21st Century Payment/Delivery Reform: What Have We Learned, What Haven’t We Learned?

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Health Industry Forum
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Payment and Delivery Innovation

• Past: Centers of Excellence for Uncommon Conditions (United Resource Networks)

• Present: Scaling Integrated Improvement and Payment Strategies
  ▪ Performance Transparency (UnitedHealth Premium)
  ▪ Incentive Alignment (Practice Rewards)
  ▪ Patient-Centered Medical Home (PCMH)

• Future: Ongoing Innovation and Progressive Reach of Performance-Based Payment
  ▪ Episode-based payment models
Centers of Excellence for Uncommon Conditions

- Industry first – began in 1986
- Largest network of its kind
- Utilized by other insurance companies, health plans, and governments across the country
- Through United Resource Networks, we offer services in:
  - Transplant
  - Congenital Heart Disease
  - Complex Cancer
  - NICU
  - ESRD/CKD
  - Bariatric Surgery
  - Infertility
Volume-Outcome Variation in Heart Transplant

Transplants that took place at 120 hospitals between 1/1/02 – 6/30/04
Source: UNOS Data (January 2006), OptumHealth Analysis (April 2006)

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Quality/Cost Dividends from Transplant COEs

Transplant Risk based on Milliman 2006 projections, including Evaluation, Procurement, Hospital, Physician, 365-days of follow-up, Immuno-suppressants. OptumHealth average paid charges based on 3,682 transplants over 2005, per Milliman methodology.

Illustrative Per Million Lives

Transplant Risk: $53.2

Reduction of Incidence: $11.2

Reduction of LOS: $3.9

Incremental Discount: $16.4

Estimated U.R.N. Paid: $21.8

59% Effective Discount

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CHD Network-Higher Volume, Better Outcomes

CHDRS Network programs perform more complex CHD procedures and have better outcomes than non-Network programs.
CHD Network—More Patient-Centered, Better Costs

CHDRS nurses coordinate with our customers’ case managers to help educate and guide patients to America’s best CHD centers with significant contractual discounts to deliver clinical and financial value.

**Centers of Excellence Effect - CHD**

- **Current Cost**: $290,000
- **LOS Reduction at U.R.N. COE Facilities**: $111,879
- **U.R.N. Avg. Discount (40.0%)**: $71,248
- **Net Cost**: $106,873

**Effective Discount ($183,127) (63%)**

**Contractual Savings**

**LOS Cost Avoidance**
The quality of care measurably differs between dialysis centers.\(^1\) Many Medicare-certified facilities do not even meet the minimum standards of care for a significant portion of their patients.

### Dialysis Facilities Meeting Medicare Standard\(^2\)

<table>
<thead>
<tr>
<th>Service</th>
<th>Does Not Meet</th>
<th>Meets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia Mgmt. (Hct &gt;33)</td>
<td>34%</td>
<td>66%</td>
</tr>
<tr>
<td>Dialysis Treatment (URR &gt;65)</td>
<td>36%</td>
<td>64%</td>
</tr>
</tbody>
</table>

- **Target COE Facilities**
- **Non-Target Facilities**

**Medicare standard:** > 80% of patients must meet quality parameters

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**Note:** COEs are credentialed along these as well as other dimensions of quality.
Sample of Dialysis Providers in Southern Florida

OptumHealth analysis of dialysis facilities in UHC So FL per Medicare Dialysis Facility Compare Database, 2003. Actual credentialed network may vary.
Centers of Excellence-Lessons:

• “Steering” to high-performers can improve quality and cost outcomes
• COE sponsors can be a “market-maker” for quality and cost improvement
• Low disease prevalence and/or a supply constraint (e.g. solid organs, volume requirements) are key enablers
• Payment is just one piece; clear performance measures, effective patient engagement are just as critical
• The modal medical practice is:
  ▪ Small
  ▪ FFS
  ▪ “loosely coupled” in a system (if at all)
• Significant local heterogeneity of the delivery “ecosystem”
• The “building blocks” for improvement are evolving
  ▪ Performance metrics and associated infra/superstructures
  ▪ Services bundles (ETGs etc)
  ▪ Improvement capacity
• Reforms should anticipate dynamic responses (multi-period game theory)
Transparent Performance Assessment: Schematic

- Improved Efficiency Based on Comparative Benchmarks
- Increased Quality Based on External Standards
- Future Premium Specialties
  - Transplantation
  - Oncology
  - Musculoskeletal
  - Cardiac
- National Networks
- Premium Designations
- Facilities
- Physicians
Performance Assessment: Empirical View

Distribution of Interventional Cardiologist: Atlanta
Bubble size reflects number of Unitedhealthcare cases seen by physician

- Higher Quality, Higher Cost
- Higher Quality, Lower Cost
- Lower Quality, Higher Cost
- Lower Quality, Lower Cost

Efficiency (Cost Compared to Market Average)
Quality Score

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How the Program Works:

24 months of data is collected and analyzed on all physicians in the specialties eligible for designation*

The quality screens are applied based on specialty and, where applicable, condition

Physicians who meet/exceed the quality criteria are designated by a quality star and proceed to the efficiency of care analysis

 Episodes/ procedures analyzed for efficiency of care benchmarking market specialty averages and case mix/severity adjusted

Physicians who meet or exceed market cost criteria are designated

Quality Only Designation

Quality and Efficiency of Care Designation

*Oncologists designated based on responses to a voluntary survey
Cardiac Results: Improved Quality, Increased Pt/Consumer Engagement, Lower Cost Trend

• Cardiac Quality: Improved Q scores (less re-work, fewer complications, higher Rx compliance)
  • Q Cardiologists have a 16% to 32% lower redo rate for stent replacement, bypass rework, implantable replacement/repair at 12 months when compared to MD’s who fail quality.
  • Average CV Surgeon Q score (108.6) up 4.1bps from 2005-6
  • Average Electrophysiologist Q score (107.6) up 2.6bps from 2005-6
  • Average Non- Interventionalist Q score (109.1) up 2.5bps from 2005-6
  • Cardiac Death (Cardiac DRG 123) rate dropped 37% in last 12 months.

• Consumer Engagement:
  • 70.9% of UHC customer access Q &E Cardiologist up from 60.% in 2005-2006
  • 2, 300 out of network cardiac enrollees~ steered 29% to Q and E
  • 6% increase percentage of referrals from primary care MD to Q&E cardiologists (2006)

• Cardiac Cost Trend:
  • 3.7% per year down from UHC trend of 8% (2005-2006)
Early Results: “Academic Detailing” to PCPs

- 5000 PCPs were mailed a letter requesting referrals for UHC members to a Premium Designated “Quality and Efficient” Cardiologist.
- Provided with hard-copy referral list to post at the referral desk (per office feedback)
- Pilot divided up into 4 test groups to study effects of different approaches, with controls
- Results: 6.3% increase in patients referred to a Premium Q&E physician
- Abstract presented at Society of General Internal Medicine April 2007
- 2007 expansion underway to other markets and additional specialties

“academic detailing” to PCPs increases referrals to high-performing specialists
UnitedHealth Practice Rewards: Financial Recognition for higher performance

UnitedHealth Practice Rewards is a financial recognition program for solo practitioners and medical groups who have:

• Met the quality and efficiency of care criteria for UnitedHealth Premium® designation program and,
• Met the more robust criteria for UnitedHealth Practice Rewards.

UnitedHealth Practice Rewards is not a bonus program; rather it is an opportunity for financial recognition of physician performance through fee schedule enhancements.

“In addition, the notion of attaching a single pay-for-performance program to all of a payer's products, as Sandy and Ile describe, is appealing both because of the advantage of larger patient populations with this approach to measurement and because of its simplicity from a provider's perspective.” (Rosenthal and Landon, NEJM 356;872-73)
Using the UnitedHealth Premium quality and efficiency of care assessment results, adding Administrative criteria, and overlaying the robust UnitedHealth Practice Rewards criteria, a physician’s UnitedHealthcare claims data and practice patterns are compared to those of their peers in the same specialty and same market.
UnitedHealth Group and physician groups to launch “medical home” pilot program to reward primary care doctors who improve patients’ total health

MINNEAPOLIS – (Aug. 6, 2007) – UnitedHealth Group (NYSE: UNH), the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP) and the American College of Physicians (ACP) are announcing a pilot program to accelerate the implementation of a primary care model, called the patient-centered medical home, designed to improve patients’ total health and care delivery.

For the first time, UnitedHealth Group, with the support of the professional societies, will provide enhanced payment to reward primary care doctors whose care is based on this model, and who demonstrate measurable improvements in the overall health of their patients.
PC-MH: Reimbursement Model

Reimbursement will be a combined Fee for Service (FFS) and PMPM Fee for all attributed practice patients.

- Enhanced payment derived through improved resource utilization (within the care system).
- Physicians remain on current contracted fee schedules and will be reimbursed based on services provided.
- Monthly PMPM supplement based upon quality, efficiency, and satisfaction improvements.
- PC-MH is grounded in providing more comprehensive and coordinated care; it is not about delivering less care to the patient – it is not capitation.
- We project primary care FFS reimbursement may increase by approximately 10 - 15%.
- Potential upside gain sharing will be explored based on pilot practice performance and actual medical cost savings realized.
Future Payment Strategy Considerations:

- Payment must better align incentives across: plan sponsor, payer, delivery system and patient/consumer
- Payment strategy should align with and reinforce transparent performance assessment
- Strategy needs to tackle: the consumer experience; appropriateness of care; effectiveness; and efficiency
- Administrative feasibility and alignment with CMS are critical considerations
Payment Models Must Account for Local Delivery

"Ecosystem"

- Consolidated
  - Staff Model
  - Flat Rate Per Patient
  - Packaged Services- Gain Share
  - Fee For Service
  - Capitation (Primary)
  - Capitation (Specialist)

- Multi-Specialty Clinic Dominance
  - Cincinnati
  - Kentucky
  - N. California
  - S. California
  - Cleveland
  - Boston

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Future Payment Strategy: Directions

• Incentives for quality, efficiency and patient experience improvement in long-term contracts
• Episode-based payment models
• Tailor payment strategies to local market ecology
Measuring Physician Quality and Efficiency
What is an Episode of Care?

Episode Example

ETG 29: Type 2 Diabetes, with comorbidity (other illnesses)

All clinically related services for a discrete diagnostic condition from the onset of symptoms until treatment is complete.
Payment Reform can:
- Promote greater alignment of incentives
- Signal what’s important
- Facilitate other aspects of a high-performing health system

Payment Reform (probably) cannot:
- Transform fragmented delivery systems
- Address most supply-side issues alone

Is a national model a siren song…or is payment strategy inevitably defined by regional delivery system configuration?