Consumer Engagement and Payment Reform

May 17, 2012

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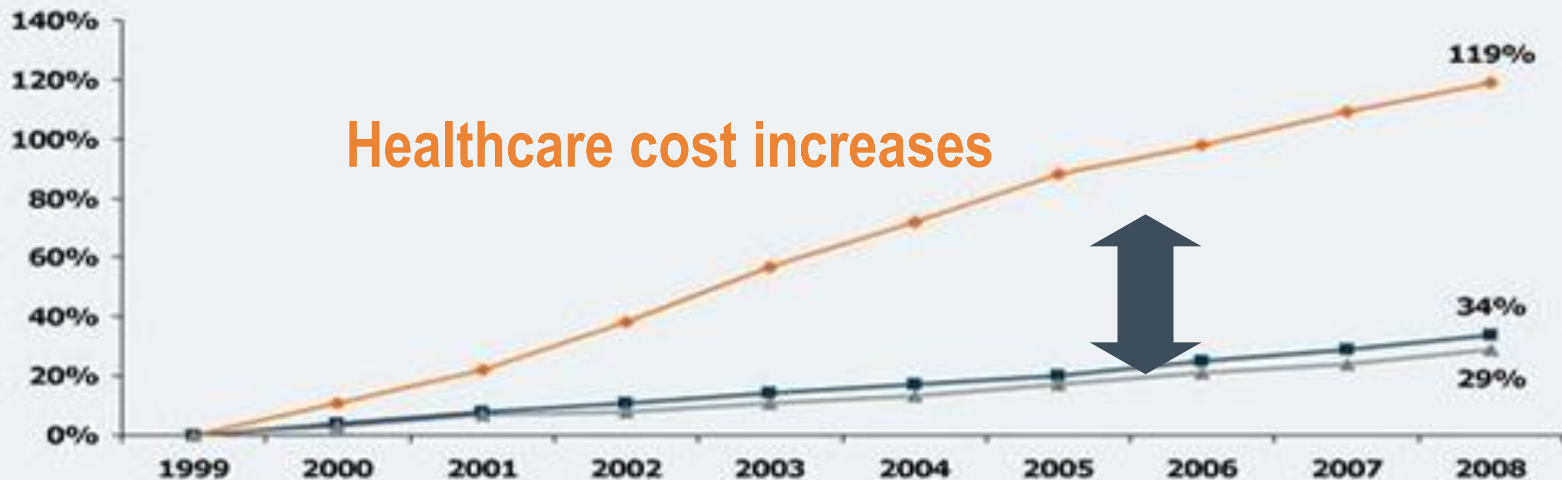
Thea Cardamone

Health Care Costs Are Out-of-Control.. But What Can We Do About it?



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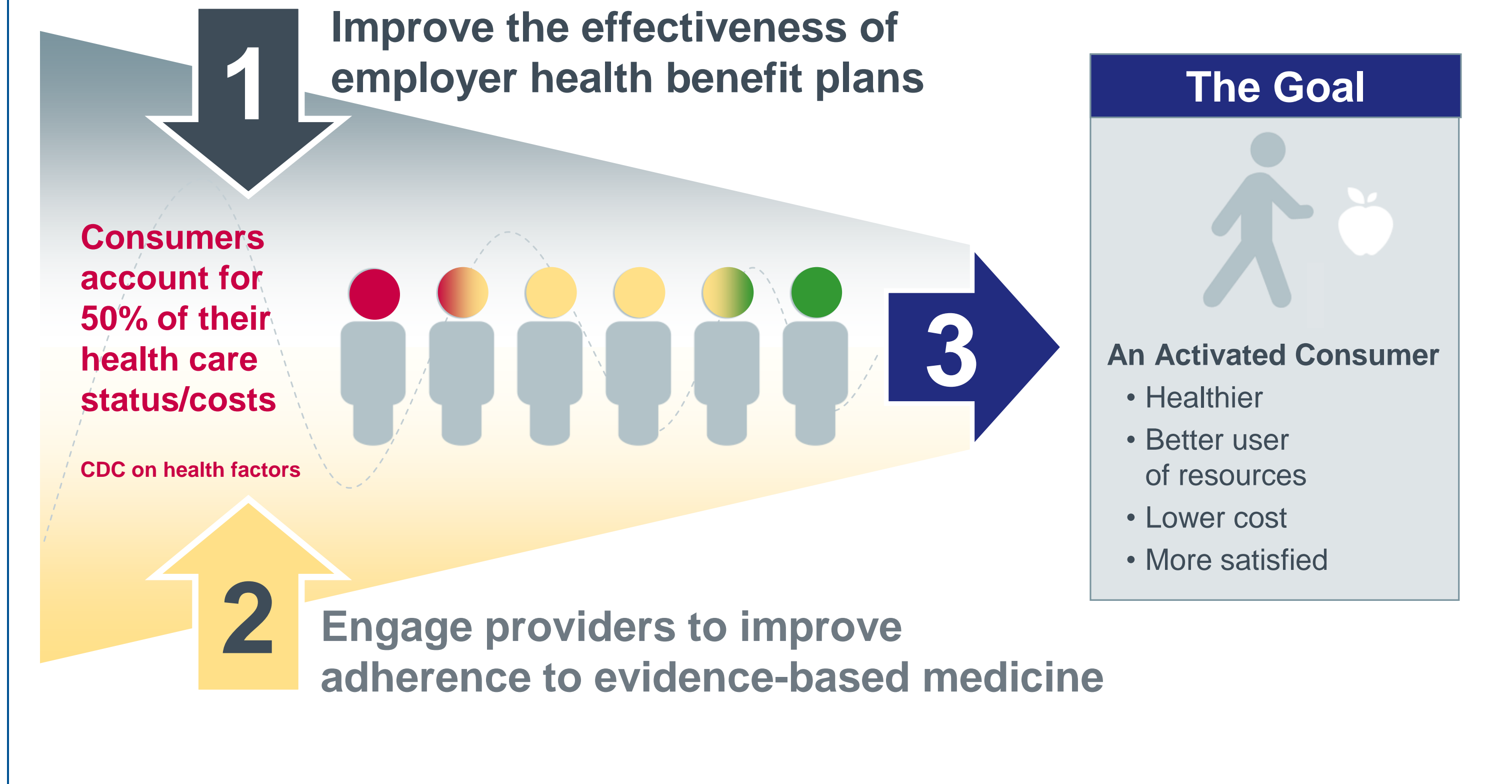
Identifying Opportunities for Better Performance

Consumer Activation Index™ Evaluates Member Choices



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Taking Action: What Levers Can We Pull?

Personalize the Experience

Benefit and Incentives Designs	And / Or	Care and Network Resources	And / Or	Communication and Change Campaigns
• High Deduct Plan Design Improvements • Value-Based Designs and Health Incentives		• Cancer Resource Services • Healthy Pregnancy Engagement		• Explore opportunity for targeted campaigns where activation is lowest (e.g. prevention and screenings)

Provide Quality Care at an Affordable Price

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Providing Quality Care at an Affordable Price

ACO Delivery and Payment Model

- **What is an ACO? Some Basics:**
  - **ACO = Accountable Care Organization**
  - **Coalition of HC Providers -** work together to coordinate care for their patients, meet quality and cost targets

- **How does it work?**
  - **ACO establishes a spending target based on expected spend**
  - **If the ACO can improve quality while slowing spending growth, it receives shared savings from participating payers (both public and private)**
  - **ACO is held accountable for the total patient experience, from all providers**
  - **Idea is to coordinate care among the diversity of specialists and other providers**

- **Example: Brookings-Dartmouth ACO pilots – such as** Tucson Medical Center Physician-Hospital Organization

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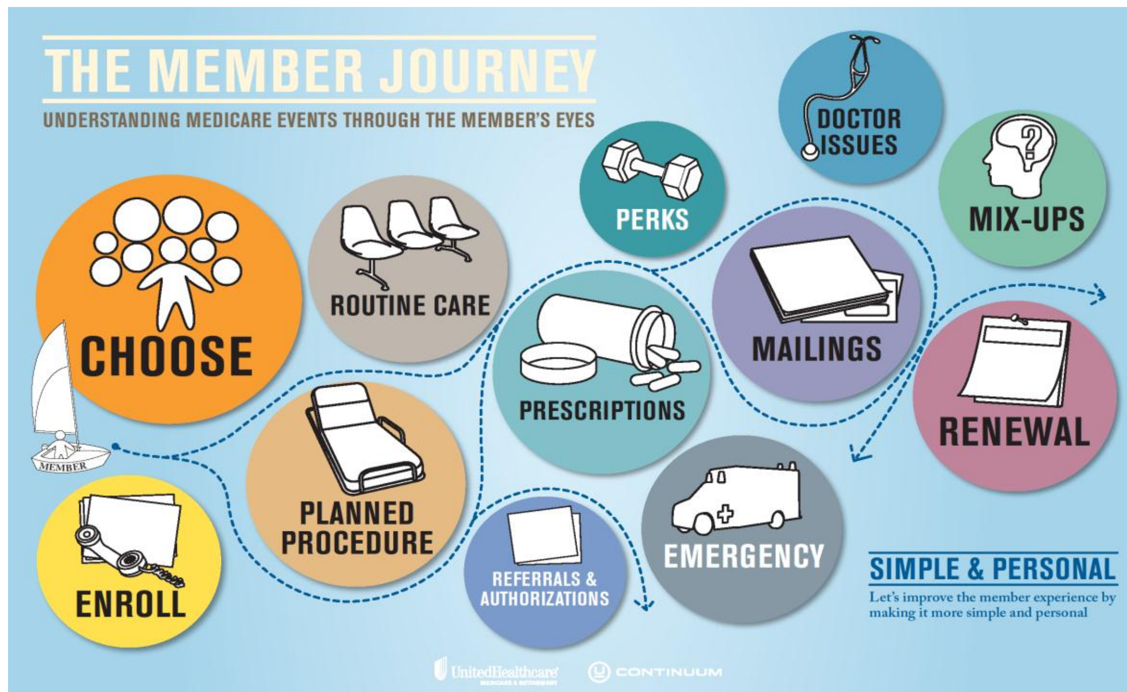
What is the Patient Experience?

- **Example**: Patient with chronic conditions – cardiac, HBP, diabetes, obesity, etc., taking several scripts, multiple providers involved
- **Traditional setting**: Specialists do not coordinate with each other, meds prescribed by different physicians may be in conflict and (hopefully!) caught by Pharmacist
- **ACO**: Managed by PCP with supervision by other specialists, nutrition counselor, etc., meds overseen by care coordinator (PCP)



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ACO Criteria for Success

Patient – centered:

- Care coordination across all settings
- Proactive care management

Provider-driven infrastructure:

- Physician leadership and organizational structure
- Ability and willingness to accept risk
- Shared risk and pay-for-performance experience
- Robust end-to-end clinical programs
- Performance management, measurement and reporting – important that providers see where they stand!
- IT infrastructure

Provider – patient – payer collaboration:

- Consumer engagement strategies - benefit design can provide incentive to engage with providers
- Financial systems and strength (payers' support can help facilitate)

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Accountable Care Objectives

Improve Population Health and Patient Experience

Reduce Medical Costs/Trend

Deliver Best Possible Quality Outcomes

How Payers Can Support ACOs

- Membership (volume, products, multiple lines of business)
- Contracting based on provider readiness (risk sharing)
- Comprehensive performance measurement and reporting
- Member empowerment strategies (plan design incentives)
- Clinical consultation to help improve performance
- Robust suite of tools offered by some vendors (e.g., Optum)
- Mechanism to distribute funds based upon performance
- Facilitate access to health information technology
- Physician and patient portals; transparency
- Option to apply ACO to the delivery system's employee lives - gain experience and lower their own healthcare costs

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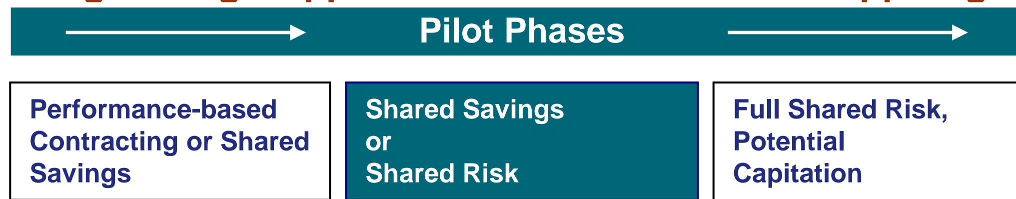
UnitedHealthcare Pilot Strategy

- **Current state – 3 ACO pilots selected**
  - UnitedHealthcare is the payer partner in the Southern Arizona ACO pilot (SAACO)
    - We are participating in the nationally prominent Dartmouth-Brookings ACO collaborative
    - Pilot is located in Tucson, AZ
    - Southern Arizona Accountable Care Organization (SAACO) includes Tucson Medical Center and independent physicians in the community
  - UnitedHealthcare has selected 2 additional pilots in the NY and IL markets
    - We continue discussions with providers in these markets around the structure of these arrangements

- **Future state – Additional ACO pilots to be selected in 2012**
  - Plan to select additional ACO pilots in 2012; goal is 8-10 pilots
  - Compiled candidate list of additional prospective partners
  - Leveraging diagnostic tool to identify high-potential providers
  - Assessing strategic opportunities with the ACO to support growth



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Medicare ACO Role

- Middle ground:
- Fee for Service ➔ ACO ➔ Capitation/Managed Care
- CMS Requirements for ACOs:
  - PCPs: 5,000+ Medicare beneficiaries
  - Formal legal structure
  - Leadership and management structure
  - Clinical and administrative systems
  - Cost and quality measurement data (and others identified by CMS)
  - Accept principles of evidence-based medicine, patient engagement, and patient-centeredness
  - Remain accountable for cost and quality of all services (even services from outside its organization)
  - Challenge: can ACO coordinate care for services received outside its organization?

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Progress to Date: Medicare Pioneer ACOs

- **December 2011: CMS selected 32 ACO "Pioneers" as the first Medicare ACOs**
- **Idea is to learn what does / does not work**
- **Not "one size fits all"**
- **Recognize provider variations** in
  - Risk exposure, acceptance of fixed payment
  - Varying practice patterns in various geographic areas

Number of Pioneer Medicare ACOs by state

State	Number
AZ	1
CA	**6**
FL	**1**
IA	1
IL	1
IN	1
MA	**5**
ME	**1**
MI	3

State	Number
MI	3
MN	3
NH	**1**
NM	1
NV	1
NY	**1**
PA	**1**
TX	2
WI	2

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Further Progress: Medicare Shared Savings Program

- **April, 2012 27 Shared Savings Program ACOs announced**
  - » **Serving 375,000 beneficiaries in 18 states**

- **Total Medicare ACO beneficiaries** : 1.1 million members

- **Stats** (as of April, 2012):
  - – 10,000+ physicians
  - – 10 hospitals
  - – 13 smaller physician-driven organizations (urban and rural)
  - – 33 quality measures:
    - care coordination, patient safety, use of preventive services, care for at-risk populations, and patient and care-giver experience of care
  - – CMS reviewing > 150 applications from ACOs seeking to enter in July
  - – Additional Program – Advanced Payment ACO Model - for participating rural and physician-based ACOs to help build needed infrastructure – 5 ACOs in program to date

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Regulatory Considerations

- **Legal Considerations:**
  - Possible antitrust issues with independent providers joining together (March, 2012 – GAO Report to Congress)
- **Private Payer Approach –** Varies by payer
  - Some larger payers (e.g., UHG, Aetna, some Blues) may partner with several organizations to pilot different approaches
  - Others – wait and see
  - Likely, more flexibility with private payers than with CMS
- **CMS Approach – Structure with Flexibility**
  - **Less rigidity than prior programs**
    - Traditional Fee for Service regulations:
      - Hospital IP – **512 pages** in Federal Register
      - Physician – **680 pages** in Federal Register
  - **More Recent Example: Medicare Part D**
    - CMS had more interaction with health plans for this program
    - Able to minimize unintended consequences through feedback from stakeholders

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Other Considerations

- **Investment in Health IT**
  - Private payers recognizing need to support ACO's Health IT investment through various reimbursement methods
  - Example: UnitedHealthcare including clinical integration fee as part of its provider bonus payment if providers meet targets (cost and/or quality)

– **Actuarial Considerations**:

  - Need to cover provider bonus payments through premiums (or fees if ASO)
  - Impact on claims analysis if part of claims provided through capitation
  - Market dominance by consolidated provider organizations may lead to higher provider fees

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Further Resources

- ACO Learning Network (Brookings-Dartmouth project)
- http://www.acolearningnetwork.org

- Premier Inc. Accountable care collaborative
  - **https://premierinc.com**
  - From Premier's website: Serving more than 2,500 U.S. hospitals and 80,000-plus other healthcare sites, the Premier healthcare alliance and its members are transforming healthcare together. Approximately 200 hospitals and health systems created and entirely own the Premier alliance. Premier's mission is "to improve the health of communities."

- CMS website:
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/ACO/

- Health Affairs (Published monthly) – online archive is searchable

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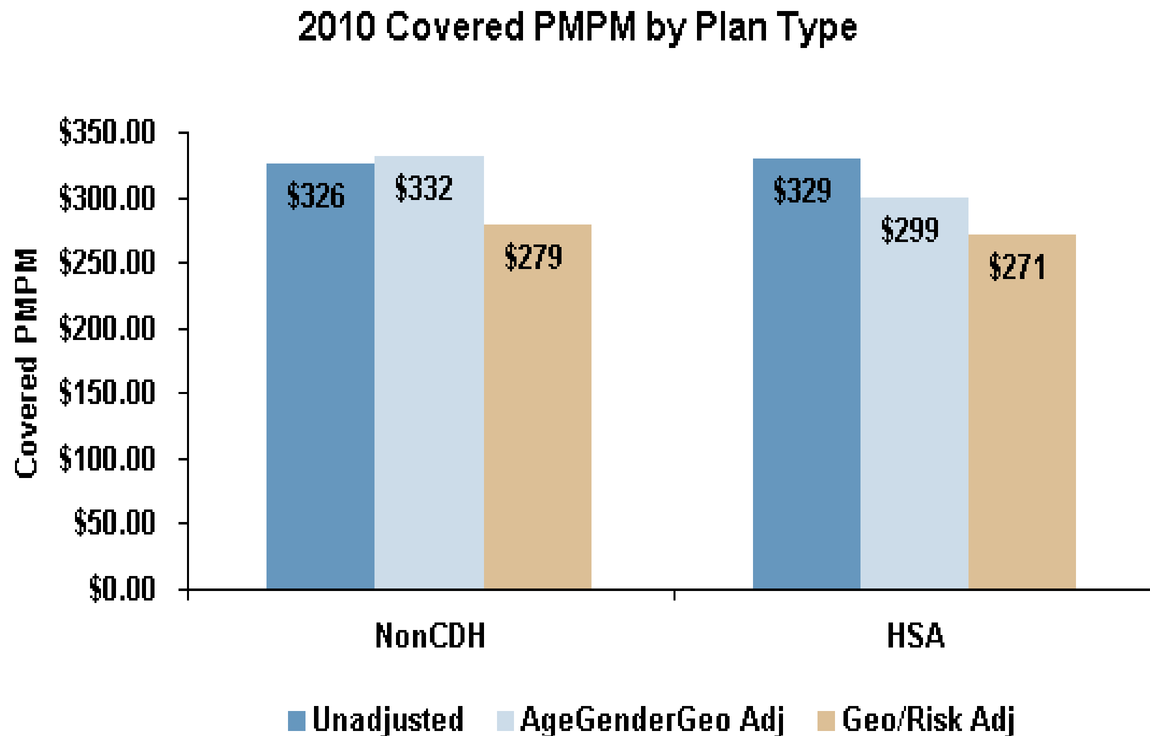
Benefits and Incentives

Well-designed CDH plans save 2% to 5% on an “all other things being equal” basis



- Based on the UHC book, we see that on average CDH plans cost 2% to 5% less than non-CDH plan after adjusting for demographics, area, selection and other factors that may skew the results.

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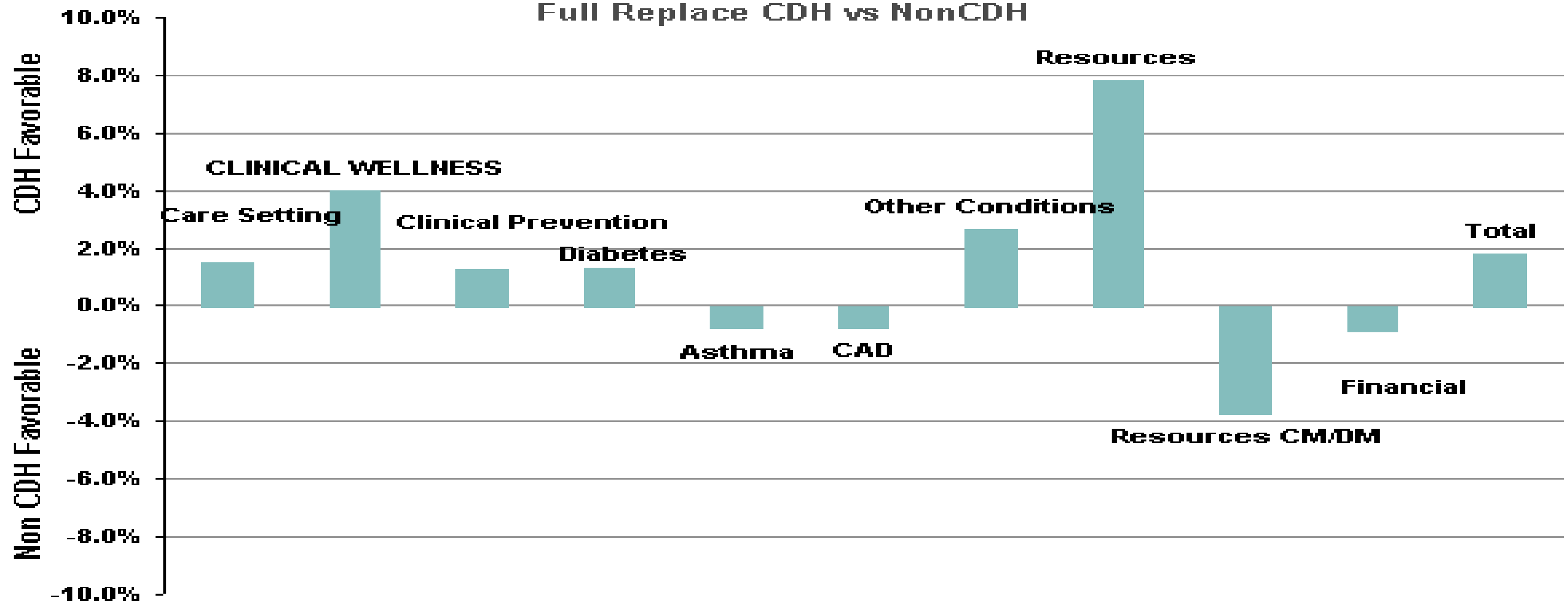
Overall, CDH members make better decisions - based on UHG's Consumer Activation Index (CAI)

Overall Consumer Activation Index score Full Replacement to CDH Plan	
CDH Plan Population	60.6%
Non-CDH Plan Population	58.5%

+2.1%



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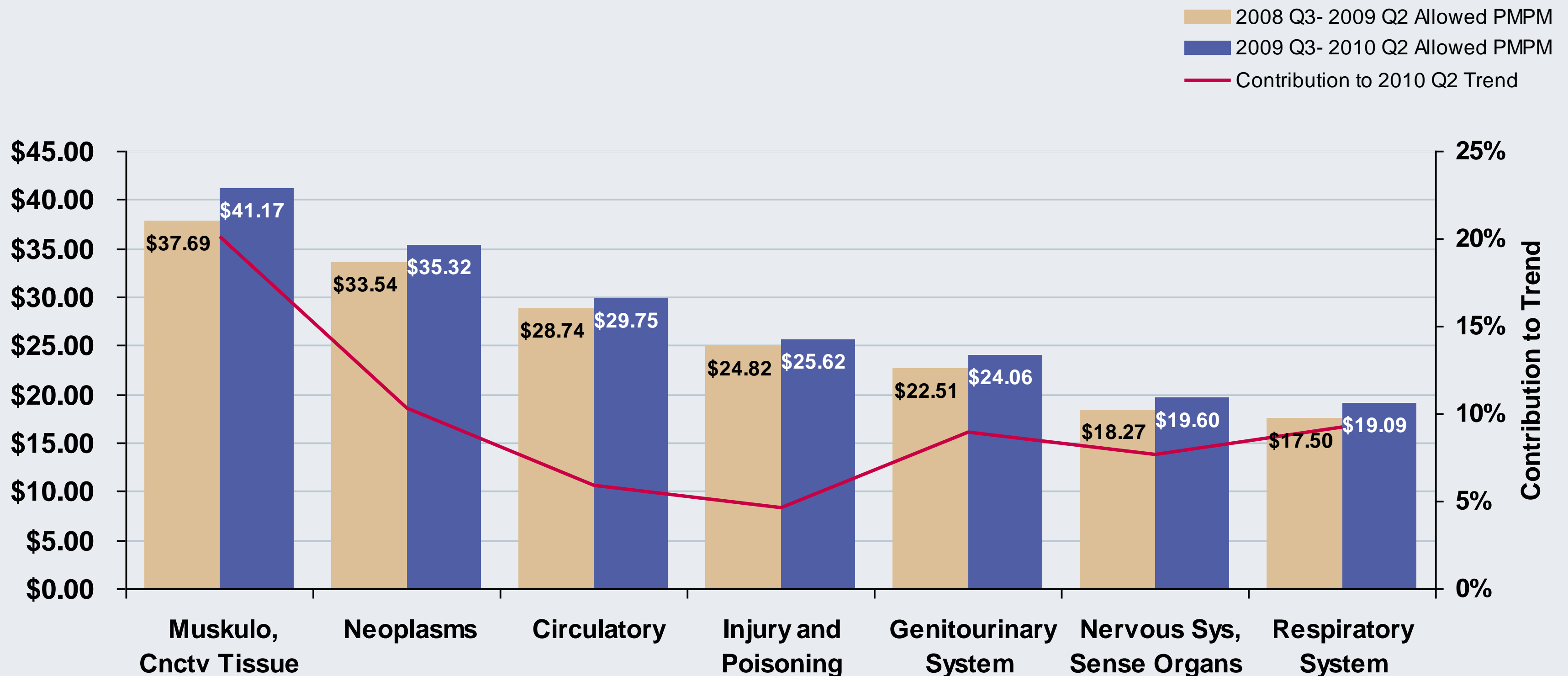
Obesity is a Key Risk Factor for Top 3 Cost Drivers



- Smoking is a risk factor for Neoplasms and Circulatory

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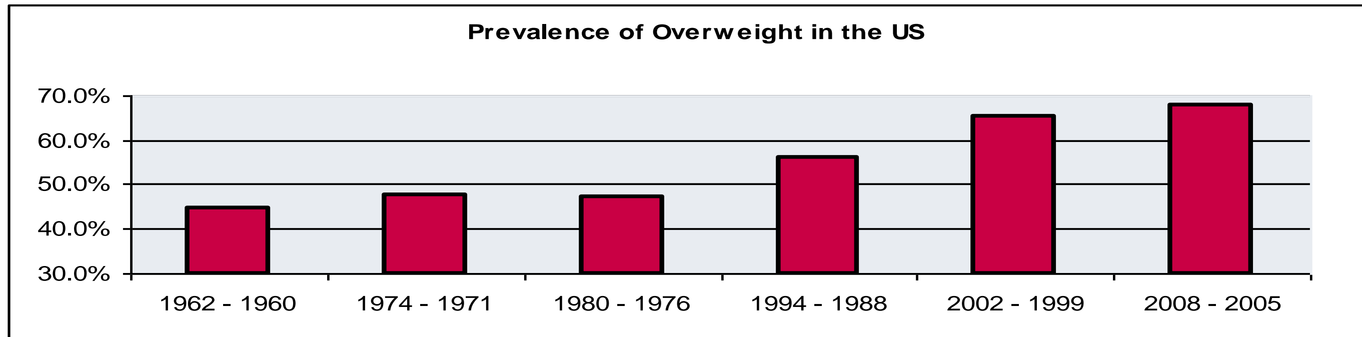
Lifestyle Trend Drivers



- **2 out of every 3 Americans are overweight**
- **Overweight people cost about 36% more than people of normal weight (Finkelstein, *Health Affairs*, 2003)**
- **In 1965 42.4% of adults were smokers; in 2009 only about 20.6% of adults smoke**

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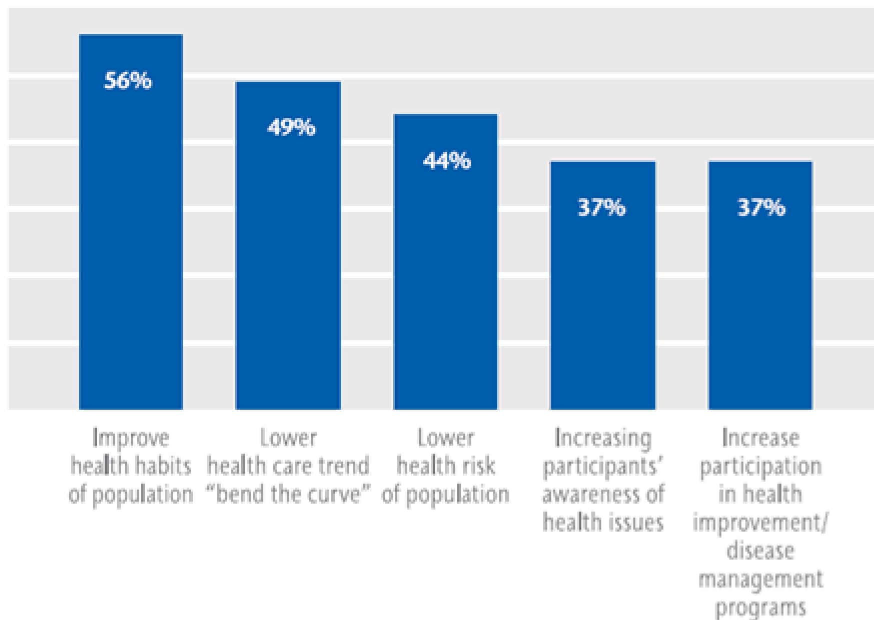
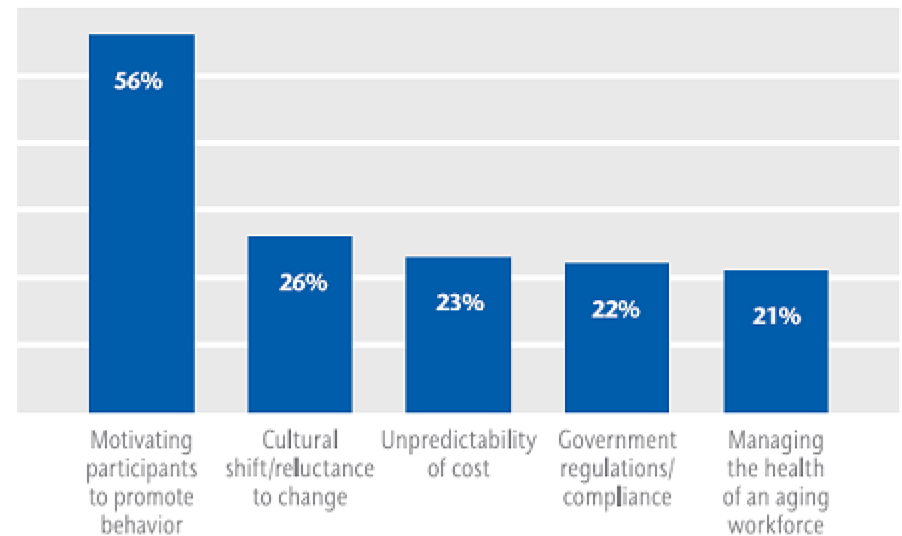
2011 Aon Hewitt Survey Confirms the Priority of Health and the Challenges of Motivation

Top 5 Desired Outcomes



Top 5 2011 Challenges



Aon Hewitt 2011 Health Care Survey (>1,000 employer sponsored health plans represented covering ~10 million of the US population).

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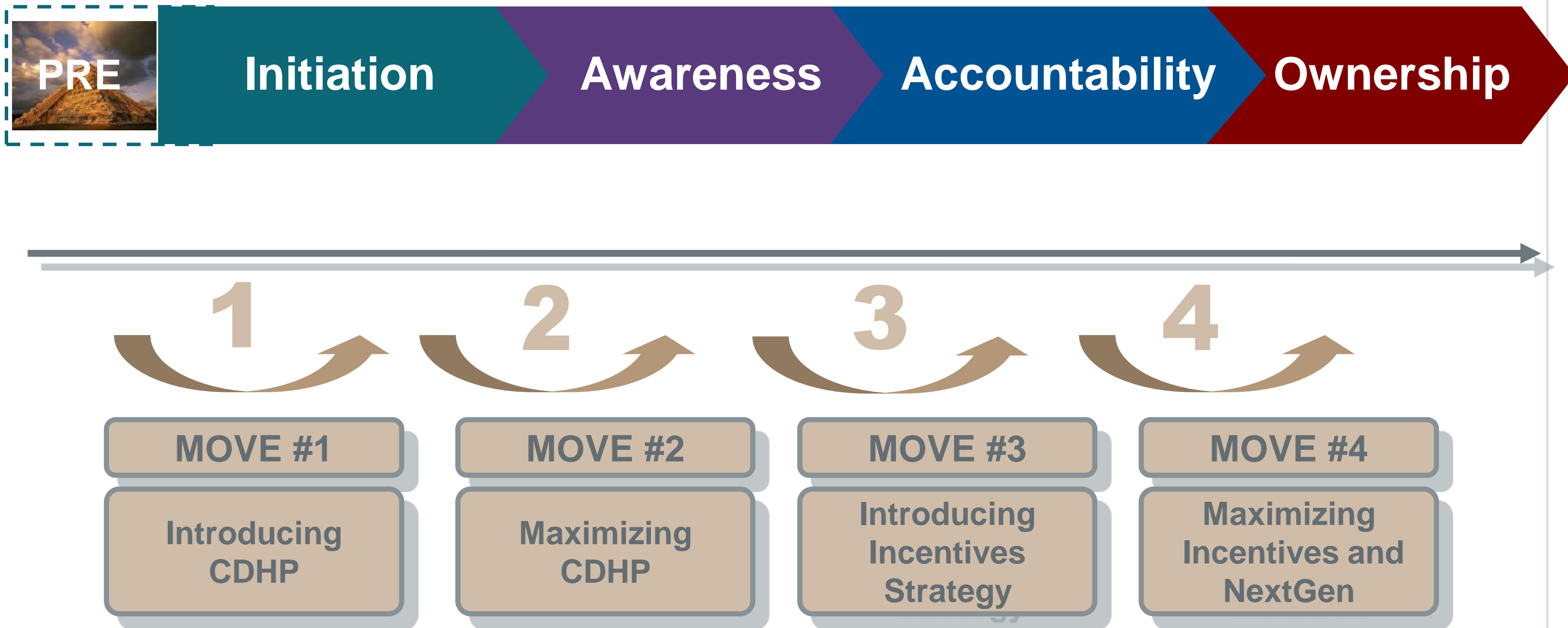
UHC's Health Plan Modernization Continuum



ALL ASPECTS of the Health Plan are scored for position on the continuum: CDHP structure, cost sharing, network design and tiering, clinical programs, coaching / wellness support, incentives, communication.

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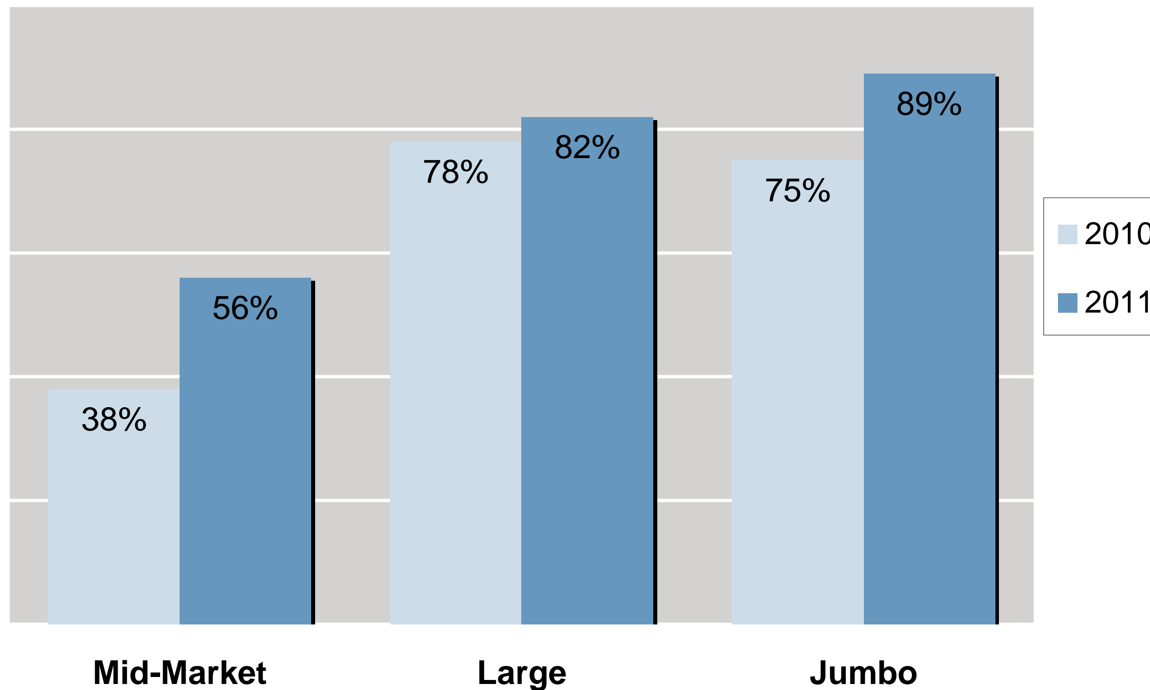
What are people doing?



Fidelity Survey

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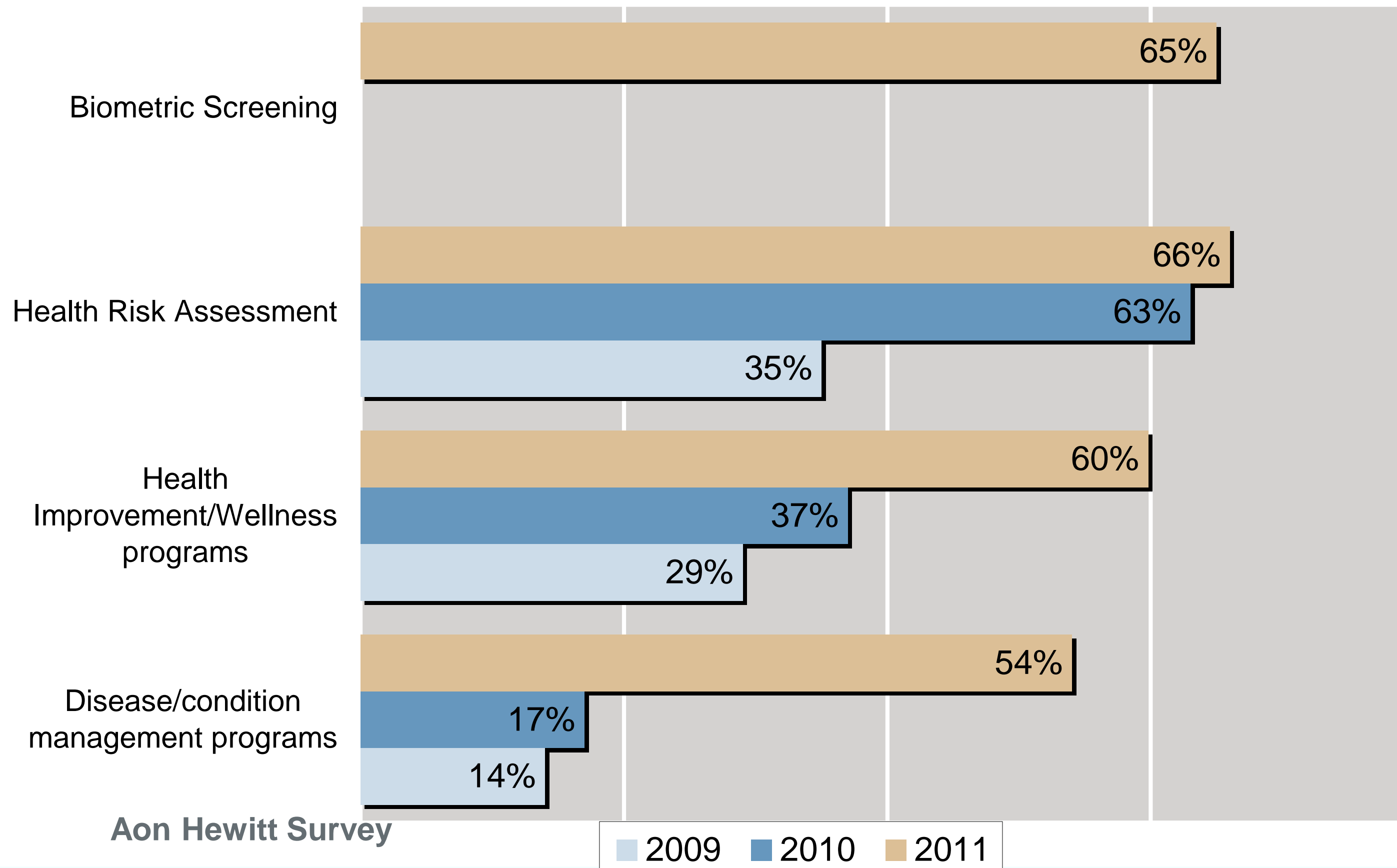
Most Common Incentives: Biometric Screenings and Health Risk Assessments



Aon Hewitt Survey

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Clinical

Typical Goals for Clinical Programs

- **Reduce gaps in care**
  - Rx compliance
  - Tests, office visits
- **Steer to lower cost, higher quality alternatives**
  - In-network providers
  - Centers of excellence
  - Generic drugs
- **Lifestyle coaching**
  - Diet/exercise
  - Smoking cessation
  - Depression

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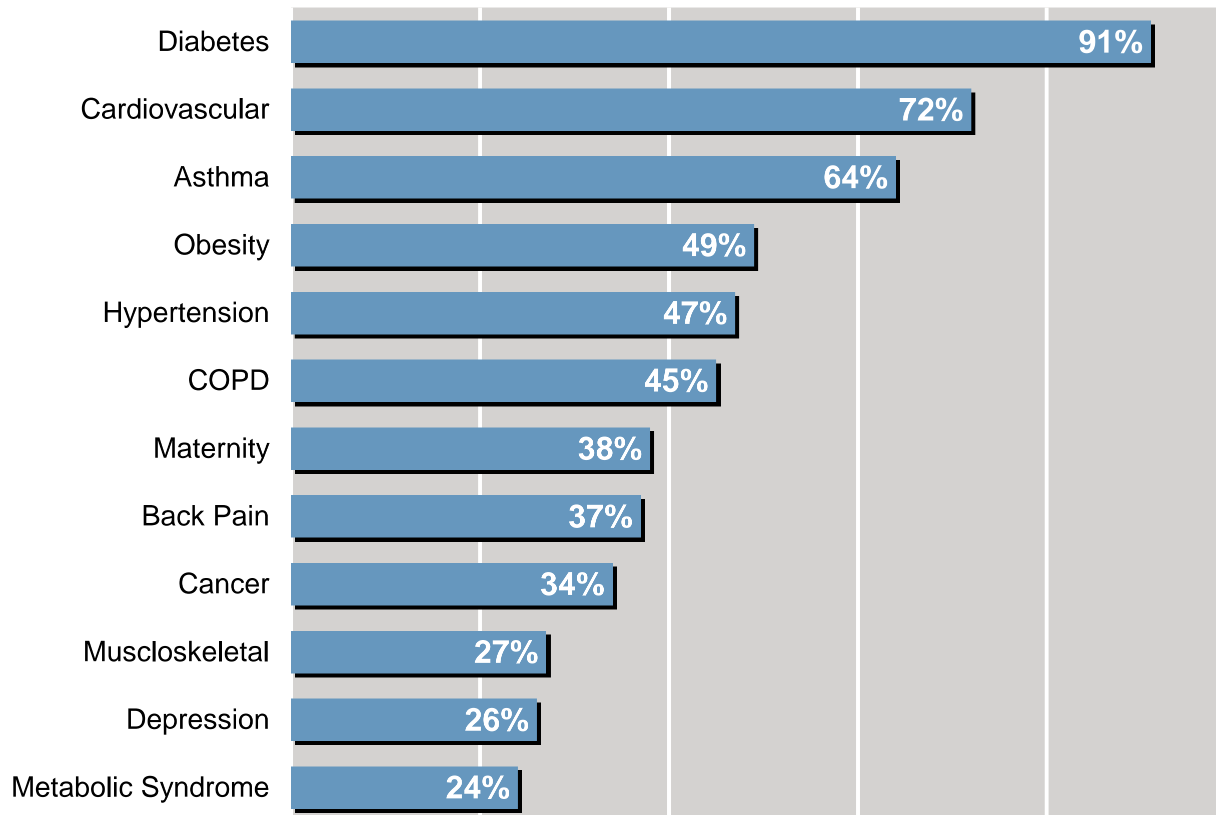
Diabetes is Most Targeted Condition



Aon Hewitt Survey

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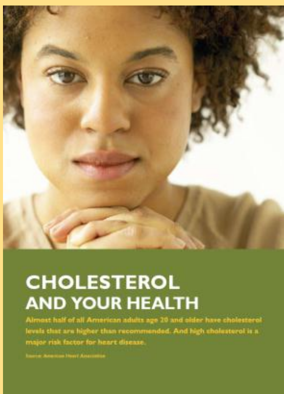
Communications

Custom Communications
Cholesterol Screenings

The Action

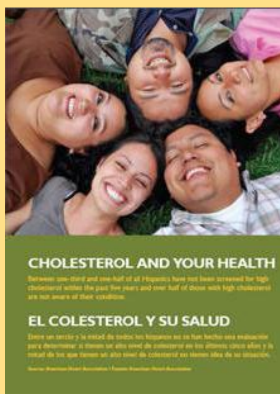
Standard



Target Audience
1) General population
2) Subset of Hispanic population

Customizations:
- Imagery
- Content
- Statistics spec. to Hispanic pop.
- English on one side/Spanish on the other

Enhanced



Target Audience
1) Subset of Hispanic population

Schedule a cholesterol screening.

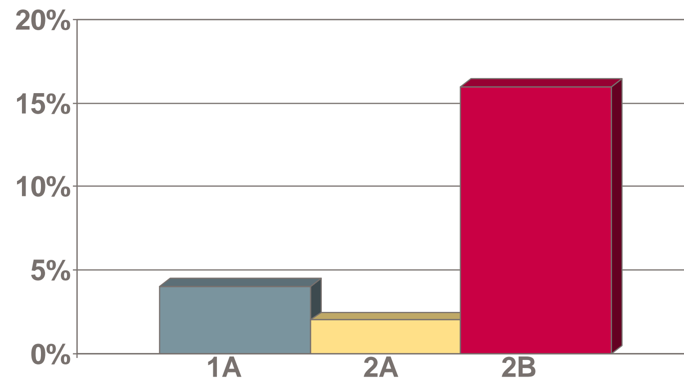
Key Client demographics:
- Nationwide grocery chain
- 60,000 members
- Large Hispanic population
- Low cholesterol screenings rates among Hispanic population

The Result

Company ABC increase (2-16% by audience) Results varied by nature of communication:

- General Population (1A) – Standard Communication:
  - 4% increase in cholesterol screenings
- Hispanic (2A) – Standard Communication:
  - 2% increase in cholesterol screenings
- Hispanic (2B) – Culturally Enhanced w/ Spanish language:
  - 16% increase in cholesterol screenings

% Increase in Compliance



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