Successful strategies for aligning payment innovation to value-based contracts

October 29, 2019
Meet our presenters

Sri Vangala
General Manager
Network Payment Innovation, Optum

Ron Myers
Vice President
Network Payment Innovation, Optum
Agenda

1. Background: U.S. health care priority
2. Market trends: Evolving payment models landscape
3. Key considerations: Approach
4. Moving forward: Successes and opportunities
5. Q&A
Our mission

UNITEDHEALTH GROUP

Ranked 6th of the Fortune 500

$226.2B FY18 revenue

A diversified enterprise with complementary but distinct business platforms

Health Benefits

Health Services

OUR MISSION
Helping people live healthier lives and helping make the health system work better for everyone

OUR VALUES
Integrity  Compassion  Relationships  Innovation  Performance

As of Q2 2019
Background
U.S. health care priority
Health care spending $5.96T by 2027

National Health Expenditures by Source of Funds

*Projected figures

By spending category

Health Expenditures by Spending Category

- Physician, clinical, dental and other professional services
- Hospital care
- Investment
- Net cost of health insurance
- Government administration and public health activity
- Prescription drugs
- Other retail outlet sales of medical products
- Nursing care and continuing care retirement communities
- Home health care
- Other health, residential and personal care

© 2019 Optum, Inc. All rights reserved.
Personal health care expenditures

Factors accounting for growth in personal health care expenditures, selected calendar years 1990–2025

*Projected

Source: Centers for Medicare and Medicaid services, Office of the Actuary, National Health Statistics Group. Notes "Use and intensity" includes quantity and mix of services. As a residual, this factor also includes any errors in measuring prices or total spending. "Medical prices" reflect a chain-weighted index of the price for all personal health care deflators. "Population" is population growth "Age-sex mix" refers to that mix in the population.
Six domains for waste cost estimates $900B

<table>
<thead>
<tr>
<th>Domain</th>
<th>Costs, $US Billion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Failure of Care Delivery</strong></td>
<td></td>
</tr>
<tr>
<td>Hospital-acquired conditions and adverse events&lt;sup&gt;19, 22&lt;/sup&gt;</td>
<td>5.7-46.6</td>
</tr>
<tr>
<td>Clinician-related inefficiency (variability in care, inefficient use of high-cost physicians)&lt;sup&gt;27, 28&lt;/sup&gt;</td>
<td>8.0</td>
</tr>
<tr>
<td>Lack of adoption of preventive care practices (obesity, vaccines, diabetes, hypertension)&lt;sup&gt;23-26&lt;/sup&gt;</td>
<td>88.6-111.1</td>
</tr>
<tr>
<td><strong>Failure of Care Coordination</strong></td>
<td></td>
</tr>
<tr>
<td>Unnecessary admissions and avoidable complications&lt;sup&gt;19, 29&lt;/sup&gt;</td>
<td>5.9-56.3</td>
</tr>
<tr>
<td>Readmissions&lt;sup&gt;30, 31&lt;/sup&gt;</td>
<td>21.25-21.93</td>
</tr>
<tr>
<td><strong>Overstreatment or Low-Value Care</strong></td>
<td></td>
</tr>
<tr>
<td>Low-value medication use&lt;sup&gt;12, 22-25&lt;/sup&gt;</td>
<td>14.4-29.1</td>
</tr>
<tr>
<td>Low-value screening, testing, or procedures&lt;sup&gt;14, 26, 37&lt;/sup&gt;</td>
<td>17.2-27.9</td>
</tr>
<tr>
<td>Overuse of end-of-life care&lt;sup&gt;38&lt;/sup&gt;</td>
<td>44.1</td>
</tr>
<tr>
<td><strong>Pricing Failure</strong></td>
<td></td>
</tr>
<tr>
<td>Medication pricing failure&lt;sup&gt;8&lt;/sup&gt;</td>
<td>169.7</td>
</tr>
<tr>
<td>Payer-based health services pricing failure&lt;sup&gt;29, 40&lt;/sup&gt;</td>
<td>31.4-41.2</td>
</tr>
<tr>
<td>Laboratory and ambulatory pricing&lt;sup&gt;41&lt;/sup&gt;</td>
<td>29.7</td>
</tr>
<tr>
<td><strong>Fraud and Abuse</strong></td>
<td></td>
</tr>
<tr>
<td>Fraud and abuse in Medicare&lt;sup&gt;42-44&lt;/sup&gt;</td>
<td>58.5-83.9</td>
</tr>
<tr>
<td><strong>Administrative Complexity</strong></td>
<td></td>
</tr>
<tr>
<td>Billing and coding waste&lt;sup&gt;45&lt;/sup&gt;</td>
<td>248</td>
</tr>
<tr>
<td>Physician time spent reporting on quality measures&lt;sup&gt;19&lt;/sup&gt;</td>
<td>17.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>766-935</td>
</tr>
</tbody>
</table>

Published online October 07, 2019
Market trends
Evolving payment models landscape
Macro trends

What we are seeing as these organizations move from volume to value — from fee-for-service to alternative payment models — payment reform leads to improved performance

**Government**
- Continued budget pressure forcing states to shift more risk to providers
- CMS exploring direct provider contracting (DPC) model
- Growing Medicare Alternative Payment Models - Accountable Care Organizations (ACOs), Specialized Care, Episode-based and Medical Home

**Commercial payers**
- Accountable care models outpace government programs nationally (~700 plus)
- New formations of payer-provider-vendor partnerships are emerging

**Employers**
- Employer-sponsored coverage shrinking with employees paying more
- Employers pursuing new strategies to target highest-cost employees
- Businesses prioritize telemedicine access and specialty drug costs

**Providers**
- BPCI-A escalating reimbursement risk for physicians
- Emerging technologies and sites of care challenge traditional care models
- Increase market share, preferred relationships with payers
- Physician-led ACOs
Value-based contracting at a glance

Value-based care cycle

- Clinical care
- Patient engagement
- Coordination of care
- Payment administration
- Reporting and transparency

What is value-based contracting?

<table>
<thead>
<tr>
<th>Improved health outcomes at lower costs</th>
<th>Why value-based contracting (VBC) incentives?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rewards for efficiency, quality and patient outcomes</td>
<td>• Accelerates adoption of outcome-based medicine</td>
</tr>
<tr>
<td></td>
<td>• Moves toward greater risk share</td>
</tr>
<tr>
<td></td>
<td>• Aligns to regulatory programs</td>
</tr>
<tr>
<td></td>
<td><strong>Bundled payments:</strong> Patient-centric management of an episode of care (e.g., knee replacement/maternity)</td>
</tr>
<tr>
<td></td>
<td><strong>Pay4Performance/gain sharing:</strong> Population-centric reward for alignment to targeted best practices</td>
</tr>
</tbody>
</table>

Common VBC payment programs

Market developments

- BPCI Advanced (BPCI-A)
- Primary Care First (PCF)
- Direct Contracting (DC)

- Larger footprint (including outpatient)
- Accelerate through risk-based models includes Quality measurement
- Leverage foundation for commercial/Medicare Advantage programs

Successful pilots lead to expansion

- Early scale enables setting of marketplace
- When successful, move beyond pilot
- Desire to be seen as a market leader

Barriers to entry

- Lack of a clear program strategy
- Leadership commitment and resource availability
- Development of aligned care pathways (clinical and operations)
- Operational and financial administration; disrupts existing payment processes
- Poor transparency into value-based formulas and metrics
- Lack of actionable insights for motivating behavior change at the point of care
Common value-based care programs

**Patient/Episodic programs**
(Bundled payments)

- **Patient-centric** management of an episode of care
- Episode designed to **ensure patient quality**
  - Surgical procedures (IP and OP)
  - Annual disease total cost of care
- **Episodic examples**
  Bundles:
  - Ortho and spine
  - Maternity
  - Oncology chemotherapy
  - Colonoscopy

**Population health programs**
(Value-based contracting)

- Provider **measures-based evaluation** against an attributed population drives reimbursement
- Measures typically **align to desired positive changes in care delivery**
  - Preventative medicine, disease management, utilization control
- Value-based contracting examples
  - Pay4Performance/Pay4Quality, upside/downside
- Frequent **provider performance reporting** critical
- Providers typically paid at end of contract year

**EMPHASIS ON PREVENTION, ELIMINATING ACUTE EPISODES**

**EMPHASIS ON EFFICIENCY AND BEST PRACTICE**
Alternative payment models spectrum

**Patient/Episodic programs**

- Retrospective
- Prospective
- Procedure based (CJR, TJR, bariatric, etc.)
- Time based
- Employer driven
- Center of Excellence
- Episode of care
- CMS BPCI Medicaid

**Common Bundle Programs**

**Population Health programs**

- Attribution management
- Preventative care and wellness
- Avoidable care management
- Disease management
- Utilization management

**Common Value Based Contracts**

- Cost, quality, utilization, patient satisfaction
Cautious optimism that value-based reimbursement will become the primary revenue model

Do you think value-based reimbursement will ever be the primary revenue model in U.S. health care?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Uncertain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executives</td>
<td>51%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical leaders</td>
<td>39%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physicians</td>
<td>37%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There is a higher incidence of executives (51%) than clinical leaders (39%) and clinicians (37%) who think value-based reimbursements will be the primary revenue model in U.S. health care.

Which value-based care models is your organization actively pursuing?

- Accountable care organization: 50%
- Bundled payment programs: 47%
- Patient-centered medical home: 39%
- Shared savings: 34%
- Employer direct contracting: 24%
- Federal Quality Payment Program (QPP): 19%
- Federal Readmissions Reduction Program (HRRP): 15%
- Full capitation: 15%
- Federal Inpatient Prospective Payment System (IPPS): 10%
- Don't know: 20%

Patient-centered medical homes are more likely to be pursued in the Northeast (48%) and South (42%) than in the Midwest (35%) and West (30%).

Value-based payment models' use of downside risk by type

<table>
<thead>
<tr>
<th>Model</th>
<th>Proportion of business in models with downside and upside risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capitation, global payment</td>
<td>7.3%</td>
</tr>
<tr>
<td>Pay for performance</td>
<td>6.5%</td>
</tr>
<tr>
<td>Prospective bundled payment</td>
<td>5%</td>
</tr>
<tr>
<td>Population-based payment</td>
<td>5.8%</td>
</tr>
<tr>
<td>Retrospective bundled payment</td>
<td>4.1%</td>
</tr>
</tbody>
</table>

Source: Modern Healthcare calculation using data from “Finding the Value in Value-based Care,” Change Healthcare
HCTTF continues to progress toward our goal of 75% of business in value-based payment arrangements by the end of 2020.

Source: Health Care Transformation Task Force (HCTTF), September 2019
Key considerations

Approach
## Where are you in your own journey from volume to value?

### Strategy

**Need**
- Formulate strategy
- Facility/professional
- Identify opportunity
- Lead marketplace
- Develop a deployment playbook
- Identify willing pilot partners
- Pilot
- Develop payment strategy

### Growth

**Need**
- Gravitate to leading practices
- Bring to larger segment (products/LOBs)
- Operationalize to scale
- Separate from competition
- Continuous evolve program
- Strength, governance and workflow
- Integrate with core systems
- Ensure realization of value to providers

### Refinement

**Need**
- Gravitate to best practices
- Tune administration waste out of system
- Leverage infrastructure, care redesign, data and analytics across multiple programs
- Automate exception processing
- Governance and workflow
What do you need to consider?

Data analytics
- Program strategy
- Claims and clinical data
- Bundle definition

Care pathway education
- Care pathway education
- Provider care transitions
- Patient engagement

Implementation/expansion
- Remodel of care pathway

Operational administration

Contract management
- Payments and distribution
- Exception processing
- Patient enrollment/attribution

Analytic reporting
- Operational reporting
- Financial and performance reporting
Approach: Payment innovation

1. **Strategy**
   What programs provide better outcomes?

2. **Action plan**
   How can my organization implement the contract/payment piece of the strategy?

3. **Administer value-based contracts**
   With a program implemented, how do I administer the contracts?

4. **Evolve strategies**
   How can my organization continuously evolve to improve outcomes?

Platforms and services to enable operational and financial success:

- Advanced analytics
- Bundle payment manager
- Value-based contract administration
- Attribution management
- Advisory services
GOAL: CREATE A FOCUSED STRATEGY THAT LEVERAGES YOUR ORGANIZATION’S STRENGTHS AND CAPABILITIES HELPS TO LEAD TO BETTER CARE AND LOWER COSTS FOR YOUR MEMBERS

Questions to answer

- What are the best episodes/bundles for your organization?
- Which provider performance metrics are most impactful for value-based contracts?
- What alternative payment model programs will drive increased quality and lower costs for members?
- Which lines of business are conducive to alternative payment model programs?
- With which providers should you contract?
- To what markets should you roll out your program?

Tasks to Perform

- Analytic data (Where do I target?)
- Timely access to claim and clinical data
- Program definition and starter kits (VBC/Bundle)
- Bundle definition "what if" modeling
- Define incentive framework.
- Define attribution rules(member to provider, member to episode)

Skillset & Partners Needed

- Finance
- Product development
- Revenue cycle management and health care economics
- Health plan and provider network contracting
- Operations – core processing, member inquiry teams
- Clinical and provider representation

Data to Gather

- Administrative claims and targeted clinical data to group and target episodes and to identify members for bundles or population-based value-based contracts
- Industry benchmark data to validate your results and identify differentiators you can bring to the market
- Provider measure scores to create impactful value-based contracts with providers
- Member and provider demographics

Technology Support

- Administrative claims bundle grouper to identify bundles
- Member-to-provider attribution engine to identify members
- Bundle and value-based contracting financial modeler to determine which payment model programs are likely to be financially viable
- Analytic reporting to pinpoint the best bundles and provider metrics for your alternative payment models
- Provider performance measure software (e.g., HEDIS®, EBM, etc.)
Which alternative payment model programs meet your goals?

Common strategy paths…

**Evolution**
Progression from pay for performance (P4P) to capitation

**Center of Excellence**
Network/condition excellence

**Disease state/“total cost of care”**
Targeted capitation

**Targeted/limited deployment**
Alignment to specific market driver, business or client objective
Evolutionary: Continuous evolution until end-state program in place

### Goals
- Establish a foundation for value-based contracts
- Identify willing lead partners in the move to value
- Once established, mature program over time
- Gracefully implement to reduce exposure due to disruption
- Validate impact before moving to more advanced models

### Considerations
- Clean, clear program design and road map leads to success
- Timely data access allows for program to adapt to contract trends
- Tailor contracts that allow for success—focus on measurements that are meaningful and achievable
- Reduced fragmentation which leads to operational energy
- Continuously tune
- Strong operational tools help curve operational costs

---

**Quality and utilization measures**
- Disease management
- Patient satisfaction
- Preventive medicine
- Utilization
## Center of Excellence model

<table>
<thead>
<tr>
<th>Goals</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Align with employer group emphasis on cost and outcome improvement</td>
<td>• Careful selection of provider partners that have efficient care pathway</td>
</tr>
<tr>
<td>• Improve the quality of the network</td>
<td>• Scale in a narrow pre-established discipline</td>
</tr>
<tr>
<td>• Reward high-quality providers with excellent outcome with strong cost management</td>
<td>• Close collaboration with provider partner on episode/bundle design</td>
</tr>
<tr>
<td>• Align with new leading plan designs</td>
<td>• Implement strong patient program education and enrollment</td>
</tr>
<tr>
<td>• Validate impact before moving to more advanced episodes/bundles</td>
<td>• Within an episode, start with executable episode definition (short pre/post windows)—evolve with more services over time</td>
</tr>
<tr>
<td></td>
<td>• Strong operational tools help curve operational costs</td>
</tr>
</tbody>
</table>
## Disease state management

### Total Cost of Care

#### Goals
- Strengthen network quality
- Move from volume to value through global payment tool allowing for *sharing of risk*
- *Identify willing lead partners* in the move to efficient disease state management
- *Transition care to high quality providers* with excellent outcome with strong cost management
- *Align to capitated costs model* for targeted disease state

#### Considerations
- Focus on episodes with wide quality and cost swings within the network
- *Careful selection of provider partners* that have efficient care pathway
- Timing of payment and downstream distribution of payment
- Within an episode, *start with executable episode definition* (short pre/post windows)—evolve with more services over time
- *Strong operational tools help curve operational costs*
## Targeted deployment

### Targeted/Limited Deployment

#### Goals
- Align to a specific market driver
- Directive from employer group desire or regulatory compliance
- Effective deployment on a limited scale—improve patient satisfaction through better outcomes or cost management
- Align to regional/product drivers
- Transition care to high-quality providers with excellent outcome with strong cost management

#### Considerations
- Focus on quality metrics, bundles or episodes with large membership impact
- Careful selection of provider partners that have experienced care pathway
- Consider established “best practice” programs that are pre-defined (bundle definitions, P4Q templates, etc.)
- Tight collaboration with targeted provider
- Strong operational tools help curve operational costs
Rollout approach

GOAL: NOW THAT THE STRATEGY HAS BEEN DEFINED, ROLLOUT PLANS HELP BUILD A FRAMEWORK TO HOW YOU WILL EXECUTE AND IMPLEMENT...

Tasks to Perform
- Analytic data (Where do I target?)
- Timely access to claim and clinical data
- Program definition and starter kits (VBC/Bundle)
- Bundle definition “what if” modeling
- Develop an incentive framework.
- Risk adjust to pay fairly
- Finalize attribution rules(member to provider, member to episode)

Questions to answer
- What bundles/metrics will I support?
- What is my right mix of patient and population programs for my patients?
- Which of my products/markets will be included in the program scope?
- How do I want to incentivize participating entities for success?
- What type of risk model will I deploy?
- How do I integrate into my existing processes?
- How do I want to expand the program beyond the initial rollout? Year 2? Year 3?

Data to Gather
- Historical claim data
- Provider demographic (light)
- Membership Roster
- Key clinical metric data (LOS, readmit, medication adherence)
- Bundle Rules (Code sets and Time Windows)
- Contract Templates

Technology Support
- Identify data intake channels and repositories
- Create report and data distribution channels
- Identify what systems need to connect together

Skillset & Partners Needed
- Product Development
- Revenue Cycle Management and Healthcare Economics
- Payer and Provider Network Contracting
- Operations – Core Processing, Member Inquiry Teams
- Clinical/Provider Representation

© 2019 Optum, Inc. All rights reserved.
Program rollout

Considerations for building a successful strategy and rollout …

Data analytics and modeling
Use data to drive to the best program design.
Find the program that enables success for both payer and provider.

Establish metrics
Find the meaningful metrics and appropriate bundle definition.

Align incentives
Identify the “right” measurements with the “right” financial incentive to drive to desired results.

Payment administration
Integrate with existing upstream and downstream systems.
Implementation approach

Questions to answer

- Who are my right partners that are ready and able to participate in my program?
- How do I connect with my core processing systems?
- How do I train my partner on program definitions?
- How do I adapt to incentive and program definition changes introduced during contract negotiations?
- How do I perform testing that encompasses all impacted areas including my partner?
- What infrastructure do I require to support program volume?
- What and where do I send program reporting and data?

Tasks to Perform

- Development of Clinical, Provider and Patient Playbooks
- Create a strong exception management process
- Finish Reporting: Program, Scorecard & Financial Reporting
- Connect with “check writing” entities
- Training: Partner, Internal operations, claims, clinical & contracting
- Delivery partner historical reporting package

Skillset & Partners Needed

- Product/Payer Relations
- Contracting Department
- Training
- Operations – Core Processing, Member Inquiry Teams, Help Desk
- Clinical/Provider Representation
- Willing External Partners (Payer/Provider)

Data to Gather

- Participating provider demographic data
- Participating membership roster data
- Key clinical metric data (LOS, readmit, medication adherence)
- Partner centric bundle contract parameters (Code sets and Time Windows)

Technology Support

- Build secure partner data interfaces for inbound data
- Create secure partner report and outbound data methodologies
- Complete connection with core processing, data warehousing and population health solutions
Four phases of the implementation process

1. Program initiation
   - Identify all sources of program data (claim, metric, demographic, contract)
   - Establish Payer, Provider, IT roles
   - Review program definition and starter kits
   - Build User Profiles
   - Identify any critical reporting needs

2. Data build
   - Establish secure data delivery channels
   - Deliver all source data
   - Finish construction of any critical reporting needs
   - Validate data contents

3. Configuration
   - Configure Contact Templates
   - Build metric/bundle definition repository
   - Perform program “what if” modeling
   - Setup individual users
   - System and integrated testing

4. Deployment
   - Training: providers, payer, employer group
   - Establish communication between providers
   - Launch reporting and tools
   - Celebrate!
On-going operations approach

GOAL: PROGRAM IS LIVE, ENSURING EACH DAY THE PROGRAM IS EXECUTING, ON TRACK AND MANAGING VOLUME...

Questions to answer

- How well is my program performing?
- Are we administering the program and providing the data needed to be successful?
- Is my current program on track? Do we have any patterns of issues that need to be addressed?
- Are we managing exceptions efficiently?
- How do I respond to high volume partner inquiries?
- What tweaks to operational processes are needed for increase automation?
- How can I expand the number of bundles or measures that can be supported?

Tasks to Perform

- Execution of Clinical, Provider and Patient Playbooks
- Create a strong exception management process
- Deliver Reporting
  - Program, Scorecard
  - Financial Reporting
- Manage partner inquiries and questions

Skillset & Partners Needed

- Product/Payer Relations
- Operations – Core Processing and Issue Inquiry Teams
- Technical Operations
- Clinical/Provider Representation

Data to Gather

- Historical and current claim data
- Participating provider demographic ongoing roster management
- Membership Roster ongoing roster management
- Key clinical metric data (LOS, readmit, medication adherence)
- Bundle Contract Parameters (Code sets and Time Windows)

Technology Support

- Secure data intake and distribution
- Build secure partner data interfaces for inbound data
- Create secure partner report and data methodologies
- Complete connection with core processing, data warehousing and population health solutions
# Alternative payment operational considerations

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
</table>
| 1 | **Member and Partner Provider inquiries**  
• Which team will manage incentive questions? Should those teams connect directly into existing operational teams? Or push data to existing support platform?  
• How will I distribute contract and scorecard data to partner providers? Employer groups? |
| 2 | **Patient enrollment**  
• How will we communicate which patients are attributed to the program?  
• Will the program include a formal patient enrollment process?  
• Is patient enrollment being automatically derived from claim data?  
• How will I validate members that have been attributed to me? |
| 3 | **Intake of program payment data**  
• Claim data  
• Clinical/Metric data  
• Provider demographic  
• Provider contract  
• Contract parameters for all lines of business? All payers? All partner providers? |
| 4 | **Onboarding process**  
• Provider: Onboarding process for new payers and partnering providers. Implementation guide includes: Patient communication process, provider coordination knowledge training, in program communication and support, etc.  
• New alternative payment incentives  
  • Introducing a new bundle: Process for modeling, publishing, building and administering.  
  • Introducing a new metric: Calculation definition, monitoring and reporting. |
| 5 | **Transparency: Operational and Performance Reporting**  
• Operational performance management enabling contract partners to identify early adjustment areas and become successful  
• Financial performance management showing the volume, program spend, alignment to targets and financial health |
Full program orchestration approach

Move beyond claim administration to program administration

Quick Start Program
- 100+ ready-made bundle definitions
- Value-based contract templates
- Pre-packaged workflow and governance

Analytics and modeling
- Opportunity analytics
- “What if” contract modeling

Payment/claims
*Bundle Payment Manager*
- Prospective/Retrospective
- BPCI/Medicaid/Commercial
*Value-Based Contract Admin.*
- Cost quality utilization and patient satisfaction
- Attribution management

Both platforms
- Upside and shared risk
- Contract management

Risk assessment
- Identify patient co-morbidities
- Align patient to proper bundle definition

Transparency and distribution
- Provider scorecard
- Identify appropriate provider payment distribution

Operational reporting
- Bundle case review
- Exception reporting

Analytic and program reporting
- BPCI reporting
- Provider scorecard
- Payment distribution
- Program performance

Governance and workflow
Actionable data = Success

Structure + Tools + Culture

Democratize data:
Organize your data into a single data source accessible to everyone

Standardized data definitions, measure sets:
Consistent definitions and clear metrics

Scale operations:
Invest in the right analytics and self-service data tools

Implement leading practices:
Good governance, processes and support systems

Developing the Health Care Enterprise Analytics Strategy Overview. Source: Gartner, January 2018
Analytics escalator

- Opportunity assessment
- What-if analysis
- Contracting strategy
- Return on investment and cost benefit analysis
- Risk-adjusted models and spending trends
- Patient segmentation
- Ongoing performance monitoring
- Expansion initiatives

The analytics value pyramid

- Descriptive
  - What has happened?
  - Business dashboards, KPI tracking, ETL, etc.

- Diagnostics
  - Why has it happened?
  - Search, query tools, data exploration, etc.

- Predictive
  - What may happen?
  - Modeling, data science, etc.

- Prescriptive
  - What action to take?
  - Recommendations, automation, etc.

Business value
Bundled payments: Financial modeling
Bundled payments: Performance reporting

Broad spectrum of reporting in flight to enable multiple consumer types to receive program info

<table>
<thead>
<tr>
<th>Report type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive reporting</td>
</tr>
<tr>
<td>Program reporting</td>
</tr>
<tr>
<td>Financial reporting</td>
</tr>
<tr>
<td>Operational reporting</td>
</tr>
<tr>
<td>Clinical metric reporting</td>
</tr>
<tr>
<td>Performance metric reporting</td>
</tr>
<tr>
<td>PGP financial reporting</td>
</tr>
<tr>
<td>NPI (physician) financial reporting</td>
</tr>
</tbody>
</table>
VBC-A: Opportunity analytics
VBC-A: Contract and payment
VBC-A sample provider group scorecard

Report Summary

Contract Name: ABC Provider Group
Provider Group Name: Provider Group Name (TIN)
Contract Date: July 1, 2015 - June 30, 2017

List View

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Compliant</th>
<th>Non-Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult patient(s) with a computed axial tomography (CT) or magnetic resonance imaging (MRI) study of the head that was not medically indicated.</td>
<td>28</td>
<td>164</td>
</tr>
<tr>
<td>Adult patients persistently taking ACE inhibitor or ARB who received a serum potassium test AND either a serum creatinine or blood urea nitrogen test within the last 12 reported months (MHDIS criteria)</td>
<td>786</td>
<td>40</td>
</tr>
<tr>
<td>Patient(s) 12 - 21 years of age that had one comprehensive well-care visit with a PCP or an OB/GYN in the last 12 reported months.</td>
<td>1,233</td>
<td>493</td>
</tr>
<tr>
<td>Patient(s) 18 - 75 years of age that had annual screening for nephropathy or evidence or nephropathy.</td>
<td>405</td>
<td>84</td>
</tr>
<tr>
<td>Patient(s) that had appropriate pneumonia testing to confirm COPD diagnosis.</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td>Woman that appropriate screening for cervical cancer</td>
<td>1,467</td>
<td>1,512</td>
</tr>
<tr>
<td>TOTAL</td>
<td>4,910</td>
<td>2,310</td>
</tr>
</tbody>
</table>

Chart View

- A: Adult patient(s) with a computed axial tomography (CT) or magnetic resonance imaging (MRI) study of the head that was not medically indicated.
- B: Adult patients persistently taking ACE inhibitor or ARB who received a serum potassium test AND either a serum creatinine or blood urea nitrogen test within the last 12 reported months.
- C: Patient(s) 12 - 21 years of age that had one comprehensive well-care visit with a PCP or an OB/GYN in the last 12 reported months.
VBC-A attribution
Keys to successful move to program scale

A gradual transition to risk allows you to move from an activity-based model to a more engaged, coordinated and high-performing health care organization.

**DAY 1**

**Build foundation**

- Find willing partners: Employer groups and providers.
- Use industry template “starter kits” to quickly build initial alternative payment incentives.
- Build internal collaboration across the organization.
- Leverage existing operational and analytic reporting foundation.
- Develop exception process for program outliers. Don’t get paralyzed by achieving 100% automation.

**DAY 2**

**Expand product offerings**

- Increase number of facilities and provider groups in the program.
- Expand to new alternative payment definitions beyond initial baselines.
- Expand to new markets beyond initial markets.
- Operationalize and automate high-volume exception processing events.

**DAY 3**

**Advanced analytics and operations to drive program efficiency**

- Evolve program definitions beyond baseline to drive to better results.
  - Bundle contracts: Retrospective to Prospective
  - Population health contracts: Preventative medicine to disease state management
- Continue to operationalize and automate exception processing.
- Continue to expand analytic reporting.
- Utilize internal common capabilities (reporting, portals, etc.) to drive efficiency.
Technology and Processing
Population Health: Common Value Based Contract Data Flow

**Core Processing system**

1. **Common claim flows**
   - 1. Direct data delivery from core processing system
   - 2. Delivery from data warehouse

2. 837/Flat File

3. Data warehouse
   - Claims
   - Facility
   - Professional
   - Pharmacy

4. Provider Data intake (demographic, product)
5. Member Data Intake (Demographic, Product)

**VBC administration**
- Attribution
- Contract Metric repository
- Definition and modeling
- Payment administration
- Performance reporting
- Contract management

**User interface**
- Reporting
- Exception management

**Attribution Processing (Claim)**
- Ongoing Performance Reporting
- Contract Payment Calculation
Bundle Payment Retrospective: Common data flow

Common claim flows
1. Direct data delivery from core processing system
2. Delivery from data warehouse

- Data intake (Demographic, contract and reimbursement)
- Eligibility check: Call 3: Verify the patient
- Bundle Administration
  - Patient enrollment
  - Payment admin
  - Definition and design
  - Contract management

Core Processing system
- Claim interface:
  - Delivery of historical claims
  - 837
  - 835
  - Other

Data warehouse
- Paid claims
- Historical claims
- Claim-related provider demo and pick data

User interface
Reporting
Data extract
Common prospective data flow

Adjudication considerations

- **Pre-pricing**: Leverage existing intake and pre-pricing processing (provider/patient/product match)
- **Pricing claim delivery**: Incorporate fee-for-service claim delivery process (Batch/837 or Service/XML)
- **Processing**: Price and return processed claim to adjudication system
- **Exception**: Exception processing occurs within processing solution
- **Payment**: Adjudication systems continues payment

**Bundle Payment Manager**

- Patient enrollment
- Payment admin
- Definition and design
- Contract management

**Data intake**

- (demographic, contract and reimbursement)

**Patient registration**

- Derived from claim
- Delivered from provider

**User interface**

- Reporting
- Exception management
Moving forward

Successes and opportunities
Early successes

Getting ahead of the care-delivery trends of more care given in **ambulatory settings** than inpatient ones — site of care shift

More **focus on wellness** than sick care — moving upstream to improve population health

Optimizing care coordination through proven **care transition** protocols — acute to post acute care settings

More **incentives for patients** to engage and be accountable for their role in their care — integrated outcomes-based orientation and rewards
Success stories

**Bundle payment success**

**Multi-specialty academic hospital**
- Early entrant into BPCI classic
- With BPCI success, expanded into commercial

**Large national health plan**
- Accelerate advanced payment programs using bundle payment across its markets
- Implemented prospective/retrospective programs across all lines of business

**Convener**
- Administrative solution within the convener partnership
- Leverage convener BPCI program to enter commercial markets

**Value-based contract administration success**

**Regional health plan**
- Execute the state’s mandate to expand value-based incentives using pay for quality programs
- Administration of a state SHIP program with 50+ largest physician group participating in 2017
- Enroll 50% of state employees into VBC program by end of 2018

**National Medicare Advantage health plan**
- Enterprise attribution engine supporting the STARs portion of program
- Leveraged attribution rule modeling to provide analytics about member and provider alignment
## Top 5 opportunities

Value-based arrangements are for long-haul for payers, purchasers, providers and patients

<table>
<thead>
<tr>
<th><strong>Collaborative design</strong></th>
<th>Provider networks leveraged in the product design (purpose-built to deliver value) Comprehensive outcomes emphasized with upside and downside risk distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefit design</strong></td>
<td>Shaped by consumer input and dynamic design</td>
</tr>
<tr>
<td><strong>Delivery models</strong></td>
<td>Transformation as a market differentiator (being intentional) Targeted operational changes</td>
</tr>
<tr>
<td><strong>Consumer behavior</strong></td>
<td>Empowerment through technology-assisted decision making and integrated outcome-based orientation</td>
</tr>
<tr>
<td><strong>Data sharing</strong></td>
<td>Connective Information Technology across organizational boundaries</td>
</tr>
</tbody>
</table>
Thank you

Sri Vangala  
General Manager, Network Payment Innovation, Optum  
sri.vangala@optum.com — 1-321-277-6939

Ron Myers  
Vice President, Network Payment Innovation, Optum  
ron.myers@optum.com — 1-801-319-9082