Value-Based Design Approaches

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CONDUENT

Introductions

Ruth Hunt
Principal
Engagement and Communication

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Principal
Health and Productivity

Meeting agenda

Types of Designs

Health Carrier Approaches

Case Study

Developing a Strategy

What is value-based healthcare?

What is value-based healthcare?

Plan Design

Provider Networks/Models

Member Engagement

Value-based care definitions

Demand (member) side: Benefit or network design

- Plan design includes incentives to use higher-value care that provides quality at a lower cost
- Incentives may occur:
  - At benefits enrollment, via plan (and network) selection, and/or
  - At time of purchase of health care
- Approaches have evolved from “free” preventive care and lower-cost medications to bundled services or differentials in network tiers’ pricing

Supply (provider) side: Outcome-based payments

- Providers take on financial responsibility for the cost of care, health outcomes and the consumer experience
- Reimbursement is **pay for performance** rather than **fee for service** – rewarding effective and efficient care (or penalizing poor performance)

Triple aim of value-based design (VBD), moving from volume to value: better care for patients, better health for the population, at lower cost for all.

Value-based care examples

Demand (member) side: Benefit or network design

- Pharmacy benefit tiers
- Site of care tiered copayments
  - Convenience care, telemedicine, urgent care, ER
  - Lab and imaging
- Incentives for wellness and prevention
- Smart shopper benefits
- Centers of excellence
- Incentives for condition management compliance
- Medical tourism
- Tiered networks
  - High performance networks (HPNs)
  - Narrow networks
  - Accountable care organizations (ACOs)
  - Patient-centered medical homes (PCMH)

Supply (provider) side: Outcome-based payments

- Pay for performance (instead of fee for service) – achieving triple aim:
  - Better care for patients
  - Better health for populations
  - Lower costs
- Quality outcome measures may include:
  - Complications and comorbidities
  - Readmissions
  - Infection rates
  - Evidence based metrics
  - Patient satisfaction scores

Types of plan designs (demand side)

A look back: Typical PPO

Medical	In-Network	Out-of-Network
Deductible	$500/$1,000	$1,000/$2,000
Coinsurance	10%	40%
Out-of-Pocket	$2,000/4,000	$4,000/$8,000
Preventive Services	0% no charge	40% after deductible
Primary Care Office Visit	$25 copayment	40% after deductible
Specialist Office Visit	$35 copayment	40% after deductible
Lab and Imaging	10% after deductible	40% after deductible
Inpatient Hospital	10% after deductible	40% after deductible
Outpatient Hospital	10% after deductible	40% after deductible
Physician/Surgeon	10% after deductible	40% after deductible
Urgent Care	$35 copayment	40% after deductible
Emergency	$100 copayment	10% after deductible
Other	10% after deductible	40% after deductible
Prescription Drug	In-Network	Out-of-Network
Generic	$8 copayment	
Brand Formulary	$25 copayment	no coverage
Brand Non-Formulary	$40 copayment	

Typical PPO plus VBD features

Medical	In-Network	Out-of-Network
Deductible	$500/$1,000	$1,000/$2,000
Coinsurance	10%	40%
Out-of-Pocket	$2,000/4,000	$4,000/$8,000
Preventive Services	0% no charge	40% after deductible
Primary Care Office Visit	$25 copayment (Waive if participating in chronic condition program)	40% after deductible
Specialist Office Visit	$35 copayment (Waive if participating in chronic condition program)	40% after deductible
Lab and Imaging - free standing	10% after deductible	40% after deductible
Lab and Imaging - office or hospital	20% after deductible	40% after deductible
Inpatient Hospital	10% after deductible	40% after deductible
Outpatient Hospital	10% after deductible	40% after deductible
Physician/Surgeon	10% after deductible	40% after deductible
Telemedicine Services	$10 copayment	no coverage
Urgent Care	10% after deductible	40% after deductible
Emergency	10% after deductible	10% after deductible
Other	10% after deductible	40% after deductible
Prescription Drug	In-Network	Out-of-Network
Generic	$8 copayment (Waive if participating in chronic condition program)	
Brand Formulary	10% after deductible ($20 min/$40 max) (Waive if participating in chronic condition program)	no coverage
Brand Non-Formulary	20% after deductible ($40 min/$80 max)	

Look ahead: PPO with HPN or tiered networks

Medical	Designated High Quality / Low Cost	Network But Not Designated	Out-of-Network
Deductible	$500/$1,000	$500/$1,000	$1,000/$2,000
Coinsurance	10%	20%	40%
Out-of-Pocket	$2,000/4,000	$2,000/4,000	$4,000/$8,000
Preventive Services	0% no charge	0% no charge	40% after deductible
Primary Care Office Visit	$25 copayment (Waive if participating in chronic condition program)	$35 copayment (Waive if participating in chronic condition program)	40% after deductible
Specialist Office Visit	$35 copayment (Waive if participating in chronic condition program)	$50 copayment (Waive if participating in chronic condition program)	40% after deductible
Lab and Imaging - free standing	10% after deductible	20% after deductible	40% after deductible
Lab and Imaging - office or hospital	20% after deductible	30% after deductible	40% after deductible
Inpatient Hospital	10% after deductible	10% after deductible	40% after deductible
Outpatient Hospital	10% after deductible	10% after deductible	40% after deductible
Physician/Surgeon	10% after deductible	10% after deductible	40% after deductible
Telemedicine Services	$10 copayment	$10 copayment	no coverage
Urgent Care	10% after deductible	10% after deductible	40% after deductible
Emergency	10% after deductible	10% after deductible	10% after deductible
Other	10% after deductible	10% after deductible	40% after deductible
Prescription Drug	In-Network	Out-of-Network	Out-of-Network
Generic	$8 copayment (Waive if participating in chronic condition program)		
Brand Formulary	10% after deductible ($20 min/$40 max) (Waive if participating in chronic condition program)	no coverage	no coverage
Brand Non-Formulary	20% after deductible ($40 min/$80 max)		

A look back: Typical HDHP

Medical	In-Network	Out-of-Network
Deductible	$1,350/$2,700	$2,700/$5,400
Coinsurance	10%	40%
Out-of-Pocket	$2,000/4,000	$4,000/$8,000
Preventive Services	0% no charge	40% after deductible
Primary Care Office Visit	10% after deductible	40% after deductible
Specialist Office Visit	10% after deductible	40% after deductible
Lab and Imaging	10% after deductible	40% after deductible
Inpatient Hospital	10% after deductible	40% after deductible
Outpatient Hospital	10% after deductible	40% after deductible
Physician/Surgeon	10% after deductible	40% after deductible
Urgent Care	10% after deductible	40% after deductible
Emergency	10% after deductible	10% after deductible
Other	10% after deductible	40% after deductible
Prescription Drug	In-Network	Out-of-Network
Generic	0% after deductible	
Brand Formulary	10% after deductible	no coverage
	($20 min/$40 max)	
Brand Non-Formulary	20% after deductible	
	($40 min/$80 max)	

Look ahead: HDHP with VBD including HPN or tiered networks

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Medical	Designated High Quality / Low Cost	Out-of-Network
Deductible	$1,350/$2,700	$2,700/$5,400
Coinsurance	10%	40%
Out-of-Pocket	$2,000/4,000	$4,000/$8,000
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Other possible design features: Incentives for…

- Wellness program participation and outcomes
- Centers of excellence; bundled service providers
- Evidence-based treatments
- Prescription drug choices
- Other tools and services

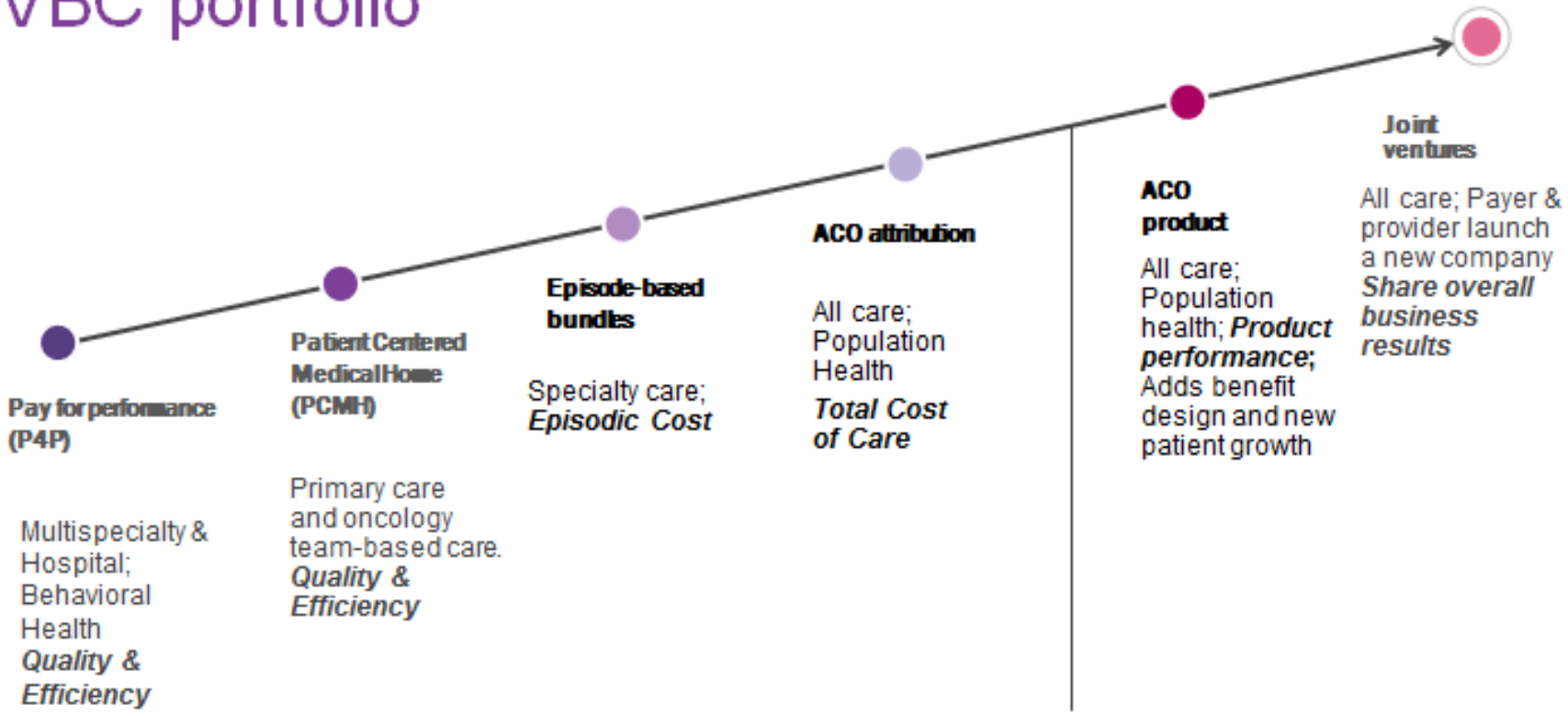
Health carrier approaches (supply side)

Aetna

- Aetna has a full continuum of value-based contracting, with all features included in Aetna's broadest network on a passive basis
- Aetna Premier Care Network (narrow network of specialists – not value-based contracts, but high performers)
- Aetna has three types of ACOs:
  - Attribution model – opens data flow, develops care teams, produces better outcomes/ small capitation at risk
  - Product model – risk-sharing thresholds at the employer level
  - JV model with ACO becomes its own standalone organization
- ACOs can include two- or three-tier network designs (in most cases) and Aetna Premier Care network is a two-tier design only

Aetna

VBC portfolio



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Accountable Care Organizations: backed by proven results

Quality outcomes

80% of ACOs maintained high levels or improved diabetes HbA1C control and persistent use of medications for chronic diseases*

Savings outcomes

Average savings of **$29.25 PMPM**[1]

Engagement outcomes

Proactive outreach and between-visit support to high risk patients through team based care, reduces in-person visits[2]

Savings outcomes

$4.51 PMPM reduction in radiology and a **$4.54 PMPM reduction** in lab[2]

*12 months through June 2016 versus 12 months through June 2015. Market comparison includes all attributed non-value-based contract members. Results exclude individual, student health and coordination of benefits. Results differ due to differences in time periods and adjustments.

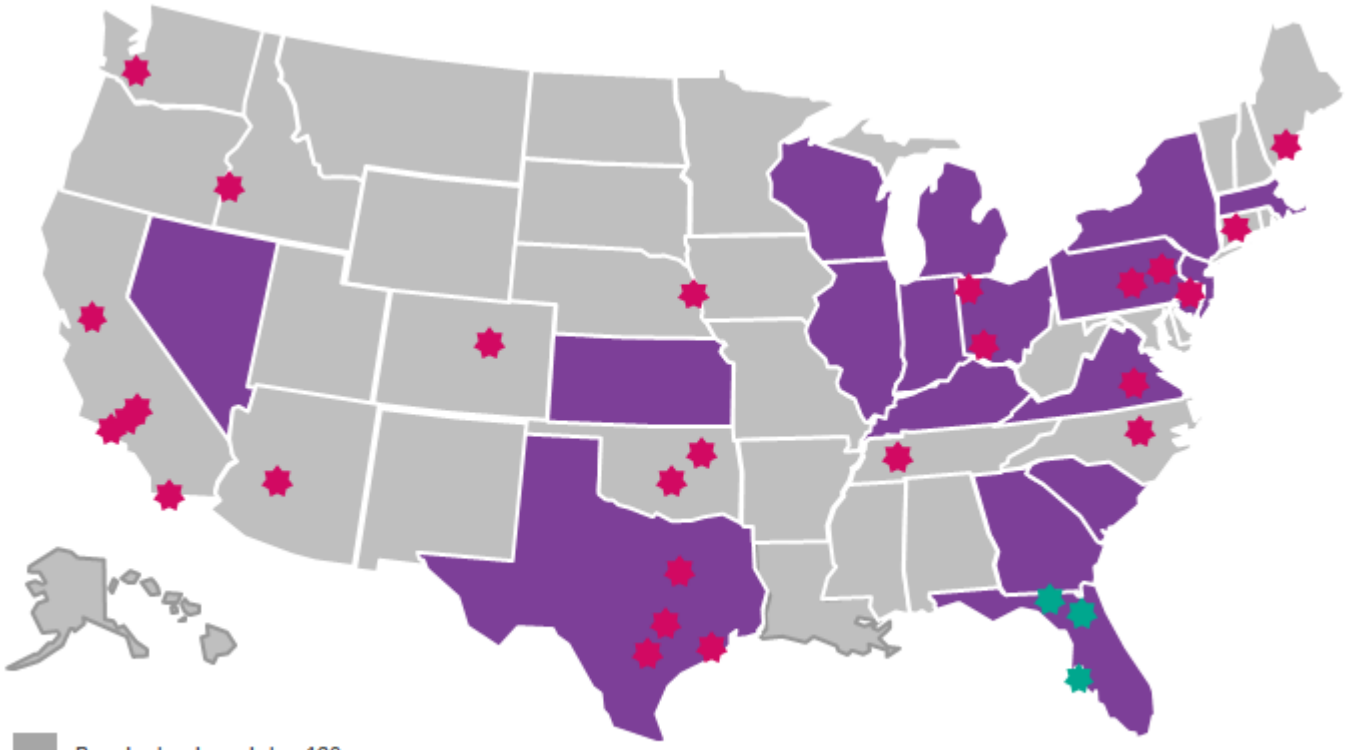
[1] Compared to broad Aetna network plans. Actual results may vary; savings may be less when compared to other value-based or narrow network plans.

[2]Inaugural ACO Product Evaluation Study results based on Aetna data, October 2017, for members with 2016 effective dates. Six-month baseline period prior to ACO effective date and six-month study period after ACO effective date.

aetna®

Aetna

2019 Aetna Premier Care Network Plus – market configurations



Cigna

- “Cigna Care Distinction” designation is archived by providing high quality outcomes at low cost. These Tier 1 designated high-performing providers are in the following:
  - Broad network
  - Specialty networks(covering 6 specialties)
  - Local Plus networks – 50% to 62% HPN (7% savings)
  - Sure Fit or Focused networks – 100% HPN (17% savings)
- ACOs are the foundation for the HPNs
- Benefits can be tiered in all options
- ACOs in western Pennsylvania (UPMC and Washington) are new and not providing risk sharing arrangements for now.
- Key to ACOs is nurse care coordinator and information feed to that individual

Cigna

CIGNA
- Supports treatment
- Encourages follow-up care
- Coordinates health and coaching programs
- Offers **One Guide®** support*

CUSTOMER
- Receives the right care, at the right time
- Gets coordinated care to help improve health
- Takes a more active role to drive better health, better costs, better experience

COLLABORATIVE CARE PROVIDER
- Nurse Care Coordinator
- Provides patient-centered care
- Coordinates ongoing care and programs to improve whole health
- Helps guide patients to the right care at the right time – referring to the right specialist

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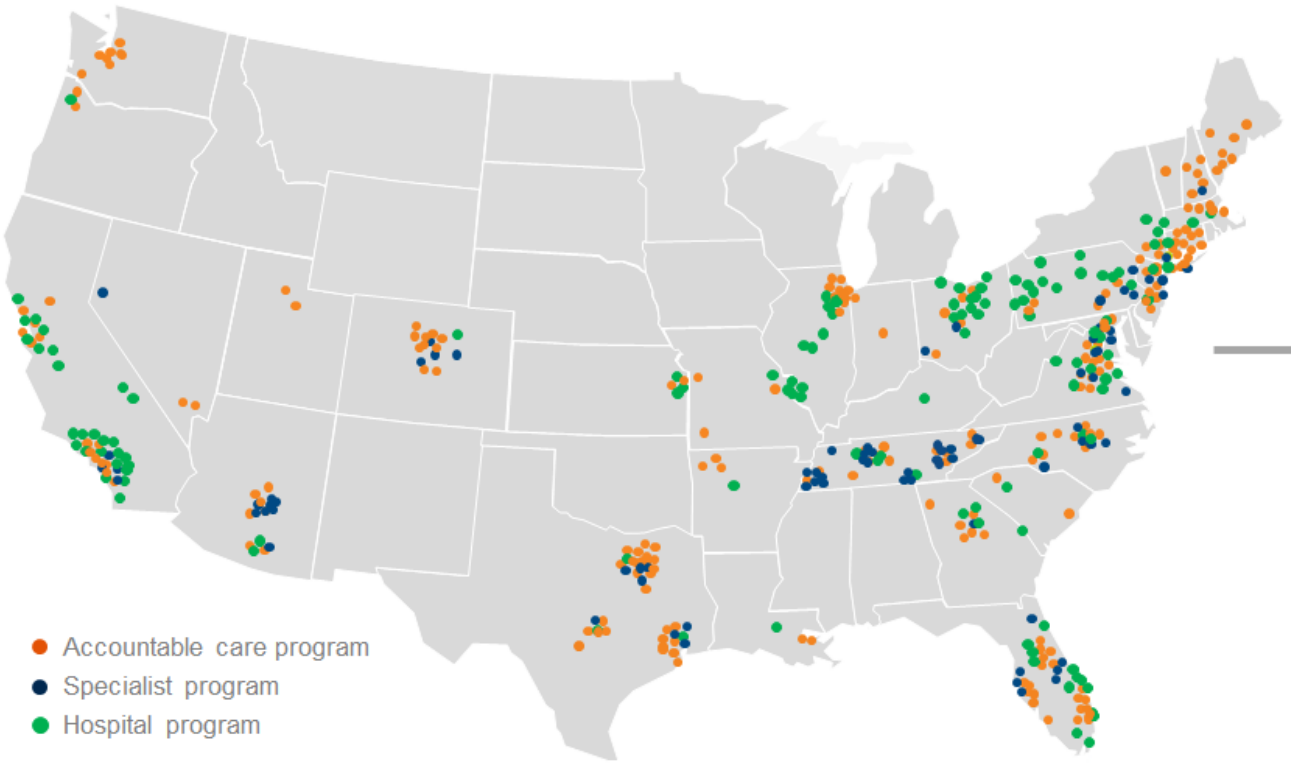

200+ ACO programs*

160+ specialist programs in six disciplines*

140+ hospital programs*

99%

of customers in top 40 markets are within 15 miles of a participating provider**

Map is illustrative.
*Cigna internal analysis of existing arrangements as of April 2018. Subject to change.
**Cigna August 2017 analysis of medical commercial Book of Business customers in top 40 U.S. markets, defined by market size, within 15-mile zip code radius (zip code to zip code distance) of one CCC primary care physician. Subject to change.

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ACCOUNTABLE CARE PROGRAM

Outperforming the market, lowering total medical cost

10% better quality

Compliance with evidence-based medicine guidelines[1]

- Avoidable ER visits[2,3] **59%**
- Hospitalizations[2,4] **28%**
- Readmissions[2,5] **63%**
- Advanced imaging[2,6] **42%**
- Generic Rx use[2,7] **3%**

Comparisons to market are established using Cigna internal claims data. 1. Cigna 7/2017 analysis (weighted average) of top 7 CCC primary care physician groups nationally per metric compared to local market in 2016. 2. Cigna 6/2017 analysis of 2016 data of CCC primary care physician groups nationally, active at least one year. 3. Accounts for top 5 groups with 28,000 aligned customers. Examples of avoidable visits include nonemergency minor illnesses such as headaches and skin rashes. 4. Accounts for top 5 groups with 50,000 aligned customers. 5. Accounts for top 5 groups with 37,000 aligned customers. 6. Accounts for top 5 groups with 50,000 aligned customers. Total scans per thousand. 7. Accounts for top 5 groups with 54,000 aligned customers. Average is market.

Highmark Blue Cross

- Many Accountable Care Organizations – bearing full risk in a few nationally and locally
- Implemented “True Performance” physician pay for cost and quality of care performance (Three year glide path (True Performance Plus with shared savings trigger, and True Performance Advanced with risk sharing)
- Using “Alt” networks or soon to be named “Select Networks” (growing from 12 to 24 regions)
- Developing “Flex-net” program – customized for top hospitals based on cost and quality data
- Client Centric Centers of Excellence and Blue Destination Programs (bariatric, cancer, cardiac, fertility, knee/hip/spine, transplants)
- Network tiering and pilots available on all approaches

Highmark Blue Cross

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Blue Distinction® Portfolio

Bluecard PPO – a quality-driven foundation for creating custom benefit designs tailored to your objectives.

Total Care (Value-Based Care)

The nation's largest network of ACOs and value-based providers, driving higher quality outcomes and lower costs.

- BDTC+ coming 1/1/19
- Proven Results
  - Better control of chronic conditions
  - Improved delivery of preventive care
  - Improved patient experience
  - Lower utilization[1]
  - 10% lower total cost of care in more than 100 MSAs[2]

1. 2016 Value-based Program RFI Survey, Plan reported information 2. 2016 BDTC National Evaluation comparing BDTC attributed to non-BDTC members, BCBSA analysis of markets with at least one ACO or value-based provider group 3. BDC/BDC+ eligible facilities vs. relevant comparison group 4. BDC+ eligible facilities vs. relevant comparison group

Specialty Care (Centers of Excellence)

Centers of excellence across 99 of the top 100 MSAs, targeting seven high-cost specialty care areas.

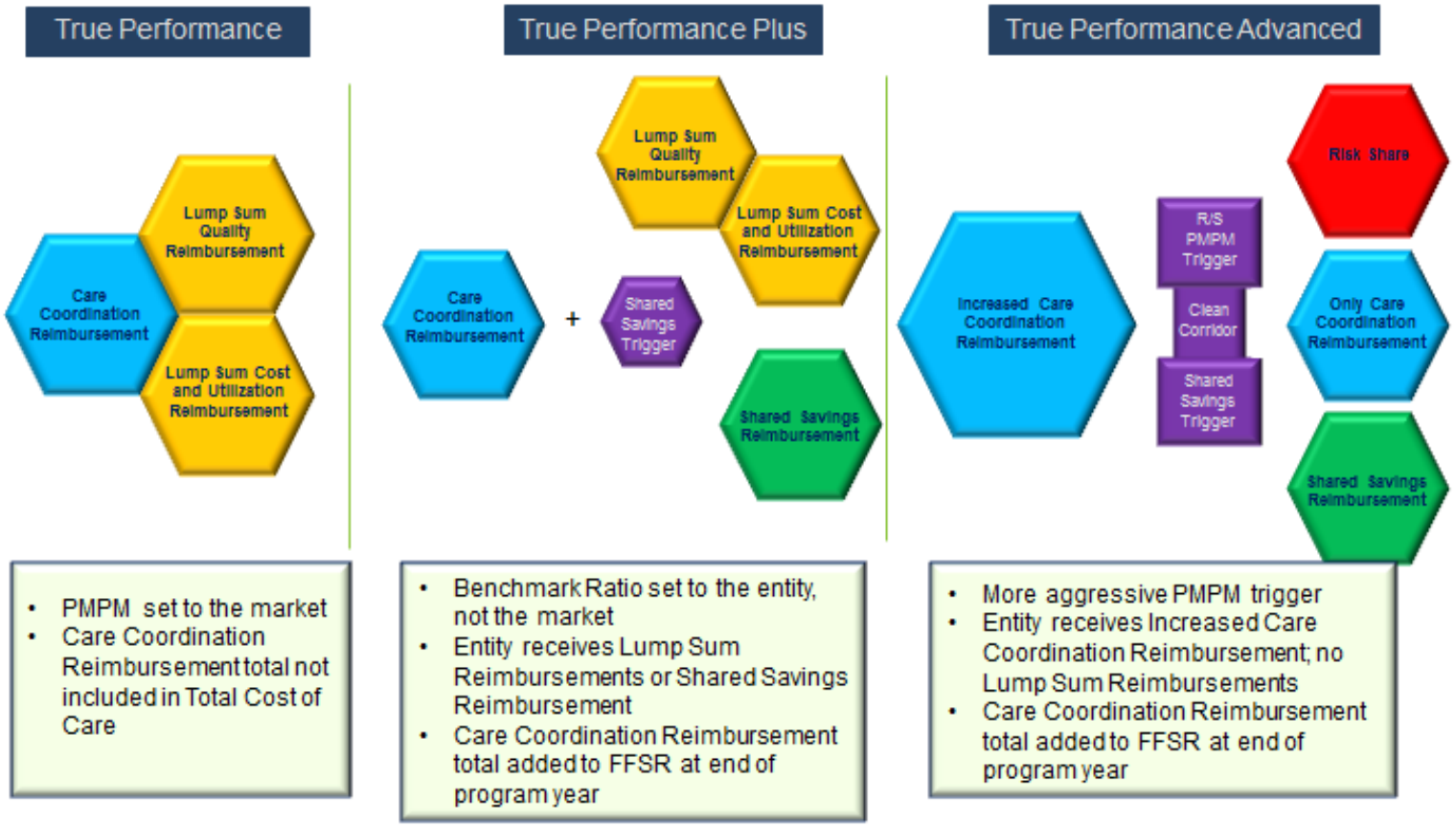
- Highmark's Customized Client-Centric Centers of Excellence built using BDSC facilities.
- Proven Results
  - Lower hospital readmission rates
  - Fewer complications
  - Fewer reoperations[3]
  - Average episode savings of 20%[4]

Flexible Networks *New* (Tiered Networks 1/2019)

The nation's largest custom-tiered network solution, addressing 50% of medical spend.

- Allows tiering of the network to achieve the optimal balance of savings and employee access.
- Expanding scope in 2019 to include not only acute care hospitals and ASCs, but also PCPs and Specialists.
- Expanding the geographic scope--the MSAs to more than double for 2019 in key areas.

Highmark Blue Cross



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Highmark will embark on an aggressive 3-year reimbursement roadmap which will span across the care continuum and increase the weight of value throughout

	2018	2019	2020
Consumerism	• Social Determinants of Health Pilot (Medicaid & Commercial) • **High Value Network** (HVN) Configuration	• Implement HVN • Pilot **Member-level incentives** • Pilot Member education & transparency program	• Member develops consumeristic tendencies • **Transparency of cost & quality** utilized to drive utilization shift
PCP	• Expand TP/TP+/TPA • Refine TP suite • **Communicate Fee Schedule Adjustment in 2019**	• Shift more members into TP+/TPA • **Implement Fee Schedule Adj.** • Expand Prof. Capitated Program	• Enhance TP Suite & Expand • **Expand Fee Schedule Adj.** • Expand Capitated Program
Specialists	• Pilot **Bundled Payments** • Pilot Alternative Site of Care Program (Incentive for ASC)	• Implement Bundled Payment • **Implement A SOC Program** • Communicate Fee Schedule Adjustments for 2020	• Expand Bundled Payments to more Specialties • **Implement Fee Schedule Adj.** • Pilot Disease-specific bundle
Facilities	• Implement **new QBH program** • Introduce QBH+ & QBH Advanced glide path • Pilot Global Capitated Model	• Expand QBH to more episodes • **Launch QBH+ and QBHA** • Expand risk/cap model	• Enhance QBH to more episode • Shift entities to QBH+/QBHA • **Increase entities in risk/cap program**
Rx	• Site of Care (SOC) pilot • **Macular Degeneration Program** • Specialty Rx Drug Report	• **Implement SOC Program** • Introduce Specialty Rx metric to TP suite • Communicate downside risk	• Introduce **downside risk for appropriate SOC** to PCP/Spec. • Ad Hoc VBR Programs for specific Rx opportunities
Post Acute	• **Expand SNF P4V Program** • Pilot SNF VBR Bundle Program • Pilot Home Health (HHA) VBR Program	• Expand SNF P4V to SNF Bundle • **Implement HHA VBR program** • Pilot 60-day SNF/HHA bundle • Pilot e-home health visits	• Expand SNF/HHA VBR program • **Implement 60-day SNF/HHA bundle** • Pilot e-consult for HHA

Highmark Blue Cross

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Client-Centric Centers of Excellence (CCOE)

UnitedHealthcare

The UnitedHealth Premium® program provides physician data based on quality and cost efficiency criteria, to help members make more informed and personally appropriate choices for their medical care. The UnitedHealth Premium® program assesses physicians annually, using updated quality and cost efficiency methodologies and data. Three tiers:

- **Premium Care Physician** – the physician meets the UnitedHealth Premium program quality and cost-efficient care criteria,
- **Quality Care Physician** – the physician meets the UnitedHealth Premium program quality care criteria but does not meet the program's cost-efficient care criteria, or
- **Not Evaluated For Premium Care or Does Not Meet Premium Quality Criteria**

UnitedHealthcare

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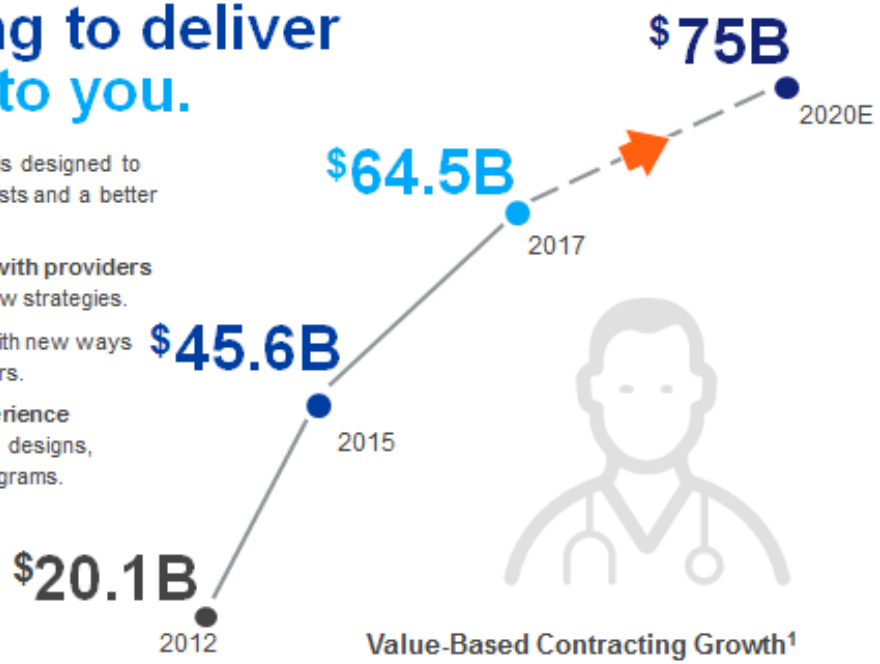
Collaborating to deliver more value to you.

Value-based provider contracting is designed to deliver quality outcomes, lower costs and a better experience for your employees.

- **Creates stronger alignment with providers** through actionable data and new strategies.
- **Controls health care costs** with new ways to share risk and incent providers.
- **Improves the employee experience** by integrating network and plan designs, consumer tools and clinical programs.



Value-Based Contracting Growth[1]

ts VBC spend across all lines of business from 2012 to December, 2017. Results shown are not a guarantee of future performance.

Up to 6% lower medical costs with value-based care programs.[1]

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National Networks	**Broad Access**	Over 884,000 care professionals.	One of the largest single health plan network.
	Tiered Plans	2% to 8% savings.	Incentives to use Tier 1 physicians who may deliver the best benefit value.
	Centers of Excellence (COE)	10% to 20% in episode savings.	Incentives to use COEs for specialized and chronic care.
Local Networks	**Primary Care-Centered and Narrow**	3% to 8% savings.	Combines primary care-centered and narrow high-value networks.
	Narrow	2% to 5% savings.	Choices within defined high-value networks driven by local markets.
National and Local Networks	**NexusACO® Tiered and Primary Care-Centered**	Up to 15% projected savings.	Members choose a primary care physician and are incentivized to use ACO and other Tier 1 providers.

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State	Market	Provider *Effective 1/1/17 unless otherwise noted*
AZ	Phoenix	Commonwealth Primary Care ACO
AZ	Tucson	Arizona Connected Care
CA	Los Angeles	Davita/Healthcare Partners
CA	Orange County	Monarch HealthCare
CA	San Francisco / Bay Area	Hill Physicians Medical Group Brown & Toland Physicians *(1/1/18)*
CA	Sacramento	Hill Physicians Medical Group
CO	Denver	Centura Health New West Physicians Physician Health Partners (South Metro Primary Care, Primary Physician Partners)
CT	Hartford	St. Francis *(1/1/18)*
IL	Chicago	Advocate Health Care
OH	Cleveland	University Hospitals
OH	Columbus	Central Ohio Primary Care
NJ	Northern NJ	JFK ACO Osler Health Hunterdon *(1/1/18)* Optimus *(1/1/18)*
NY	NYC	Mt. Sinai *(1/1/18)*
RI	Statewide	Coastal Medical
TN	Memphis	HealthChoice *(1/1/18)*
TX	Austin	Seton Health Alliance
TX	Dallas	Baylor *(1/1/18)* Catalyst *(1/1/18)* PPN *(1/1/18)* USMD *(1/1/18)*
TX	Houston	Memorial Hermann
TX	San Antonio	WellMed
VA	Richmond	Virginia Care Partners

UPMC Health Plan

- UPMC Health Plan has a number of shared savings models used with both UPMC and other “Premier” providers. UPMC uses the term, Integrated Delivery Financing System.
- Shared savings programs focus on meeting both cost and quality metrics, including compliance with preventive services.
- Added incentives encourage provider offices to continue to build care support models.
- The Health Plan has three networks:
  - Advantage network
  - My Care Advantage network
  - Premier network
- The Advantage network can be two or three tier, using a PPO or EPO model.
- Moving toward full risk contracts.

Case study with ACO

Value-based design: ACO overview

- Partnership between two industry leaders: Inova Health (IH) and Aetna
- Inova is a nationally recognized not-for-profit health care system serving more than 2M people each year. Aetna is one of the nation's leading health care benefits companies serving over 22M members.
- More than 250,000 members and 1,700 customers
- Promises and delivers better care, improved quality, and lower costs (8%-20%)

1	Discounts	Inova facility discounts – extra 15%
2	Risk Share	Actual claims significantly lower than projected
3	Signature Partners	PCP and specialist network in place and growing
4	Clinical Integration	Care management identifies high utilizers and refers without a doctor to Signature Partner providers
5	Medical Management	IH membership outperforming Aetna membership and other segments within IH

Evaluating quality and clinical outcomes

- ACOs/HPNs strive to reduce healthcare cost, improve healthcare quality and produce better patient outcomes. Cost differentials are easy to observe.
- Key to success: measure healthcare quality and improved health outcomes.
- Sample quality indicators include:
  - Measuring behavioral changes in members with **actionable chronic conditions** (medication adherence, routine visits to specialist/PCP, cost movement associated with managing the disease)
  - Compliance with **preventive screenings** to intervene early, better manage care and improve outcomes
  - Improving **key quality metrics** such as reducing re-admission rates and percent of procedures resulting in complications

Case study background

- Large national employer with critical mass in Northern Virginia, Maryland and Washington D.C.
- Employee enters zip code in benefit administration system at time of hire or at open enrollment to view local medical options.
- Northern VA, MD and DC plan and contributions match other locations (except additional ACO tier)
- Inova Health (IH) agreed to risk sharing in the Northern VA (IH J1) market:
  - Negotiate a target PMPM cost with employer's own trend
  - Inova at risk above target, if target is not met
  - ACO rewarded with a percent of savings if below target

Plan highlights

Medical	IH	In-Network	Out-of-Network
Deductible	$1,350/$2,700	$1,350/$2,700	$2,700/$5,400
Coinsurance	varies	varies	40%
Out-of-Pocket	$2,000/$4,000	$2,000/$4,000	$4,000/$8,000
Preventive Services	0% - no charge	0% - no charge	40% after deductible
Primary Care Office Visit	0% - after deductible	15% after deductible	40% after deductible
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Lab - office	0% - after deductible	15% after deductible	40% after deductible
Lab - hospital/free standing	10% after deductible	10% after deductible	40% after deductible
Imaging	0% - after deductible	15% after deductible	40% after deductible
Inpatient Hospital	10% after deductible	10% after deductible	40% after deductible
Outpatient Hospital	0% - after deductible	10% after deductible	40% after deductible
Physician/Surgeon	0% - after deductible	15% after deductible	40% after deductible
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Emergency	10% after deductible	10% after deductible	10% after deductible
Other	10% after deductible	10% after deductible	40% after deductible
Prescription Drug	In-Network	In-Network	Out-of-Network
Generic	0% - after deductible		
Brand Formulary	10% after deductible	no coverage	no coverage
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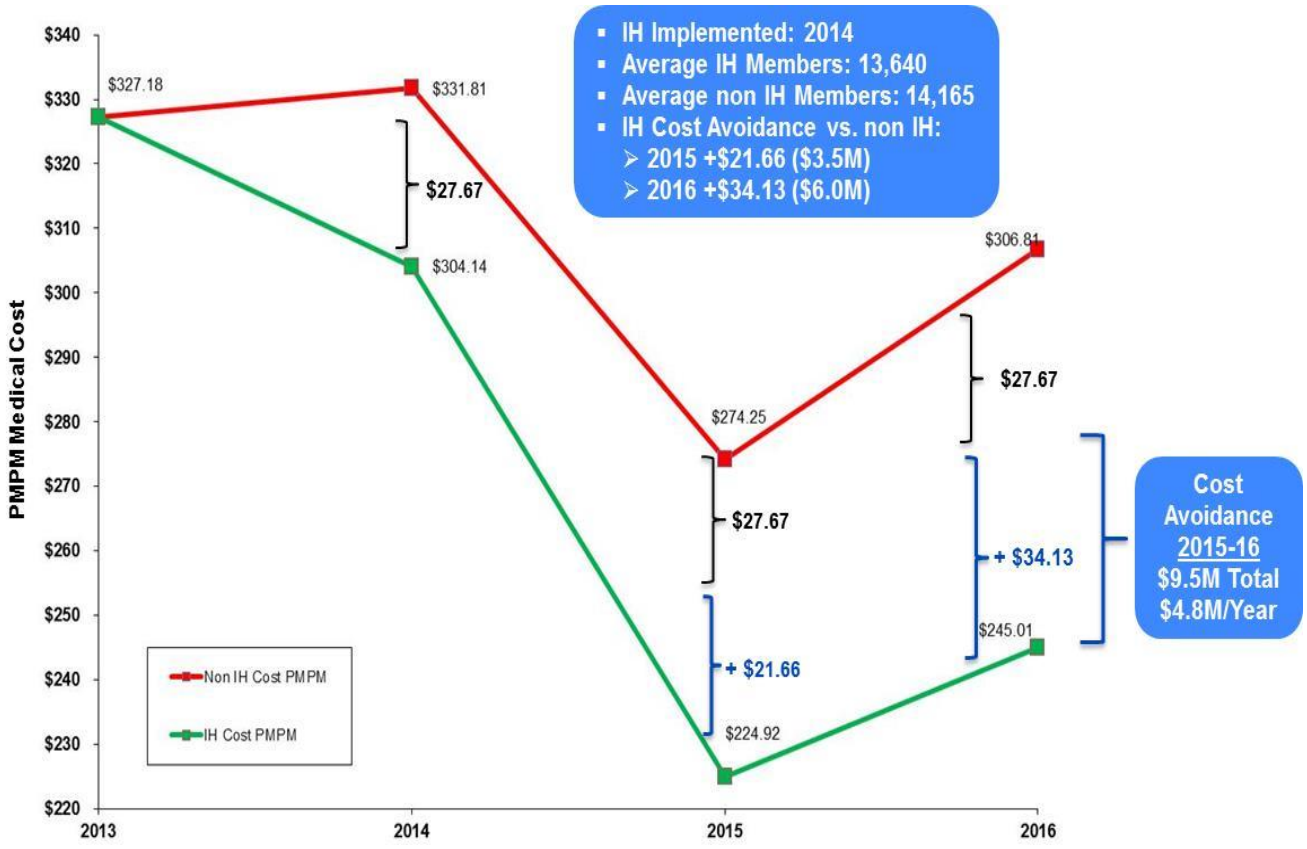
Brand Non-Formulary	10% after deductible		
	($40 min/$80 max)		

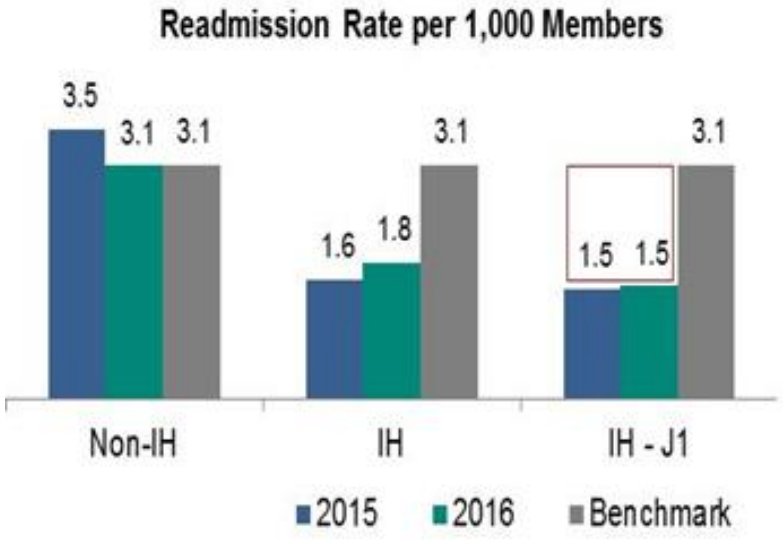
ACO case study: Achieving results

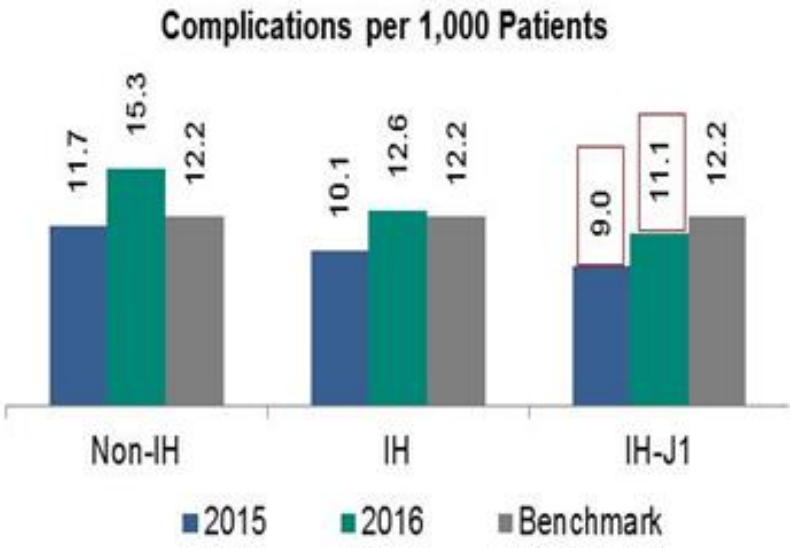
Cost reduction



ACO case study: Achieving results

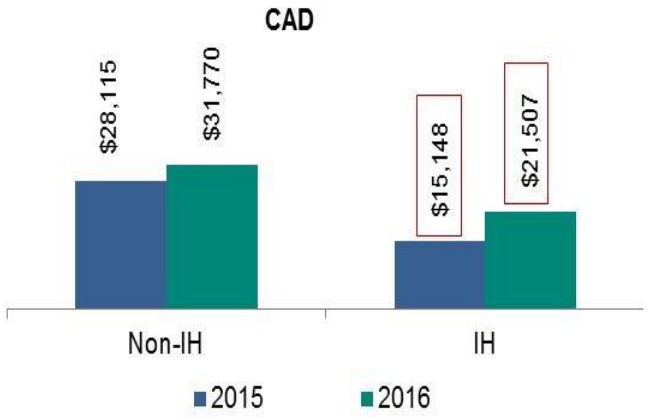
Controlling these types of care

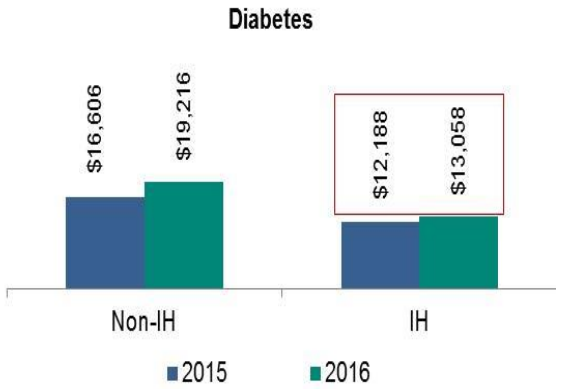


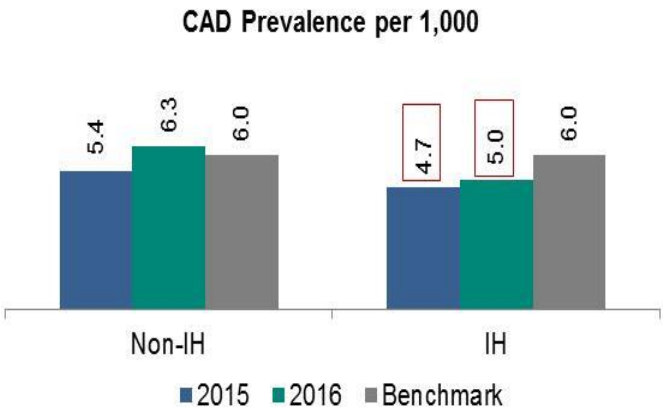


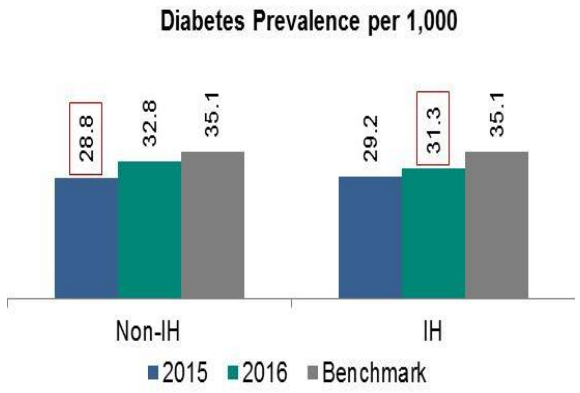
ACO case study: Achieving results

Improving chronic conditions and quality



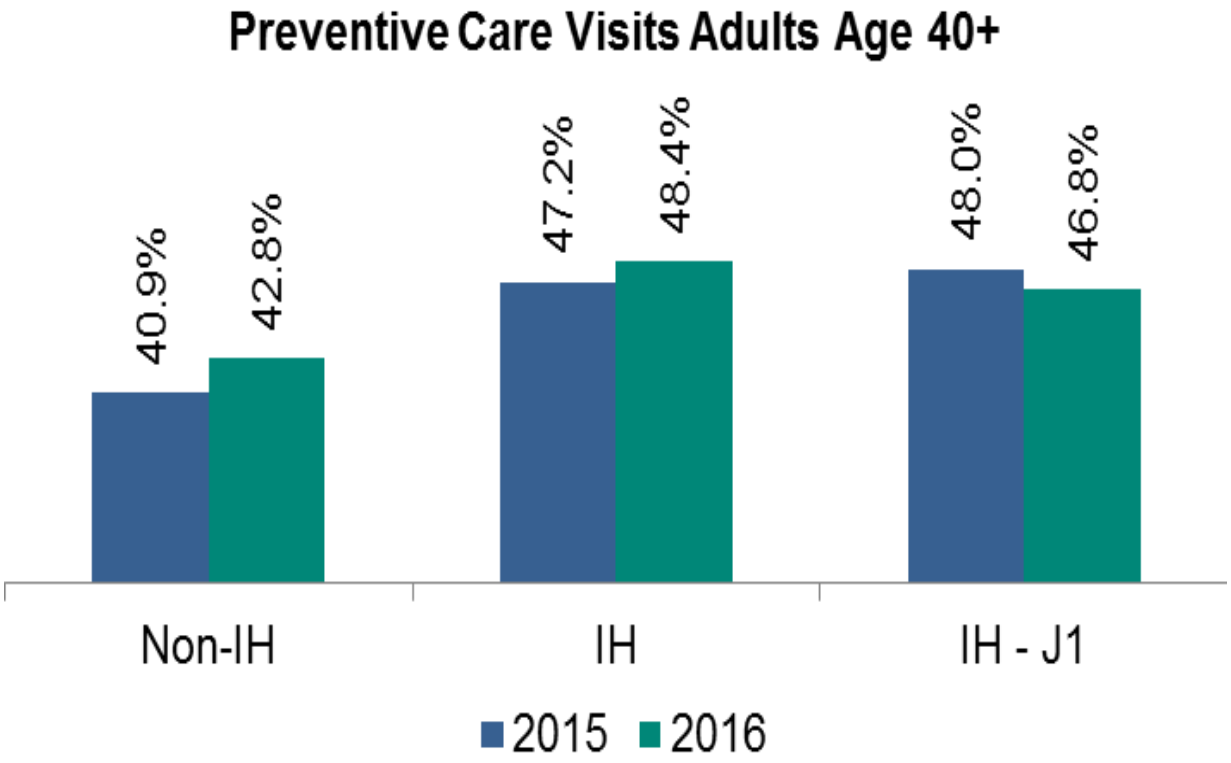






ACO case study: Achieving results

Improving preventive metrics



Developing a strategy

VB and HPN issues

- **Design/communication:** How to handle out-of-network scenarios?
  - Emergencies; travel away from home
  - Dependents out of area
- **Jargon:** “Evidence-based care,” “value-based” aren’t intuitive
- **Enrollment:** Consider an active process to nudge participation
- **Pre-authorization:** Restrictions may rub, like gatekeeper HMO days
- **Rural employees:** Choices may be more limited; resistance to travel
- **Leadership alignment:** Reduce push-back, increase advocacy
- **Change readiness:** Context, barriers, use of tools on cost and quality
- **Personal impact:** WIIFM; health care is personal and emotional; socioeconomics matter

Communication challenges

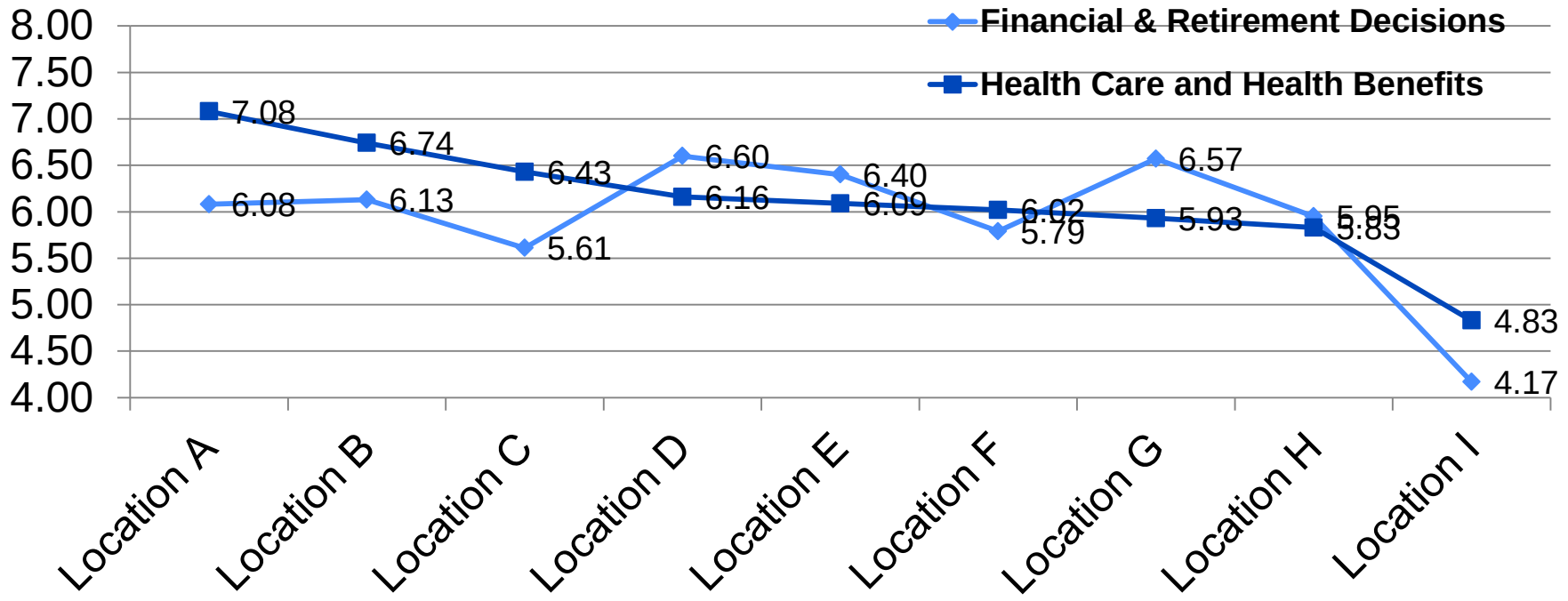
Trust	• “I’ve had my doctor for 25 years; I trust his guidance.” • “You took away my choice and you’re just trying to cut costs and keep me from getting care I need.”
Time and hassle	• “I live across the street from a top-branded hospital and now I can’t go there?” • “I had to drive 45 miles for a specialist so I quit my therapy.”
Complexity	• “Why do we have to jump through so many hoops to get care (or my medication)?” • “I just don’t believe there’s a quality difference.”

What's needed: consumerism

- **Data** – easy access for the carrier and employer and consumers; **transparency** to enable informed decision-making by all ("quality makes a difference")
- **Decision support tools** – for consumers' **informed choice**
  - At plan enrollment
  - At point of care
- **Communication** – between providers, patients, etc.
- **Convenience** – with help available "just in time," conveniently, simply (e.g., optimal user experience online, mobile-enabled)
- **Advocacy** – mobile/chat/videoconference JIT guidance and navigation support
- **Motivation** – instilling a sense of responsibility and empowerment
- **Monitoring and measuring** – set goals; get feedback (surveys, focus groups)

Self-rating HC knowledge/skills

From highest-to-lowest; by year 2, ACO location rated selves 2nd highest.



Focus group and plan performance data confirmed rising consumerism – across both ACO and non-ACO participants.

Personas anticipate VB reactions

Define; use to inform VBD design and communication strategy

Consumers do seek quality

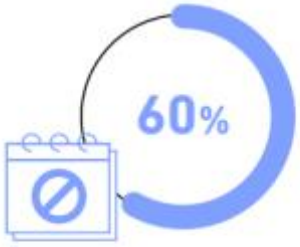
Those with online access prove it; support those not online

will frequently or always change their mind about a referral due to the provider's **poor or weak online reputation** (a rating of less than three out of five stars).

will **read reviews about a referred provider** occasionally, frequently, or always, *even after they've been referred.*

will occasionally, frequently or always **change their mind** about a provider with a rating of less than 3 stars.

consider ***quality of reviews*** to be most important.



would **not book** with a provider with ***poor quality reviews.***

Source:
Klick Health, May 28, 2018, citing survey results by Doctor.com (1,718 respondents across all age groups)

Additional findings:*

- 90% sometimes change their mind if a provider has less than 3 stars
- 80% read online reviews occasionally or more often
- 76% did an online health search in the last year
- 67% say online information from providers has influenced decisions

*Age 60+ respondents for the above

Example: Imagine Health data

CONDUENT

Show me the data:

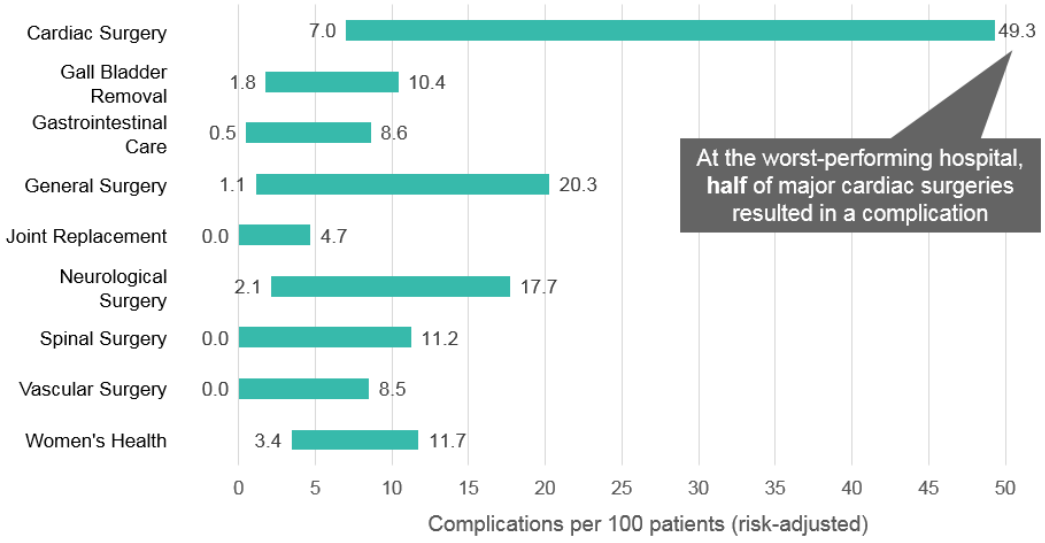
- 37 hospital quality scores, e.g., complications, readmissions, errors, mortality, satisfaction
- Doctors and specialists rated on 0 to 100% scale…

Hospital	Overall care	Cancer care	Cardiac care	General surgery	Interventional coronary	Neurological surgery	Orthopedic care	Orthopedic surgery	Spinal surgery	Vascular surgery	Women's health	Marketshare
Top performer	100	92	99	100	97	97	100	98	89	100	97	
Hospital 1	100	59 1,278	99 9,424	98 2,479	90 941	97 481	100 1,471	98 3,762	89 1,492	97 792	92 613	5.5%
Hospital 2	98	92 480	83 4,885	100 1,528	27 152	66 41	83 891	91 1,216	82 501	97 380	95 161	2.4%
Hospital 3	97	92 1,275	94 8,767	99 2,714	25 1,219	89 221	88 1,698	58 1,814	4 1,106	97 888	95 412	5.3%
Hospital 4	96	84 810	98 8,345	80 1,963	97 1,022	72 19	88 1,405	88 1,450	14 219	87 679	75 193	4.2%
				78 1,793	89 784	76 98	91 1,398	84 2,399	13 631	3 456	97 385	3.6%
				98 2,120	68 1,187	77 259	92 1,048	37 1,606	79 715	100 1,392	92 443	5.4%
				89 950	91 238	8 31	68 679	94 2,248	57 324	84 160	96 304	1.9%

Why Focus on Selected Providers? Quality!

imagine HEALTH

Example: at nearby hospitals, complication rates can vary – a lot



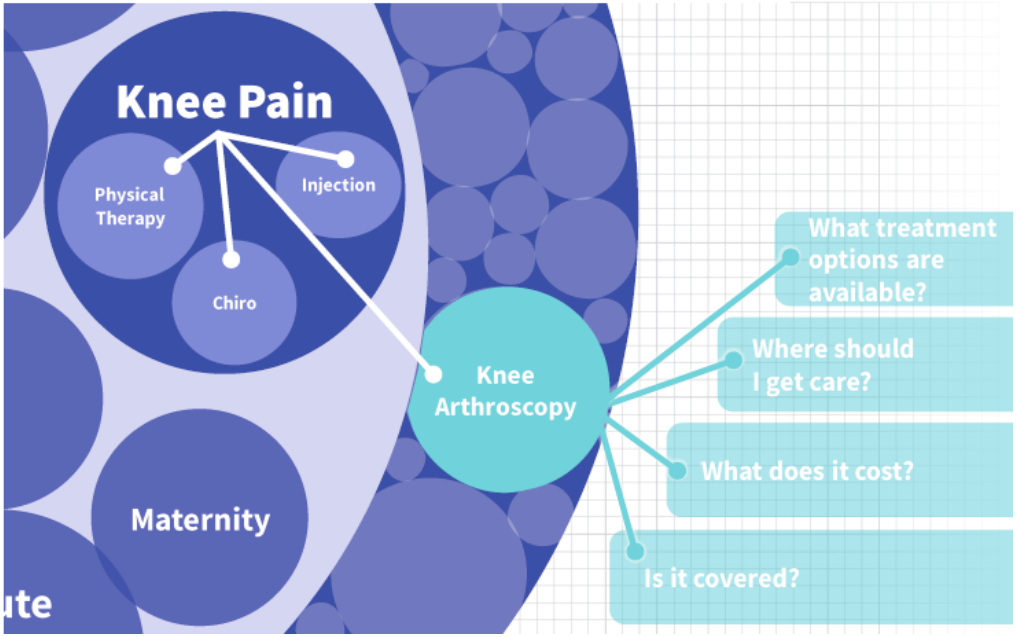
Provider choices significantly affect your health outcomes.

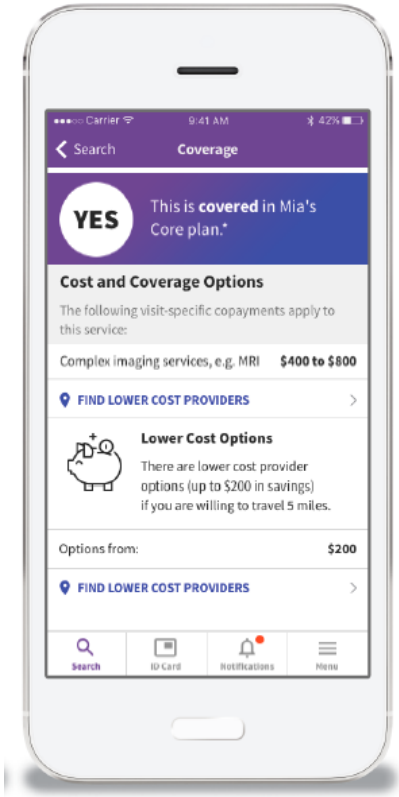
- Sample low ratings at a key site: 3% on vascular care, 4% spinal, 8% neurological
- A doctor or hospital may score high on one condition/ procedure but low in others
- Emphasis on concierge and mobile support, 24/7

imagine HEALTH

Example: Bind to guide and save

- **On-demand health insurance** (core coverage plus add-ins), plus focus on high value, efficient treatments and providers
- **"Smart copays," data and decision support** nudge members to value and efficiency – members don't know "value-based care" but can understand basics: **"Use the tools and trust the data"**





bind on-demand health insurance

Case study: Swapping ACO for PPO options

Sample message:

We give all employees access to a broad network with **one** of our national carriers and in some markets, offer high-performance network options. This makes it easier for members to access high quality, efficient providers who create value and savings for you and the company, and improve member health outcomes.

Strategy components:

- Leadership alignment
- HR train-the-trainer support
  - Responsibilities in the rollout
  - White paper on change rationale
  - FAQs, including potential tough questions, tailored by market
- Advance communication mailed home to affected groups
- Face-to-face meetings
- Video for replay, spouse at home
- Decision support tools
- Ongoing concierge support

Example:
“Is the HPN right for you?”

CONDUENT

A high performing network might be right for you if…

- You like the idea of a selected network of high quality providers at lower costs than compared with a broader network
- Your preferred doctor and/or specialists are in the network
- You want the lower premium cost
- You don’t mind possibly traveling a little further to see a specialist

A high performing network might NOT be for you if…

- Your doctor is not in the network and you don’t want to change
- You’d prefer a broader network of potential future providers and don’t mind doing your homework to find quality providers right for you
- You are okay with a higher premium cost in exchange for a broader network
- You have dependents who live away from home
- You travel often

Questions?

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