Epic - Vice President of Value-Based Care at UnitedHealth Group

Interview conducted on January 20, 2023

Topics
Healthcare Technology, Data Exchange, Payers and Providers, Referral Management, Value-Based Care, Cost Reduction, Innovative Product Design

Summary
A Tegus Client spoke with the Vice President of Value-Based Care at UnitedHealth Group about the progress of near real-time data exchange between payers and providers, specifically the use of data pipes like the Epic payer portal. The Vice President expressed concern about the cost and inhibiting measures that may prevent some providers from joining the Epic platform, but emphasized the importance of value-based care arrangements and educating providers on their arrangements to avoid alert fatigue. They also discussed the use of widgets and other mechanisms for data exchange, and the barriers to providers sharing their data with payers. The conversation highlighted the potential value of near real-time data exchange for targeted risk adjustment, compliance, and population health efforts. Additionally, they discussed the use of specialty preferred specialists, EMRs, referral management, reducing co-pays for primary care visits, building wellness, and provider quality.

Expert Details
Vice President of Value-Based Care at UnitedHealth Group. Expert can speak to clinical healthcare, health insurance providers, benefit plans, and insurance product designs.

Vice President of Value-Based Care at UnitedHealth Group. The expert was responsible for the carrier delivery, developing the clinical programs for Optum, and benefit plan designs. The expert is also responsible for successfully transferring the “Virtual ACO” solution and the team from UHC Clinical Services to OptumInsight for productization and preparing the program for scale Nationally and productizing the program for sale to external payors.

The expert was also the National Director of Commercial Strategy and Outcomes at UnitedHealthcare Clinical Services. The expert was responsible for analyzing, designing, and launching population health clinical programs to solve for the small provider aggregation Nationally. The expert also led the team of clinicians and non-clinicians to drive continuous improvement clinically and financially for the population through Care Coordination for Care Transitions, Medication Therapy Management, and Referral Management.

The expert can speak to clinical healthcare, health insurance providers, benefit plans and insurance product designs.

Q: Can you describe the leading trends for novel benefit designs for commercial healthcare insurance benefits? What are the top 3-5 new features?

A: The top features of medical benefits include pharmacy, additional friends benefit with overall health insurance, dental and vision are prevalent in the market. Additionally, the assessment of how your medical pharmacy pair with employer insurance.

Q: For commercial health-insurance products, can you speak to what changes you expect to see for funding arrangements? Will there be new models added on top of traditional fully/self-insured and level-funded?

A: Yes, we going to see a trend in health insurance are paying the provider for changes in behavior. The Fully insured or ASO is taking the brunt of the cost, and there needs to be a new shared model for the chargeback

for value-based care.

Q: Can you speak to which customer segments (e.g., ASO v FI, Large v Small Group, National v Regional) are most likely to demand (or switch carriers for) these novel benefit-products?

A: Yeah, ASO customers are more likely to change to move around because benefit plans are offered by the insurance carriers.

Tegus Client
Thank you very much for making the time. I'm intrigued with the hypothesis or the perspective that payers and providers are getting closer and closer to near real-time data exchange, enabling a variety of different clinical collaboration opportunities.

Looking at things like the Epic payer portal and the ability that Humana has, I believe, and other payers, too, to inject their perspectives and information about their overlapping members and patients, support risk adjustments or align with clinical programs, all that sort of stuff. Do you see this kind of near real-time collaboration being enabled by data pipes. Do you see that happening as well? And give me your perspective on kind of where we are in progress and who's ahead, who's not and what some of the frictions might be?

Vice President of Value-Based Care at UnitedHealth Group
I see it happening. What I'm concerned about is that we may be matching out soon the number of providers that are able to be part of the Epic platform due to cost and other inhibiting measures.

What I am concerned about is the long-tailed providers, the providers who still have a very decent chunk of the population of primary care providers, those who are the holdouts, they've not joined large health systems. They've not joined large medical groups and thus, they would not really have the infrastructure in place, have the money in place to join up with Epic. So you're not catching those guys. They are declining in numbers, right?

The great resignation is affecting them. Just the cost of doing business is affecting them. So they do have more join ups than usual. But organizations, MCOs overall, I've heard a few stats out there that are still pretty high when you think about it.

So I've heard as much as 50% for some payers, depending on how rural your markets are. It may be more. If you're more in urban areas, maybe less. So that's one area that you're not catching. I do find that you have so much opportunity with a decent subset let's call it the additional 50% of providers who have the potential for real-time data sharing. And yes, there's a big opportunity there with that population.

Tegus Client
Great. So are there other mechanisms besides the Epic Payer Platform that allows this kind of near real-time data exchange? Or is that kind of the primary one?

Vice President of Value-Based Care at UnitedHealth Group
Depending on what type of data exchange you're discussing, there's hundreds. They've got the Athenas out there. You've got multiple EMRs. Payers are embedding their data through widgets, add-ons, whatever technology they're using to combine or feed their data into. They're getting sophisticated. And I'd say you've got eClinicalWorks also in the mix there. Athena is another big one. Probably if I had some time to research for you can come up with another couple of hundred.

Tegus Client
So this idea of creating an interface that between payers and providers, really building off of the EMRs, that seems like it's pretty widespread. The one we have been talking about is Cerner, are they behind?

Vice President of Value-Based Care at UnitedHealth Group
I think Cerner is probably one of the big ones. I'm not vastly familiar with their offerings. But I would imagine they're probably right up there with the Epics and I think there's a couple of others.

Tegus Client
Okay. When you say payers embedding widgets and injecting their information into the EMRs, is it going both ways. What I mean by that is, obviously, to the extent that you can either from an administrative simplification point of view, just go in and scoop up information for clinical information for a prior auth, that's a value-added opportunity.

Also just payers in general, obviously be interested in getting closer to the clinical and near real-time understanding what's going on with their members. But I can understand the providers could be a little bit reluctant to allow payers that kind of insight. So when you say we're pretty far along, you talked about the widgets. What about the payers' ability to pull data in? It sounds like the push data is there.

Vice President of Value-Based Care at UnitedHealth Group
The push data is there. The pull data is the barrier. You have work done from individual provider groups . And depending on the legal aspects of it, if you want to access EMR data, you have to go to the individual groups and then they have to turn it on through their EMR. So even if they have Epic, you have to have an individual contract.

In some states, the legality is not as intense and you could make an arrangement with Epic in general, turn around for all of the state within it. I think there's some other probably process to follow. But regardless, at the provider level, if they don't want to share their data, they don't turn it on. So that is a barrier.

Tegus Client
So, is there some segmentation or a way you can describe those drivers that seem more interested in turning it on versus those that aren't?

Vice President of Value-Based Care at UnitedHealth Group
There are various reasons for not turning it on. So they see payers as big brother. They do not want to be questioned on their decision-making. They may actually be doing something wrong and they know it, and then they definitely don't want you to have access. They may want to be paid for this data, and that's probably the most widespread reason for not granting access. I'm sure there's a handful of others, but those are the ones that I hear from providers in the marketplace.

Tegus Client
Is there an element where you've seen providers turn us on for certain payers and not for others? So if we have an unusual prior auth, usually close relationship around Medicare Advantage lies with, say, Humana and United, they'll turn it on for Humana and United, but not for the local Blue, for example, does that sort of thing happen? Is there some cherry picking and strategic relationships emerging around this?

Vice President of Value-Based Care at UnitedHealth Group
I would say that, that probably happens but I don't see that being prolific, from my understanding.

Tegus Client
Is this something new? Because how quickly has this happened over the course of the last couple of years? Or am I just new to the game, and this has actually been around for a long time? This ability particularly for payers to push and inject directly into the workflow.

Vice President of Value-Based Care at UnitedHealth Group
It's relatively recent. I would say probably United was one of the first to do it with a platform, and I'm blanking on the platform that they bought. It was an actual acquisition, it's all public data. So that was our first foray into it. And then they got smart and just like other payers are going directly to the EMR systems

and then building their widgets together. So I would say it's becoming a lot more adopted over the last three years.

Tegus Client
And I know United has got something called point-of-care assist, which sounds like it's basically the widget that makes this information available to the provider. Am I right in that? Is that kind of like the thing we're talking about when we talk about like a widget that can provide information, get information in the hands of providers?

Vice President of Value-Based Care at UnitedHealth Group
POCA, Point of Care Assist.

Tegus Client
Is there a sense that you were able to provide about like the degree to which there is a compliance alignment use of these widgets by providers? Or do they just end up being classified as like you had another alert fatigue and sort of like pushed aside and ignored?

Vice President of Value-Based Care at UnitedHealth Group
I think this is where your value-based care arrangements come into play, whatever payer you're working with, in order for us to not become alert fatigued, you have to really understand what arrangements do I have in place.

So I'm going to work the arrangements that I'm getting paid for. I'm going to work these alerts for patients who have a value-based care arrangement, whatever that is, risk, maybe I'm getting paid per click, what have you, maybe it's some Medicare Advantage or doing stuff like commission work.

So I think that where the industry has a lot of opportunity to make sure providers are educated on what arrangements they're actually in, right? You talk to an individual provider in a medical group. They might say, "Yes, I'm in value-based care arrangements. I don't know which ones. I don't know which payers," likely they know that they're probably getting more money for Medicare Advantage somewhere along the way.

But do they know Blue Cross Blue Shield versus Aetna? So I think that's an opportunity. Providers don't want to have to do that, they want to honestly go in, talk to their patients regardless and do the right thing regardless of what insurance the patient has. They want to see the patient in an agnostic way.

Tegus Client
I imagine there's also something with some of the more sophisticated providers where they're also incentivizing the individual physicians. If you got somebody basically that's on an RVU compensation basis, they're not going to spend a lot of extra time doing something like little click thing because they want to get the turns as opposed to somebody that's actually like paid on like ED visits per 1,000 admins per 1000 kind of basis and they'll spend much more time on those kinds of things.

Vice President of Value-Based Care at UnitedHealth Group
Absolutely.

Tegus Client
Are all payers equally sophisticated in their use of these kinds of widgets? So, I would imagine Humana, United Medicare Advantage are sort of at the pointy spear. And if I were to go to Blue Cross Blue Shield, I would say they would be saying like, “Am I right in that?”

Vice President of Value-Based Care at UnitedHealth Group
Absolutely. The main players are leaps and bounds ahead of these other ones they choose to go.

Tegus Client

Is the threshold basically like the classic national threshold like the top five and maybe it will throw in like Centene and Molina there to the extent that they want to do this like with their Medicaid lives? Or would you put HCSC, Blue Cross Blue Shield of Michigan, maybe Blue Shield of California kind of in this camp too, that they've kind of figured this out and are making it work?

Vice President of Value-Based Care at UnitedHealth Group
Yes, I'm not as familiar with the Blues to be able to speak to it. My general understanding is they're not in this space, they're not as sophisticated as the top dogs. But they might surprise me.

Tegus Client
There can be more specific, even among the mid to regionals. So this strikes me as something that's potentially hugely valuable for a variety of reasons. Is that true? Or is this just like kind of an incremental like lift that we get like a little bit more like on the risk adjustment or a little bit more on compliance, stuff like that.

Vice President of Value-Based Care at UnitedHealth Group
No, you're totally right. If this is executed well in the way it's designed, you really can be very targeted with whatever is important to you. If risk recaptures your thing, you can be hyper targeted. If population health, value-based care is your thing you could also be targeted there, pointing gaps in care, specific best practices, evidence-based guidelines. In that area, there's a little bit less movement and more of the areas where you're going to see your revenues or your gaps.

Tegus Client
You mean STARS performance?

Vice President of Value-Based Care at UnitedHealth Group
STARS performance, your risk recapture. What I would say is that I would like to see, and I think this is trending as specialty, preferred specialist. I think that's trending in the market. That's also an avenue for appointing members, the appropriate power providers and power providers who are also lower cost, higher quality, there's a huge value driver there.

Tegus Client
When you said “power providers”, what does that mean?

Vice President of Value-Based Care at UnitedHealth Group
I meant participating providers with an insurance organization.

Tegus Client
Pointing members to an appropriate specialist totally get that, but you're saying we're actually going to use the widget to try to tell I'm referring doc, primary care doc, "Oh, you want to send to an orthopod. Here's the ones that we'd like in effect, we think are good." Is that what you're talking about?.

Vice President of Value-Based Care at UnitedHealth Group
Yes, Athena is doing this, and it's doing that very well.

Tegus Client
Interesting because Epic, I could imagine that Epic just being part of big integrated systems, referring doc wouldn't take too time necessarily being directed to somebody outside their system because that would be leakage, so they get their risk slapped.

Athena, I think about as being probably as more penetration in sort of smaller independent primary care and practices maybe more agnostic or open to suggestions on where to refer a patient. Am I thinking about that the right way?

Vice President of Value-Based Care at UnitedHealth Group
Absolutely.

Tegus Client
So it sounds like what you're also suggesting is that for Athena, "Hey, this is something we can do for your payers." Obviously, it helps the provider side, and I'm just seeing this to loud with you because if they're risk-based arrangements, they're perfectly happy to send somebody to an orthopod that isn't going to ride away resort to surgery, fascinating. Do the EMRs charge?

Vice President of Value-Based Care at UnitedHealth Group
There's a lot of vendors that are doing referral management, focused EMR builds as well.

Tegus Client
Do they really have a hope? These vendors?

Vice President of Value-Based Care at UnitedHealth Group
Yes. So the vendors also seem to have other offerings. So it's an EMR add-on but it's also some kind of support mechanism to help support with referrals, whether it's a crew of people on the back end to help you coordinate better appointments, faster appointments, facilitate appointments, what have you. So it's always the EMR add-on, but it's something else, too.

Tegus Client
Can you name a few of these vendors just so I can investigate them?

Vice President of Value-Based Care at UnitedHealth Group
I can name one that I don't have a material partnership with that it would be appropriate for me to share. Because they're not getting a lot of attention, but there's still the marketplace out there for them. There's still some market share.

Tegus Client
So, you say this is kind of like a hot area around specialty. Is there anything else that you would point to as something that's kind of hot right now? Or is that really where the energy is?

Vice President of Value-Based Care at UnitedHealth Group
Total cost of care is hot right now. Especially in Medicare, you're going to see a trend, a shift from these health plans really sucking all of the revenue that they can out and really focusing on revenue only, rather than revenue and savings.

So now there's going to be a trend towards continued focus on revenue but really how can we start to lower the total cost of care for these Medicare members. And historically, almost no Medicare health plans have done that because the funding has just been so rich. They haven't needed to. But I think we're going to see a trend in the next few years, especially as we continue to see these boomers everybody is aging in.

Tegus Client
Does that add a layer of providers that actually can be more successful on value-based care? Like Humana, who put out a publication for you to see on their value-based care, and they talked about it, I think only about 20% of their MA members are in fully capitated arrangements. So maybe that's a big number. I don't know, but it's been stable for the last five, six years. So it seems like they have trouble getting beyond that 20% into getting more providers like up speed on capitation.

This ability to inject this information into the provider workflow more directly strikes me as it may be a significant enabler and actually allow you to get more providers, so it would be like functioned well in value-based care because it's made easier for them. Do you see that? And if so, is this at all linked? And I don't

know what you can share publicly about your virtual ACO stuff that you've been doing. Is it connected at all with the virtual ACO stuff that you've been doing in particular?

Vice President of Value-Based Care at UnitedHealth Group
I can't share anything about my current work. But one day, you'll see it in publications, I'm sure. I honestly do think that this pushing data is one lever of getting everybody up the risk continuum. I think it's critical, but there's so much more to it. There's provider behavior change. And whether that's going to be stimulated by how they're paid from their groups or you're going to have to change how patients behave as well.

And that's going to be driven from benefit plan design. It's going to be changed from the providers themselves. It's so multifaceted. But yes, this is a critical cornerstone to continuing towards that path.

Tegus Client
This Epic Payer Platform or these EMR services, do they charge the provider for standing up this kind of an interface? Or do they charge the plan? Do they charge both? Are they learning from the PBMs and charging both sides. How does that work just from a business point of view?

Vice President of Value-Based Care at UnitedHealth Group
The understanding is that it's not the health plans. This is the insurance companies at the highest level, almost like a corporate funding level are paying for this directly to Epic. So we go straight to Epic, and we pay for the design and the build and then the push. And so there's really should be no cost to the providers, at least as far as my understanding is to turn this on. They just must turn it on. The name that I can share with you is Stellar Health, in relation to the referral management and clinical workflow.

Tegus Client
As you've been around, I want to make sure that I probe on this. New and creative product designs for the small and medium businesses. What I'm wondering about is I'm thinking about like level-funded, different kind of risk carve-outs, various kinds of creative approaches that particularly the National seem to be using to pull in groups that aren't fully insured, that may be open to a differentiated value proposition. Are you tracking that at all? And if so, what would you list off of some of the more creative designs that you see being used in the marketplace?

Vice President of Value-Based Care at UnitedHealth Group
Yes. I'm tracking to that a little bit. What I'm really enjoying seeing just because I live and breathe in population health is the designs that are reducing the co-pays for primary care provider visits across the board and moving towards more of a wellness model, you can actually see your primary care provider as many times as you want, and you're not going to have a copay.

It reduces ER use, reduces urgent care use that actually improves the continuity of care because you're not having patients bounce around from facility to facility. So, I really appreciate a focus more towards building wellness instead of a reactive model to health care.

Tegus Client
I totally get what you're saying and I get the idea of sort of no charge for visits to primary care. Are there other aspects of that you've seen beyond that, that planned clients can do?

Vice President of Value-Based Care at UnitedHealth Group
Yes. I guess I would need to or want more information. It really comes down to knowing your population. So what is the population that you're trying to solve for? Are they higher economic status? Are they lower economic status? What is their health, education, their health status overall? What's the risk, the age of the population.

I've recently seen, some plan designs around value-based care organizations, and it's kind of an HMO-type style, but you can only see value-based care or specific value-based care organizations for the carrier, that's been interesting.

Tegus Client
Do you see anything where the employer has directly contracted primary care and that there's been a sort of a product built around that? It sounds a little bit what you're saying in terms of networks built around BBC or like a SenTiva model or something like that. But we've also heard that sometimes employers will bring in like the workplace clinic or one medical directly contracted primary care into building a product around that. Have you come across that at all?

Vice President of Value-Based Care at UnitedHealth Group
Michelin did that, and they were proud of their success. They came and presented to a conference I attended. I see some barriers to that model. There's a distrust between patients and their employers. There's a level of risk or you could call it big brother. “I don't want XYZ to know my cardiology status”. So I think there's probably pros and cons. I did some research on that Michelin model and actually it works for them, it's not going to work everywhere. And that's what goes back to the population that you're serving.

Tegus Client
One last thing I just want to throw at you in the time we've got. Provider quality, there's several different major vendors that are out there that do this thing, notably Grand Rounds/Included Health and Bold. I don't know, half a dozen others.

I encountered mixed views about whether people really think they've got it figured out or whether it's all basically smoke and mirrors. What is your take on that at this point? Those vendors, have they really got a good eye at this point on who are high-performing providers? Or is it still pretty unclear and you get different answers from each vendor?

Vice President of Value-Based Care at UnitedHealth Group
I haven't really heard of many vendors doing this. Payers, they have the cost and quality data. So combining that, if you could feed a vendor all of that same data and do it across a market, that would be great, you would have the true view of how a provider performs for the full population.

So I would say that's the limiting factor. Of course, Medicare data is available publicly. Of course, it's identified, and you could essentially get the data out there and do this on your own if you wanted to, but it's only a subset of the population.

Tegus Client
It sounds like you're saying it could be done, you have to get it big enough and if you've got sample size, and that's the major limitation you see.

Vice President of Value-Based Care at UnitedHealth Group
Right.

Tegus Client
Thank you very much. I appreciate your patience, you’ve been really helpful. Have a great rest of your day.