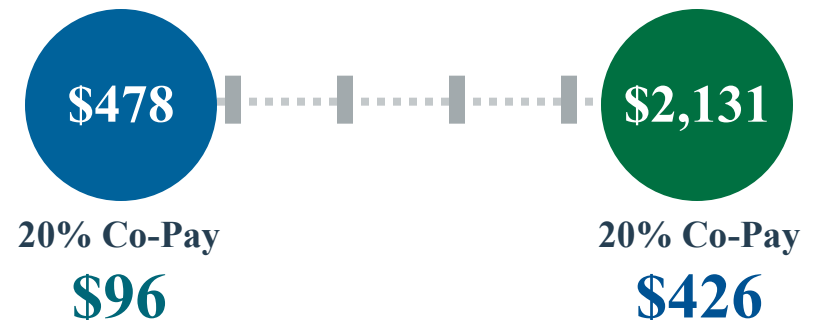
Cost and Quality Transparency Support Better Informed Decisions

Intuitive tool supports consumer decisions with consistently reliable cost estimates

- Helps each member make the best personal value choice – based on price, quality and convenience
- Methodology gives consumers consistently reliable estimates based on historic claims data, validated against actual fee schedules
- Links separate health events – appointments, procedures and follow-up – into an understandable care path
- Fully integrated within myuhc.com® – so members can speak with customer service professionals, get trusted data from care management nurses and make informed decisions with a single tool



Chicago, IL Knee MRI Range of Costs



And the Ability to Manage Population Health:

Ability to Mitigate Readmission Risk

- **Half** of non-surgical readmits did not see a physician post-discharge¹
- Failure to follow-up with physician or therapy is the **most common cause** of readmits¹



Ability to Impact the Future Medical Costs of a Population

- **Half** of high cost claimants had minimal to no engagement with the delivery system in the prior year²



Ability to Control Resource Utilization

- **A quarter** of patients given more information about planned elective surgery change course; either deferring, choosing a less intensive option, or changing facility or proceduralist³



Optum Solutions

Transition Management

Unnecessary readmissions, ED visits, and elective surgery

Population Management

Individual engagement in health care system

Referral Management

Right care, right source, right system

1. Jencks et al. "Rehospitalizations among Patients in the Medicare Fee-for-Service Program." N Engl J Med 2009; 360:1418-1428.

2. Commercial insured population analysis, 2010.

3. National Account Book of Business Analysis, Utilizing Data from January - September 2010.

High Performing Care Delivery Systems ... How They Work (WellMed Example)

WellMed: Physician-owned; manages the operations of medical groups; specializes in senior health care services; affiliated with over 200 Board Certified Family Practice and Internal Medicine physicians in **San Antonio and Austin, TX** and FL. These practices:

- Work on specific goals e.g., reduce 30-day readmission rate
 - Deploy IHI Rapid Cycle Improvement approach
- Develop new care management approaches and processes
 - Example: Functional Patient Care Committee
 - Facilitates information exchange between the Hospitalist and the entire care team (PCPs, the Clinic Administrator, Health Coaches, the Clinic Care Manager, Social Worker, NP and Medical Director)
 - Patients assigned to Red, Yellow or Green Status – guides Intensity of Health Coach Intervention
- Use an expanded set of people and approaches:
 - Health coaches, transition plans, home visits, etc
- Focus on data, results and continuous improvement:
 - Process Measures Rigorously Collected and Analyzed (Days to F/U Post-discharge. Medication Reconciliation, Emergency Room Record Review)
- Deploy advanced technology and clinical analytic infrastructure to support the practice

Results: Readmissions reduced from 18% to 11% in one year!

Accountable Care Platform



Impact

Performance-based Program

- Our **Primary Care Incentive Program** in Rhode Island has produced medical cost savings through:
 - 8% decrease in non-generic prescriptions
 - 14% reduction in non-participating laboratory services
 - 2:1 Return on Investment (ROI)



Performance-based Program

- Our **Performance-based Contracts** drive optimal value; initial results from our national physician program demonstrate:
 - 14% reduction in the use of non-Tier 1 prescriptions
 - 25% reduction in the use of non-participating laboratory services



Centers of Excellence

- Our transplant **Centers of Excellence** program has resulted in improved outcomes:
 - 25% decrease in the average length of hospital stays for transplants
 - Improved transplant survival rates at Centers of Excellence
 - 3% reduction in one-year mortality for liver transplants
 - 5% reduction in one-year mortality for heart transplants
 - 16% reduction in the incidence of transplants through application of evidence-based appropriateness criteria



Accountable Care Program

- Our Commercial **Patient-centered Medical Home** initial results (RI, OH, CO and AZ markets) reflect:
 - 4-4.5% medical cost reduction
 - 2:1 Return on Investment (ROI)
 - Clinical quality results trending above program targets on 95% of all measures



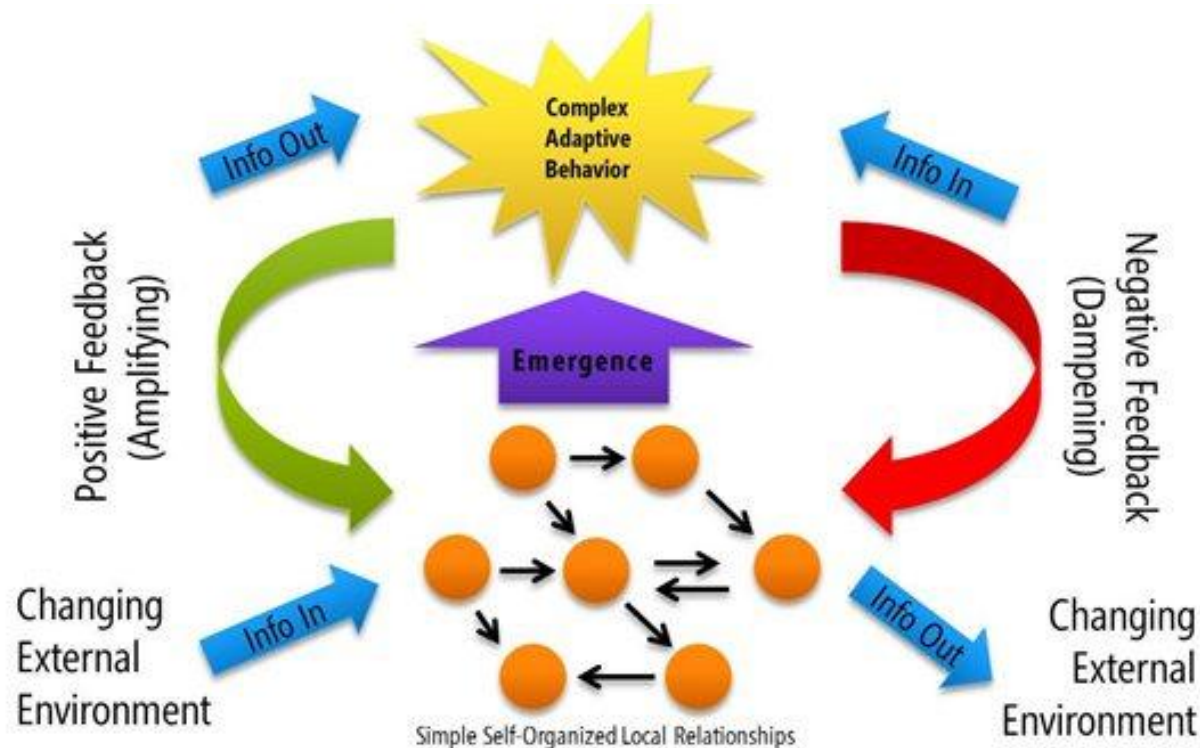
Accountable Care Program

- Our Medicare **Shared Savings** contracts demonstrate:
 - 73% of groups achieved all quality targets and earned a bonus incentive
 - 2:1 Return on Investment (ROI)



Summing Up: Curley's "Secret of Life" Is....

The "One Thing" Is...
That There Isn't Just One Thing!
(Or...that healthcare is a complex adaptive system)



" The best way to predict the future is to invent
it." - Alan Kay

