Alternatives to Traditional Fee-for-Service Models

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UnitedHealthcare Networks

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Aligning Incentives
Accountability Continuum

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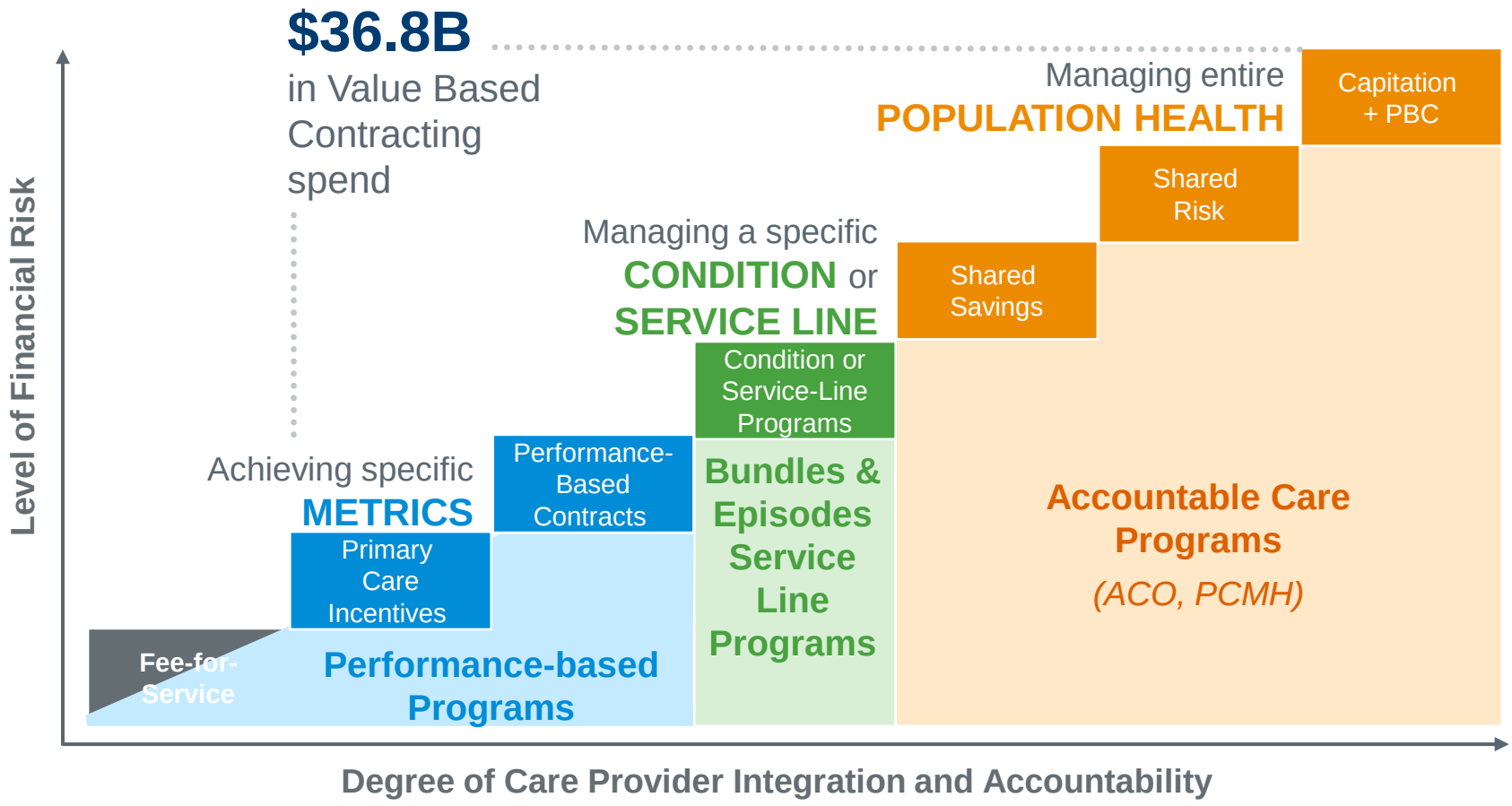
Modular set of value-based payment models deployed across the accountability continuum that can be aligned with a care provider's level of risk readiness



Aligning Incentives

UHC's Experience & Results

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520 Accountable Care Programs

100,000 physicians

850 hospitals

impacting over **11 million** members

PERFORMANCE-BASED PROGRAMS

3.6% readmit reduction

9% inpatient length of stay reduction

CONDITION OR SERVICELINE PROGRAMS

34% reduction in medical cost savings for cancer therapy pilot

25% decrease in average length of stay for transplants

ACCOUNTABLE CARE PROGRAMS

1–6% lower medical cost

Over the long term, our goal is to deliver **10–15%** lower medical cost through our accountable care programs

Paying for value incents higher quality care instead of a greater volume of services

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Value-Based Payments

- Shift away from payments based on the quantity and intensity of services delivered
- Reward high-quality and effective care rather than higher volume of more complex services
- Include multiple approaches that allow payments to be tailored to the diverse capacities of providers

Advanced Service Delivery Models

Medical Homes and Accountable Care Models:

Multi-disciplinary care teams

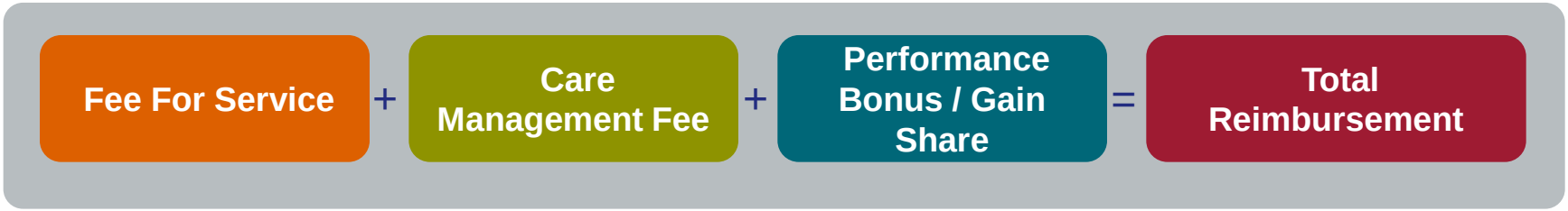
Health information technology

Focus on care coordination

Treating the whole patient

Structuring PCMH Models

UHC's PCMH reimbursement model builds on the current Fee for Service (FFS) schedule with a PMPM Care Management Fee and in some cases a bonus / gain share option based on performance.



- FFS: Physicians remain on current contracted fee schedules and continue to be reimbursed based on actual services provided (no plan re-design or FFS payment schedule changes)
- CARE MANAGEMENT FEE: Prospective fixed-rate, PMPM payments for anticipated quality, efficiency and satisfaction improvements under the PCMH Model [note: contract addendum required]
- BONUS: For some programs, practices are eligible for a periodic performance bonus or rate adjustment that aligns with clearly defined clinical quality, medical cost and operational measures
- GAIN SHARE: For some programs, practices have a lower Care Management Fee in consideration for sharing in the risk/benefit of realized cost reduction outcomes

Medical homes that transform care delivery & pay for value have improved quality & reduced costs

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Medical Home Outcomes in Arizona, Colorado, Ohio, and Rhode Island*

- 6 to 1 return on investment for care coordination activities
- ↓ 6.2% net savings on third-year medical costs
- ↓ Reduced avoidable hospital stays
- ↑ Improved diabetes management
- ↑ Improved patient satisfaction
- ↑ Increased care coordination

Medical home models don't always succeed.
A common factor in many successful models is paying for value through measures of quality, outcomes, and appropriate utilization

*UnitedHealthcare Medical Homes

Critical Success Factors for PCMH

- Funding and resource support enable transformation
  - Practices need to be ready and willing to change
  - Need clearly defined, engaged physician and administrative leadership
  - Structure alone does not drive outcomes
  - Processes need to be adopted and sustained to realize clinical and operational efficiency improvements
- Areas which practices deem important for transformation:
  - Actionable data, analytics and reporting
  - Healthcare Information Technology acquisition support
  - Development of care coordination roles and processes
- Proactive patient engagement and retention maximizes value
  - Original cohort analysis show greater medical cost savings and ROI

Oncology Episode

Payment program strategy

UnitedHealthcare launched a three-year episode payment pilot focused on oncology services

Treatment savings for 810 patients:	$33 Million

Rewards physicians for improved quality and reduction in total cost of cancer

Separates oncologist's income from drug sales

Builds a learning system to identify best practices for cost and quality

Participants:

The West Clinic, Memphis; **Northwest Georgia Oncology Centers, PC**, Marietta; **Center for Cancer and Blood Disorders**, Forth Worth; **Advanced Medical Specialties**, Miami and **Dayton Physicians LLC**, Dayton

"Changing Physician Incentives for Affordable, Quality Cancer Care: Results of an Episode Payment Model, *The Journal of Oncology Practice*, July, 2014, Lee Newcomer; M.D.; Bruce Gould, M.D; Ray D. Page, D.O., Ph.D..; Sheila A. Donelan, M.S. and Monica Perkins, Ph.D.

Cancer Pilot with MD Anderson

3 Year Head and Neck Cancer Bundled Payment Pilot Launched

Based on MD Anderson's extensive mapping of the complex components required for head and neck cancers diagnoses

Bundled Payment Models include: tests, treatments, follow-up care and supportive services required for most head and neck diagnoses

Strong dialog between MD Anderson and the health plan / consensus to share data and work together

Goal is to reduce medical costs by eliminating unnecessary tasks and services and paying more for those essential services

Appendix

Why Focus on Primary Care?

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Primary care is the foundation of the U.S. health care system

- 55% of over 1 billion physician office visits annually
- 6% – 8% of national health care spending ($200 - $250 billion annually)
- The ACA could generate 25 million additional visits each year

High value of primary care

- Central to effective treatment and efficient care delivery
- Emphasis on preventive services
- Core element in advanced care delivery models

Accessing primary care is a major challenge for many individuals

- Lack of capacity and access in rural areas and low-income communities
- 70% of ER visits by commercially insured individuals are non-emergencies

Practical, proven, and scalable solutions exist in the marketplace to advance primary care delivery

Bolstering Capacity

Diverse Workforce

- Over 190,000 nurse practitioners (NPs), as well as other clinicians, can increase primary care capacity
- Evidence indicates high quality of primary care delivered by NPs

Multi-Disciplinary Teams

- A primary care physician with a panel of 2,000 patients would need to spend 17.4 hours per day providing recommended care
- Integrating NPs and other providers into team-based care can allow practices to double the number of patients they see
- Practicing in teams increases the satisfaction of PCPs

Health Information Technology (HIT)

- Broader implementation of HIT, including Electronic Health Records (EHRs), increases system-wide quality and care coordination
- Lack of interoperability prevents effective data sharing
- Cost of adoption and ongoing support is a challenge for smaller practices

Defining the Patient-Centered Medical Home

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Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for patients

Principal Characteristics of PCMH:

- Personal Physician
- Physician Directed Practice
- Whole Person Care Orientation
- Coordinated Care
- More time for patients
- Better Care Continuity
- Improved Care Transitions
- Simplified and Coordinated Health Care Experience

Improved Clinical Indicators

Lower Per Capita Costs

Increased Patient Participation in Health Care Decisions and Adherence to Care Plans

Quality and Safety

Enhanced Care Access

Optimization through HIT integration

Increase in Practice Profitability and Satisfaction

The PCMH is a health care setting that facilitates partnerships between individual patients, their personal physicians and, when appropriate, the patient's family.