UNITEDHEALTH GROUP®

North Carolina Medicaid Reform

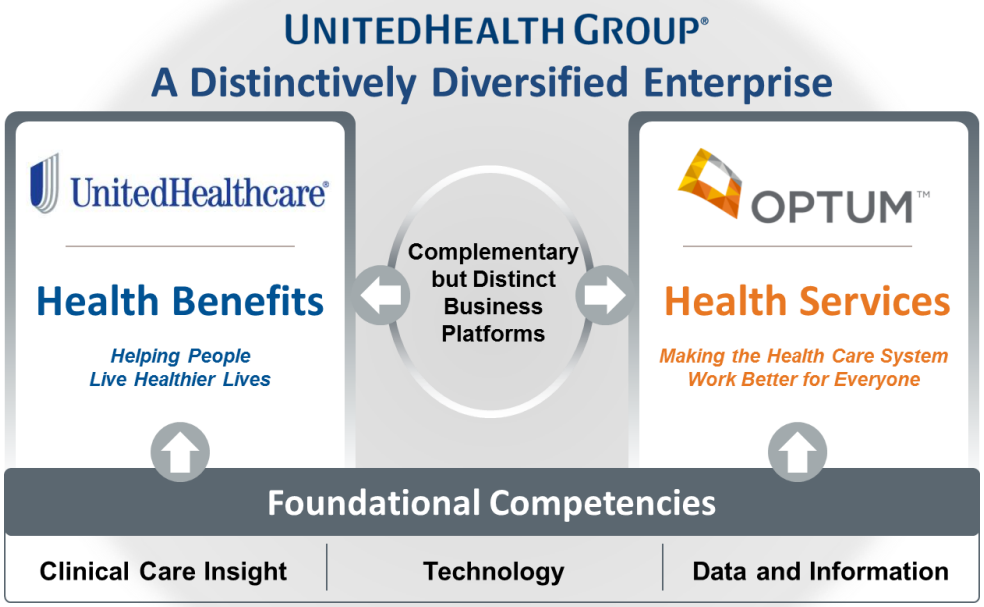
Presentation to the
North Carolina Medical Care Commission

UnitedHealth Group
February 11, 2015

Agenda

- UnitedHealth Group in North Carolina
- Overview of Approaches to Manage Medicaid Populations
- Experience from Other States

UnitedHealth Group: Creating a More Aligned, Innovative, and Efficient Health Care System



- Workforce of Nearly 183,000 People
- 58,000 Physicians, Nurses, and Clinical Practitioners
- 14,000 Technologists
- Added More Than 84,000 Jobs in the Last Five Years
- Serve 85 Million Consumers, 200,000 Plan Sponsors
- Provide $53 Million in Philanthropic Initiatives Annually
- Ranked No. 1 in Innovation and First Overall in the Sector on Fortune's List of the World's Most Admired Companies

- Fortune 14 Company and 39th Largest Company in the World
- Invest Over $2 Billion in Technology and Innovation Annually
- Manage More Than 31 Million Personal Health Records
- Manage More Than 450 Billion Transactions a Year
- Database of 200 Million Consumers
- Optum Bank has Nearly 3.1 Million Consumer Health Accounts
- OptumRx Processes Nearly 600 Million Adjusted Retail, Mail and Specialty Drug Prescriptions Annually

UnitedHealth Group: Committed to North Carolina

UnitedHealth Group in North Carolina

- **Employs More Than 5,000 People**
  - **Optum:** 3,050 Employees
  - **UnitedHealthcare:** 2,000 Employees
- **Serves:**
  - **657,300** People Through Individual or Employer-Sponsored Coverage
  - **173,00** Medicare Advantage Beneficiaries
  - **182,200** Part D Beneficiaries
  - **2,300** Active Duty Service Members, Veterans, and Their Families
- **8 Office Locations**
- **Contributes More Than $396 Million in Annual Financial Investments**

Key Optum Customers in North Carolina

Old Dominion Freight Line
Novant Health
Lowe's
Duke Energy
Vidant Health
Snyder's-Lance

Key UnitedHealthcare Customers in North Carolina

U.S. Airways
LabCorp
Duke Energy
GlaxoSmithKline
Cisco
Corning
Greensboro

UnitedHealthcare: Helping People Live Healthier Lives

UnitedHealthcare is Comprised of Five Business Segments Serving Nearly 45 Million People at Every Stage of Life

UnitedHealthcare EMPLOYER & INDIVIDUAL | UnitedHealthcare MEDICARE & RETIREMENT | UnitedHealthcare COMMUNITY & STATE | UnitedHealthcare MILITARY & VETERANS

- **UnitedHealthcare serves:**
  - **25.9 million** people through individual and employer-sponsored plans
  - **10.5 million** seniors, including **3 million** Medicare Advantage members
  - **5.1 million** Medicaid beneficiaries, including **2.5 million** children
  - **2.9 million** active duty service members, veterans, and their families
  - **4.4 million** individuals internationally

- UnitedHealthcare's network includes nearly **855,000 physicians and care professionals**, approximately **6,100 hospitals and other care facilities**, and more than **295,000 dental access points**

- UnitedHealthcare Medicare & Retirement is the **largest U.S. business dedicated to the growing health care needs of seniors**, providing innovative Medicare Advantage plans, Medicare Part D plans, Medicare Supplement plans, and retiree services

- UnitedHealthcare provides benefits for State employees and/ or State retirees in **19 States**

Optum: Making the Health System Work Better for Everyone

Working Collaboratively Across the Health Care System, Optum Drives Consumer Engagement, Aligns Care Delivery, and Modernizes the System Infrastructure for Those who Need Care, Those who Provide Care, and Those who Pay for Care

Who Optum Serves

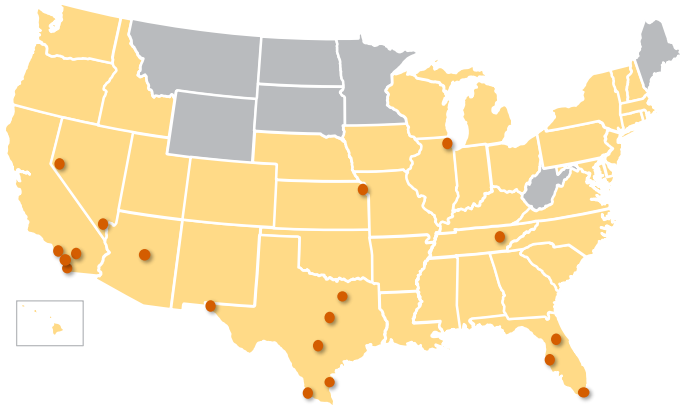
- More than **63 million** individuals
- **Four out of five** U.S. hospitals
- **88,000** physician practices and other health care facilities
- **67,000** retail pharmacies
- **300** health plans
- **200** global life sciences organizations
- **350** government agencies
- More than **30 million** people with pharmacy benefit management services

Optum partners with **35 States and the District of Columbia** to provide solutions that transform the entire health ecosystem, including around **program integrity**, **data warehousing**, **Medicaid**, **health information exchanges**, **clinical management**, and **behavioral health**.

Optum's LHI provides medical services for the U.S. military throughout the course of the service member's career – from enlistment through retirement. In 2013, Optum's LHI provided more than **1.9 million** health care services and served nearly **480,000 service members and veterans**.

Optum's Collaborative Care Footprint

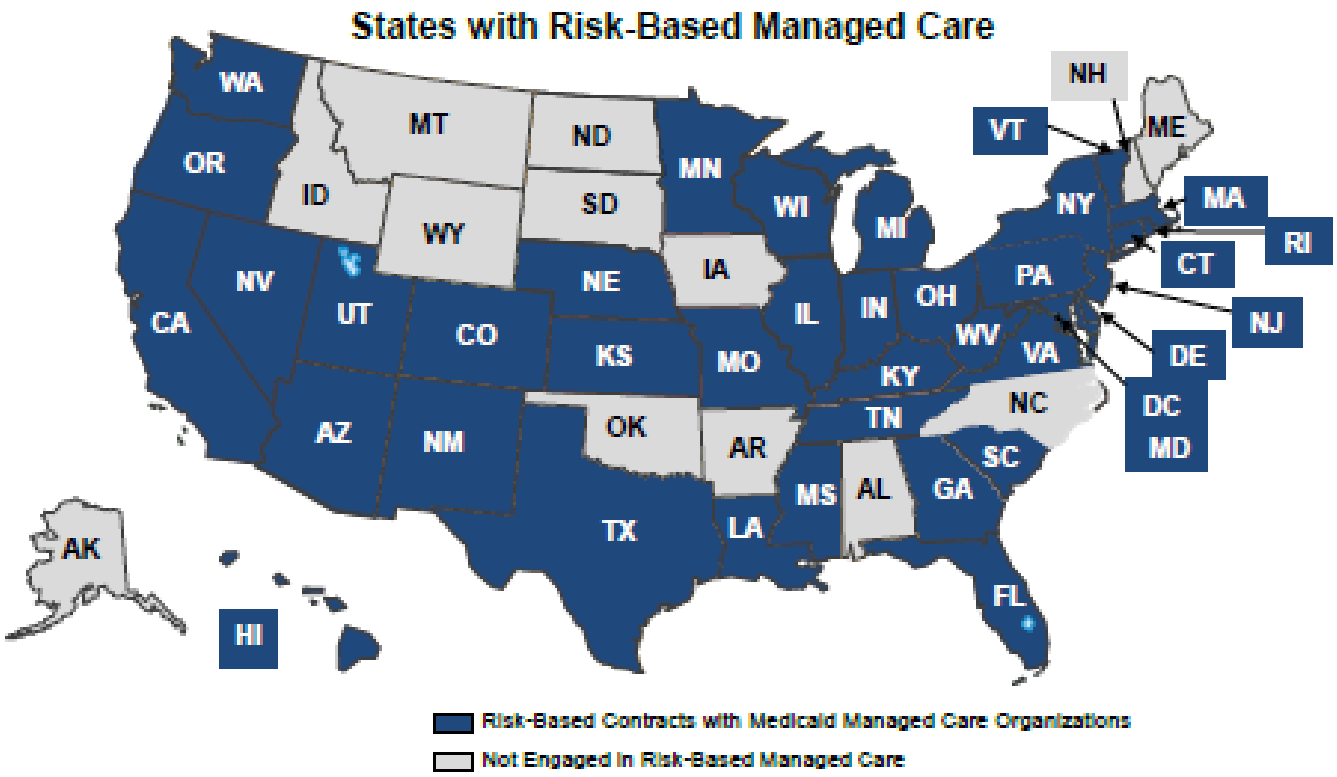
Optum's **Collaborative Care** applies **proven innovations** and **advanced technology** to local care delivery systems and complex care population management services to **simplify the health care system** and **connect patients to an entire care community** that fits their individual needs.



Southwest Medical Associates · WellMed · AppleCare Medical Management · NAMM California · Monarch HealthCare A Medical Group, Inc. · Memorial Healthcare

Medicaid Managed Care Across the States

Nearly 75 Percent of States Have Adopted Risk-Based Managed Care to Improve Care Quality and Control Costs



Source: UnitedHealth Group Medicaid Managed Care: Improving Health, Driving Innovation, and Fostering Efficiency

Benefits of Risk-Based Models for Medicaid Programs

- Ability for states to have improved budget predictability and system accountability by transferring risk to qualified partners
- Improved ability to implement broad variety of payment and delivery models to support the continuum of providers
- Increased accountability and transparency for quality and outcomes
- Improved ability to reduce fragmentation and implement whole-person approaches with comprehensive care coordination
- Increased access to robust data analytics tools to improve outcomes
- Ability to encourage innovations to support beneficiaries and transform delivery

Budget Predictability, Shifts Risk and Accountability

- Under a risk-bearing model, a State pays a capitated amount to a qualified entity for each enrollee.
  - Typically rates differ by age, gender, and eligibility category to ensure appropriate payment for individuals served by the program
- The capitation shifts the financial risk away from the State and incentivizes the qualified partners to adopt innovative tools that improve outcomes and efficiencies
  - For example, risk-bearing entities can leverage sophisticated data analytics to target disease management programs or consumer engagement strategies
- Through advanced analytics, historic trends and utilization patterns are analyzed to anticipate future demands, estimate impacts of emerging trends, technologies, or other initiatives impacting costs and appropriately align services to support beneficiaries
- Risk-based models also consolidate administrative responsibilities thereby reducing costs while allowing the State to focus on appropriate oversight rather than delivery of services

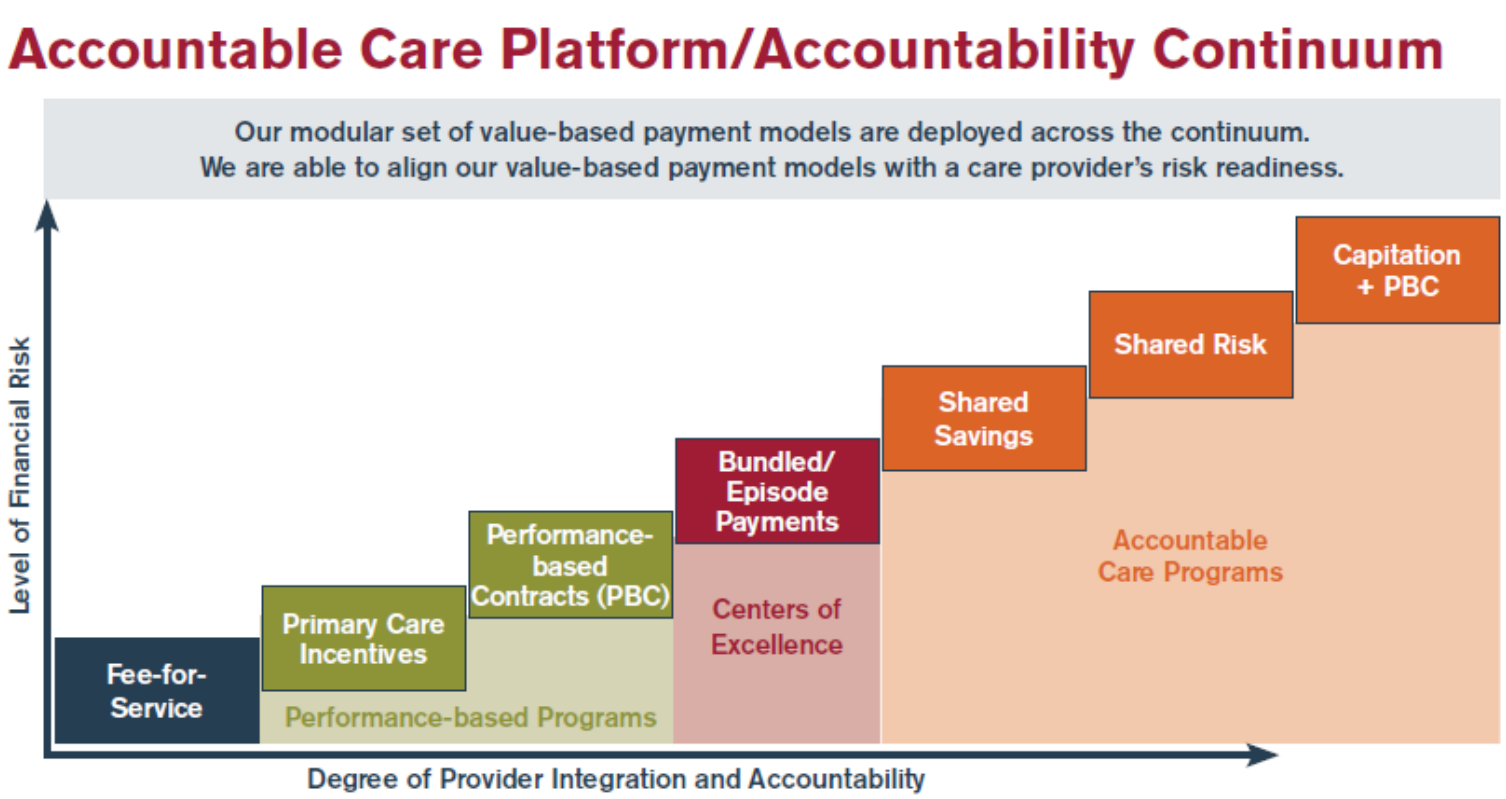
Risk-Bearing Model Serves as Foundation to Delivery

- The development of a risk-bearing approach is fundamental to improving the sustainability of a State's Medicaid program
- The delivery of services can provided by managed care organizations, risk-bearing provider organizations, or a combination of the two
- Based upon the creation of a risk-bearing model, states can partner with qualified entities to meet the goals set forth by the state
- Qualified entities should at a minimum:
  - Have financial ability to bear risk and protect the program's viability with adequate reserves
  - Have experience engaging members and improving utilization
  - Have resources to drive innovation
  - Have capability to provide whole-person care and engage across a broad continuum of health care and social service providers
  - Have access to tools to identify beneficiary and population needs and support systemic improvement

Critical Elements for Transitioning Risk-Bearing Organizations

- Establish ongoing partnership and collaboration with providers taking on risk
- Meet minimum financial and non-financial requirements
- Build a robust network in partnership with providers that meets State network criteria and supports covered services, credential and train providers, and support provider hotline and quality improvement efforts
- Provide member services including education/outreach and call centers
- Conduct care management activities and support coordination/interaction with providers' offices
- Implement disease management and clinical programs
- Collect and analyze quality performance metrics and drive improved health outcomes
- Implement a robust IT system to process and pay providers, leverage data and maintain data registries, support member engagement and improved health outcomes, and meet program integrity requirements
- Meet all other state and federal requirements

Risk-Bearing Provider Organizations



Risk-bearing models with provider delivery approaches fall on the farthest place on this continuum. Developing risk-based provider organizations may take time, but should move to capitation to truly support a state's risk-bearing model.

Collaboration and an ongoing partnership with providers is key for success.

State Experience: Florida

- Historically supported its Medicaid program through a combination of Medicaid Managed Care, a Primary Care Case Managed (PCCM) Program (known as MediPass), and Provider Sponsored Networks (PSNs)
  - Neither MediPass nor the PSNs were risk-bearing entities
- In 2013, the State eliminated non risk-bearing options by eliminating MediPass PSNs to become risk-bearing models.
  - The State also developed Children's Medical Services Network and Specialty Health Plans as part of the 2013 reform
- Participation is mandatory for TANF populations and the aged and disabled, with some exceptions
- Benefits include physical, behavioral, substance abuse treatment, dental and transportation
- The State also implemented Managed Care for the Long Term Supports and Services programs through a separate RFP with the same delivery approach

State Experience: Tennessee

- Developed TennCare, its risk-bearing model operated by managed care organizations (MCOs) in 1994
- State limits administrative burden by contracting with 3 statewide MCOs for all medical, behavioral health, and Long-Term Services and Supports (LTSS) – provides continuity of care across all services
- Required all MCOs to become NCQA accredited
  - Incentives for high performance on select HEDIS measures and capitation withholds with returns for meeting performance expectations
- In 2010, TennCare CHOICES LTSS was implemented statewide
  - Although LTSS population was historically included in TennCare, the benefits were included in the program in 2010
  - Including broad populations in program design easily allowed for benefit flexibility and program expansion
- MCO payment rates based on competitive bids within rate ranges

The Impact of Risk-Bearing Approaches

- **Florida**
  - Florida's implementation of its new program is relatively new, however, the managed care pilot initiative produced an annual savings of $118 million from 2006-2010
- **Tennessee**
  - HEDIS scores have risen – gains in 88% of HEDIS measures tracked since 2006, and in 31 of 41 measures introduced more recently
  - Enrollee satisfaction reached 95% in 2011 and has steadily increased from 61% in 1994
  - Annual per capita medical cost trends have been 3% - 4% from 2011-2013, below both national Medicaid and commercial insurance norms
  - Program evolved from dealing with volatile, poorly capitalized health plans to more stable, well-capitalized contractors

Questions?