ACO and Risk Sharing – Approaches to Risk Sharing Analytics
April 30, 2015
Value Based Care Market Tipping Point

Value Market Opportunity by Funding Source
2010-2025

$3.7T in 2025 (70% of total spend)

TIPPING POINT

Value market tops 30%-40% of the total

Source: Oliver Wyman
Today’s Topics

1. Value Creation Process
2. Inefficiencies and Value Opportunity
3. Value Realization
4. Risk Sharing Analytics
5. Q&A
Risk Sharing: 4-Step Realized Value Creation Process

1. Health Care Inefficiencies

2. Creates "Value" Opportunities


4. Realized Value

Modern Health Ecosystem
Value Creation Example: ACO Shared Savings Business Model

Realized Value Occurs When Population Health Management and Value Based Risk Contracting is Applied to Value Opportunities
Today’s Topics

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30% of the total US health care spend could be eliminated – Institute of Medicine, New England Healthcare Institute, Dartmouth Atlas, McKinsey, Thomson Reuters

20% of total health care could be eliminated in just 6 categories of waste — overtreatment, failures of care coordination, failures in execution of care processes, administrative complexity, pricing failures, and fraud and abuse¹

Dr. Steven Weinberger, CEO of American College of Physicians - "Excessive testing costs $200 to $250 billion (per year)"

More than $200 billion of avoidable costs as a result of medicines not being used responsibly by patients and healthcare professionals²

Unnecessary imaging costs up to $12 billion annually³

² IMS Institute of Healthcare Informatics, June 2013
³ Peer60 2014 survey of nearly 200 medical professionals
Avoidable Expenses/Inefficiencies in the US Health Care System

$765 billion represents an overall 30% opportunity in avoidable health care expenses

$210 billion
Unnecessary Services

$190 billion
Excessive Administrative Costs

$130 billion
Inefficiently Delivered Services

$105 billion
Prices That Are Too High

$75 billion
Fraud

$55 billion
Missed Prevention Opportunities

in billions

1 Institute of Medicine – The Healthcare Imperative, February 2011
Value Opportunities: Medicare Fee-for-Service Patients

Medicare FFS patients use more resources and experience worse outcomes than patients in value-based models

<table>
<thead>
<tr>
<th>Key Operating Indicators</th>
<th>Pre-ACO Year</th>
<th>Year 3</th>
<th>Medicare Advantage</th>
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</thead>
<tbody>
<tr>
<td>Inpatient Acute Admits/K</td>
<td>280-300</td>
<td>190-200</td>
<td>170-180</td>
</tr>
<tr>
<td>Inpatient Acute Days/K</td>
<td>1,400-1,450</td>
<td>900-1,000</td>
<td>750-850</td>
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<tr>
<td>IP Acute Readmit Rate</td>
<td>High Teens</td>
<td>Mid Teens</td>
<td>Low Teens</td>
</tr>
<tr>
<td>Skilled Nursing Facility Admits/K</td>
<td>130-140</td>
<td>80-100</td>
<td>60-70</td>
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<tr>
<td>Skilled Nursing Facility Days/K</td>
<td>4,200-4,250</td>
<td>2,300-2,350</td>
<td>800-900</td>
</tr>
<tr>
<td>Skilled Nursing Facility Readmit %</td>
<td>High Teens</td>
<td>Low Teens</td>
<td>Low Teens</td>
</tr>
</tbody>
</table>

100 admits/K at $10,000 per admit for a 40,000 member ACO = $40,000,000 value annually

Same Population

Different Population, Same PCPs
Medication Adherence Importance: CMS Stars Ratings Example

Three of 11 “triple-weighted” outcome measures evaluate quality of drug therapy for diabetes patients with emphasis on correct therapy, adherence and blood glucose control.

- C8: Mental health
- C23: Readmissions
- C15: Diabetes treatment
- D16: Adherence to hypertension meds
- D17: Adherence to OAD meds
- D18: Adherence to statins
- D14: High-risk medications controlled
- D15: Diabetes treatment controlled
- D7: Improving physical health
- C19: Controlling blood pressure
- C18: Diabetes and cholesterol controlled

Average Impact on Overall Star Rating
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Value Creation

Realized Value Occurs When Population Health Management and Value Based-Risk Contracting is Applied to Value Opportunities
Four Pillars of Population Health Management

Organizations who have been successful in value-based contracts consistently cite the same four areas of critical focus for success in population health management:

1. **Optimize Network**
   - Provider performance (cost/quality reporting), referral management, post-acute optimization

2. **Manage Care Transitions**
   - Track patients across the continuum of care, manage discharges and patient follow-up visits

3. **High Acuity Interventions**
   - Identify highest risk cohorts and manage their progress and outcomes of interventions

4. **Expand Disease Management**
   - Manage all populations, not just high-risk cohorts
Population Health Management Value Action Items

Utilization
- Reduce unnecessary admissions
- Follow standard, evidence based treatment
- Reduce readmissions
- Keep healthy patients healthy
- Reduce length of stay
- Incorporate preferences in treatment
- Increase medication adherence

Unit Cost
- Steer patients to efficient providers
- Contract / partner with efficient providers
- Most efficient place of service (e.g. physician’s office vs. outpatient facility)
- Downstream value based contracting

Revenue
- Ensure accurate and complete coding for risk payments
- Achieve quality bonuses
- Acquire patients/market share

Quality
- Increase quality scores
- Comply with Evidence Based Medicine (EBM) standards
- Reduce practice pattern variation
- Increase member satisfaction

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3.a. Population Health Mgmt Interventions
Population Health Management: Capabilities Framework

3.a. Population Health Mgmt Interventions

**Strategy and Governance**

**Governance/Organization**
- Analyze and Engage
  - Population Analysis
- Identification and Stratification
- Patient Activation and Engagement

**Strategy**
- Clinical Programs / Practices
  - Health Promotion
    - Preventive Care
    - Quality Outreach
  - Transition Management
    - Home to Primary
    - Primary to Acute
    - Acute to SNF / Home
    - SNF to Home
  - Chronic / Complex / EOL
    - Advanced Illness
    - Palliative
    - Geriatric
    - Home Health
    - Hospice
    - Chronic Condition Mgmt
- UM & Standard Protocols / Practices
  - Prior/Retro Reviews
  - Concurrent Review
  - Evidence Based Guidelines
  - Referral Management
  - Patient Safety
  - Shared Decision Making
  - Decision Support
  - Nurseline

**Leadership**
- Measure & Improve
  - Financial
  - Operational
  - Productivity, Satisfaction
  - Clinical

**Provider and Payer Engagement**
- Contracting / Incentives
- Data Sharing
- Performance Management

**Underlying Technologies & Related Functions**
- Analytics and Technology
- Partner / Vendor Management: Providers, Payers, Vendors
- Other Operations / Organization, e.g., Facilities, Staffing, etc.
Most Payers & Providers are moving toward “risk” models that promote quality & high performance through coordinated care.

**Reform Driving Alternative Care Models and Reimbursement Structures**

- **Traditional Fee For Service**
  - Payment for services rendered.

- **Incentive Based Pay**
  - Payment based on improvements in cost or outcomes.

- **Patient Centered Medical Home**
  - Payers are encouraging physician practices to become an accredited PCMH to promote better-coordinated care, driving better outcomes and lower costs.

- **Bundled Payments**
  - Procedure or condition based bundled payments, also known as “case rates”, where a single payment is made for all services related to a specific procedure, event or condition.

- **Accountable Care Organization**
  - Accountable care organizations (ACOs) go a step beyond an integrated care system by transferring risk to the provider.

Most payers & providers fall here on this continuum. Have implemented some form of pay for performance and have at least begun to consider or rollout PCMH, Bundled Payment and ACO initiatives.
Value-Based Contracting: Provider Transformation Phases

Sequencing the transformation deliberately will enable providers to make the transition effectively

**“Formation” – Explore/Design**
*Establish the necessary organizational foundation and build provider network*

**“Operationalize Value”**
*Clinical integration and care redesign to shift toward quality, efficiency and pop mgmt.*

**“Commercialize”**
*Expand capabilities to full risk and accountability for expanded population*

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**Value Proposition**
- Underpinning market shifts
- Current areas of provider focus: important but limited for true transformational value yield

- Understand market shifts
- Prioritize opportunities and Risk Contracts
- Formation of clinical partnerships, provider incentives

- Efficient episode management (i.e. continuity of care)
- Service Line Management (i.e. cancer)

- Manage conditions (i.e. complex case management)
- Population health management optimization

- Integrated value transformation (all parties)
- Licensed Products

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**Value-Based Contracting: Provider Transformation Phases**

- **3.b. Value-Based Risk Contracting**

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OPTUM
Global Pharmaceutical Risk-Based Agreements

Identified schemes were split between traditional financial-based and outcomes-based schemes

Financial-based schemes

- Focused on the financial arrangements between the manufacturer and purchaser; not tied to specific performance metrics
- Includes traditional rebates/discounts, price-volume agreements, quantity limits and treatment initiation

Outcomes-based schemes

- Schemes tied to specific performance metrics such as biomarkers, clinical outcomes, or other metrics (e.g., hospitalizations)
- Includes coverage with evidence development and “guarantee” type schemes

Source: Optum literature review
Today’s Topics

1. Value Creation Process
2. Inefficiencies and Value Opportunity
3. Value Realization
4. Risk Sharing Analytics
5. Q&A
Risk Sharing Analytics: ACO Strategy, Assessments and Enablement

| Strategy | Assessments | Enablement (Design, Build & Support) *
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Lead Offering: Overall Strategy &amp; Roadmap</td>
<td>Lead Offering: ACO/Payer Readiness Assess</td>
<td>Population Health / Care Mgmt</td>
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<td>Risk, Quality &amp; Compliance</td>
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<td>Network &amp; Payment Innovation</td>
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<td>Medical Informatics &amp; Analytics</td>
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<td>Patient Attribution Methodologies</td>
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<td>ACA “3R” Estimates and Improvement</td>
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<td>ACOs &amp; Financial Risk</td>
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<td>CAP Integration and Market Segmentation</td>
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<td>Financial Product Feasibility</td>
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<td>Core Admin / System Implementation</td>
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<td>Vendor Procurement and Management</td>
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<td>Integration</td>
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<td>Public and Private Exchanges</td>
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<td>Risk Sharing / Gain Sharing</td>
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<td>Big Data Integration / Mgmt</td>
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<td>On-going analytics and reporting</td>
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<td>Commercial Pricing</td>
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<td>Value-Based Modeling &amp; Settlements</td>
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<td>Application / Technology Blueprints</td>
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<td>Enterprise Data Warehouse</td>
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<td>Optimization of PI Tools</td>
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* = not intended to be all inclusive.
# ACOs & Financial Risk: Benchmarking Savings Opportunity Analysis

## Savings Opportunities
(These estimates are designed to help understand the scale of opportunity and should be viewed as directional in nature)

### Potential Savings: Inpatient Admits

<table>
<thead>
<tr>
<th>Service</th>
<th>PA Health Plan Percentile</th>
<th>Estimated Savings Range (Low)</th>
<th>Estimated Savings Range (High)</th>
<th>PA Health Plan Count of Services</th>
<th>PA Health Plan Count of Services*</th>
<th>PA Health Plan Rate*</th>
<th>Avg Averted Cost Per Measure/Svc</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lengthy Admit</td>
<td>89 %le</td>
<td>$0</td>
<td>$0</td>
<td>73</td>
<td>73</td>
<td>0.04</td>
<td>$35,570.95</td>
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<tr>
<td>Acute Admit</td>
<td>97 %le</td>
<td>$1,442,895</td>
<td>$1,763,294</td>
<td>1,869</td>
<td>1,708</td>
<td>73.78</td>
<td>$3,125.83</td>
</tr>
<tr>
<td>Overall Avoidable Admit</td>
<td>93 %le</td>
<td>$104,344</td>
<td>$127,531</td>
<td>159</td>
<td>170</td>
<td>7.33</td>
<td>$2,816.31</td>
</tr>
<tr>
<td>One Day Admit</td>
<td>97 %le</td>
<td>$84,884</td>
<td>$103,503</td>
<td>343</td>
<td>329</td>
<td>14.22</td>
<td>$602.85</td>
</tr>
</tbody>
</table>

### Potential Savings: Emergency Department

<table>
<thead>
<tr>
<th>Service</th>
<th>PA Health Plan Percentile</th>
<th>Estimated Savings Range (Low)</th>
<th>Estimated Savings Range (High)</th>
<th>PA Health Plan Count of Services</th>
<th>PA Health Plan Count of Services*</th>
<th>PA Health Plan Rate*</th>
<th>Avg Averted Cost Per Measure/Svc</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Avoidable ED</td>
<td>47 %le</td>
<td>$67,504</td>
<td>$82,505</td>
<td>1,271</td>
<td>1,170</td>
<td>50.53</td>
<td>$1,116.24</td>
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<tr>
<td>Frequent ED</td>
<td>15 %le</td>
<td>$0</td>
<td>$0</td>
<td>247</td>
<td>247</td>
<td>10.23</td>
<td>$1,000.00</td>
</tr>
<tr>
<td>ED Utilization</td>
<td>41 %le</td>
<td>$46,530</td>
<td>$56,020</td>
<td>5,049</td>
<td>4,802</td>
<td>210.91</td>
<td>$718.01</td>
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</tbody>
</table>

### Potential Savings: Preference Sensitive Care

<table>
<thead>
<tr>
<th>Service</th>
<th>PA Health Plan Percentile</th>
<th>Estimated Savings Range (Low)</th>
<th>Estimated Savings Range (High)</th>
<th>PA Health Plan Count of Services</th>
<th>PA Health Plan Count of Services*</th>
<th>PA Health Plan Rate*</th>
<th>Avg Averted Cost Per Measure/Svc</th>
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</thead>
<tbody>
<tr>
<td>Preference Sensitive: Pacemaker Insert.</td>
<td>97 %le</td>
<td>$413,674</td>
<td>$505,602</td>
<td>14</td>
<td>17</td>
<td>0.75</td>
<td>$94,214.47</td>
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<td>CABG</td>
<td>50 %le</td>
<td>$28,398</td>
<td>$33,265</td>
<td>6</td>
<td>8</td>
<td>0.34</td>
<td>$50,277.08</td>
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<tr>
<td>Total Hip Replacement</td>
<td>23 %le</td>
<td>$0</td>
<td>$0</td>
<td>13</td>
<td>17</td>
<td>0.71</td>
<td>$317,152.74</td>
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<tr>
<td>Back Surgery</td>
<td>52 %le</td>
<td>$252,529</td>
<td>$500,047</td>
<td>41</td>
<td>48</td>
<td>2.11</td>
<td>$300,207.03</td>
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<tr>
<td>Total Knee Replacement</td>
<td>93 %le</td>
<td>$585,887</td>
<td>$716,085</td>
<td>73</td>
<td>84</td>
<td>3.63</td>
<td>$271,156.96</td>
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<tr>
<td>PCI/PTCA</td>
<td>45 %le</td>
<td>$490</td>
<td>$489</td>
<td>2</td>
<td>3</td>
<td>0.11</td>
<td>$165,884.47</td>
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<tr>
<td>Carotid Endarterectomy</td>
<td>73 %le</td>
<td>$5,171</td>
<td>$7,543</td>
<td>2</td>
<td>3</td>
<td>0.12</td>
<td>$14,383.39</td>
</tr>
<tr>
<td>Total Shoulder Replacement</td>
<td>95 %le</td>
<td>$37,752</td>
<td>$48,142</td>
<td>4</td>
<td>5</td>
<td>0.21</td>
<td>$13,958.84</td>
</tr>
<tr>
<td>Hysterectomy-Uterine Fibroids</td>
<td>19 %le</td>
<td>$0</td>
<td>$0</td>
<td>37</td>
<td>37</td>
<td>1.60</td>
<td>$13,362.08</td>
</tr>
<tr>
<td>Cholecystectomy</td>
<td>44 %le</td>
<td>$40,028</td>
<td>$50,145</td>
<td>70</td>
<td>76</td>
<td>3.82</td>
<td>$7,500.19</td>
</tr>
</tbody>
</table>

* Asterisk (*) indicates age/gender-adjusted rate. Unit Cost Savings are based on plan data and factor in costs of alternative care options.
Disease/condition areas driving medical & pharmacy cost. In this example, each percentage point above benchmark is approximately $1.1M

Spend for orthopedics/rheumatology and neoplasms are below benchmarks. Spend for neurology, pulmonology, hepatology, and neonatology are each approximately 1 percentage point above the Pennsylvania market. Each 1% percent of spend represents roughly $1.1 million for Sample PA Health Plan.

Note: Percent of spend is not age/gender adjusted.
ACOs & Financial Risk: Rx Savings Opportunity Analysis

<table>
<thead>
<tr>
<th>Drug Classification (AHFS)</th>
<th>Total Spend</th>
<th>% Spent on Brand Name</th>
<th>Potential Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antirheumatic agents (e.g. Remicade)</td>
<td>$922,309</td>
<td>99%</td>
<td></td>
</tr>
<tr>
<td>Statins</td>
<td>$842,625</td>
<td>81%</td>
<td>$150,000</td>
</tr>
<tr>
<td>Anorexigenics &amp; Resp/Cereb Stimulants</td>
<td>$820,441</td>
<td>32%</td>
<td></td>
</tr>
<tr>
<td>Insulins</td>
<td>$732,688</td>
<td>81%</td>
<td></td>
</tr>
<tr>
<td>Proton Pump Inhibitors</td>
<td>$700,669</td>
<td>63%</td>
<td>$500,000</td>
</tr>
<tr>
<td>SNRI and SSNRI (anti-depressants)</td>
<td>$645,422</td>
<td>78%</td>
<td>probable</td>
</tr>
<tr>
<td>Antineoplastic agents</td>
<td>$572,879</td>
<td>93%</td>
<td></td>
</tr>
<tr>
<td>Opiates</td>
<td>$568,982</td>
<td>21%</td>
<td></td>
</tr>
<tr>
<td>Adrenals</td>
<td>$565,857</td>
<td>82%</td>
<td></td>
</tr>
<tr>
<td>Biological Response Modifiers</td>
<td>$536,083</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>SSRIs (anti-depressants)</td>
<td>$529,970</td>
<td>78%</td>
<td>probable</td>
</tr>
<tr>
<td>Others</td>
<td>$7,437,925</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$19,573,522</strong></td>
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Opportunities include moving to generics, therapeutic substitution, over the counter alternatives and “$4 generics”
ACOs & Financial Risk: Medicare FFS ACO Shared Saving Settlement

Base projection almost 3% below updated benchmark
ACO claims net increase 3.7% from base projection once all adjustments considered
Initial estimate showed ACO revenues, final projection does not

Updated Benchmark / Target = $10,300

Per Capita Med Expense

$10,000

$10,371

-2%

-2%

-1%

-2%

-2%

-1%

1%

5%

7%

Base Projection  Ime/DSH  ACO Trends  IBNR  Substance Abuse  Membership Churn  Risk Adjustment  Eligibility Type Enrollment Mix  Opt-Out Beneficiaries  Claim Truncation  Final Projections
Medical Informatics & Analytics: Member and Provider Engagement

Statistical designs to identify “what works” re: member and provider engagement activities

Sample Statistical Prioritization Algorithms

- Call center performance metrics only loosely related to CAHPS measures (low R² or not significant)
  - Suggests a cautious approach to investment decisions related to call center performance

<table>
<thead>
<tr>
<th>Part C CAHPS</th>
<th>R² = .16</th>
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<tbody>
<tr>
<td>Customer Service</td>
<td></td>
</tr>
<tr>
<td>Does the agent communicate well?</td>
<td>R² = .15</td>
</tr>
<tr>
<td>Time of getting care</td>
<td>R² = .10</td>
</tr>
<tr>
<td>Getting appointments and wait times</td>
<td>R² = .10</td>
</tr>
<tr>
<td>Overall rating of plan</td>
<td>R² = .10</td>
</tr>
<tr>
<td>Overall quality of health plan</td>
<td>R² = .10</td>
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<tr>
<td>Customer Service (CAHPS)</td>
<td></td>
</tr>
<tr>
<td>Drug Plan Makes It Easy to Help</td>
<td></td>
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<tr>
<td>Rate of Getting Script Filled</td>
<td></td>
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<tr>
<td>Overall Ratings of Drug Plan</td>
<td></td>
</tr>
</tbody>
</table>

Sample Relationship of Measures

- CAHPS (Ease of Getting Rx) → Adherence (Oral Obstes)
  - R² = 25%
  - P = 6.5 x 10⁻²

- Low adherence highly correlated with self-reported access problems
- Plans should not assume generic tiering solves access problems
- Hypotheses:
  - Administrative claims rejections
  - Non-financial barriers (psychosocial)

Sample Taxonomy of Causal Measurement Relationship

- Customer Service (CAHPS) → R² = .56
- Overall Rating of Plan → R² = .75
- Diabetes Care (HEDIS CDC) → R² = .52
  - Rx Filled Early
  - Rx Filled in Full
  - Overall Appointment Care Quality
- Overall Rating Healthcare Quality → R² = .45
- Flu Shot (CAHPS) → R² = .50

Sample Relationship of Part D and Other Measures

- Part C CAHPS → Part D Measures
  - R² = .66
  - R² = .55

- Part D CAHPS → HEDIS
  - R² = .50
  - R² = .50
  - Drug plan provides information and help
  - Overall rating of drug plans

* Accuracy of information when members call drug plan. All other complaints about the drug plan: Members ability to fill prescriptions easily.
Today’s Topics

1. Value Creation Process
2. Inefficiencies and Value Opportunity
3. Value Realization
4. Risk Sharing Analytics
5. Q&A
ACO Questions

• Who do ACOs value as partners?

• How can Life Science companies work with ACOs?
  – Directly (medication compliance, quality scores, therapy setting optimization, risk contracts)
  – Indirectly (patience advocacy, influence public policy)

• How does/when will Part D fit into the Federal ACO program?

• How are ACOs impacting choice of medical and drug therapies?

• Is there an opportunity to innovate through a CMMI Innovation Grant?
Thank you

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