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

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Health Industry Forum
April 10, 2008

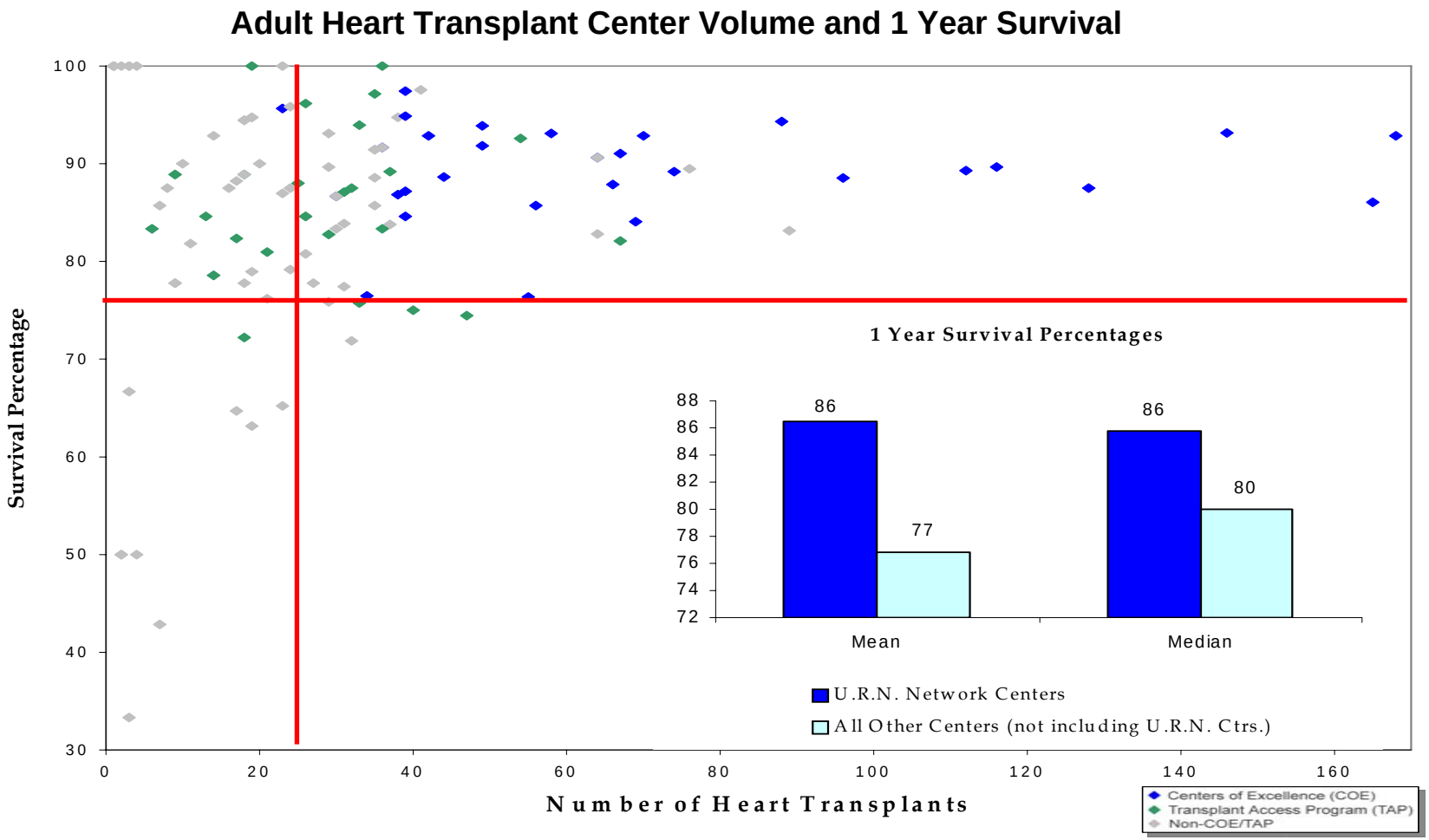
Payment and Delivery Innovation

- 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

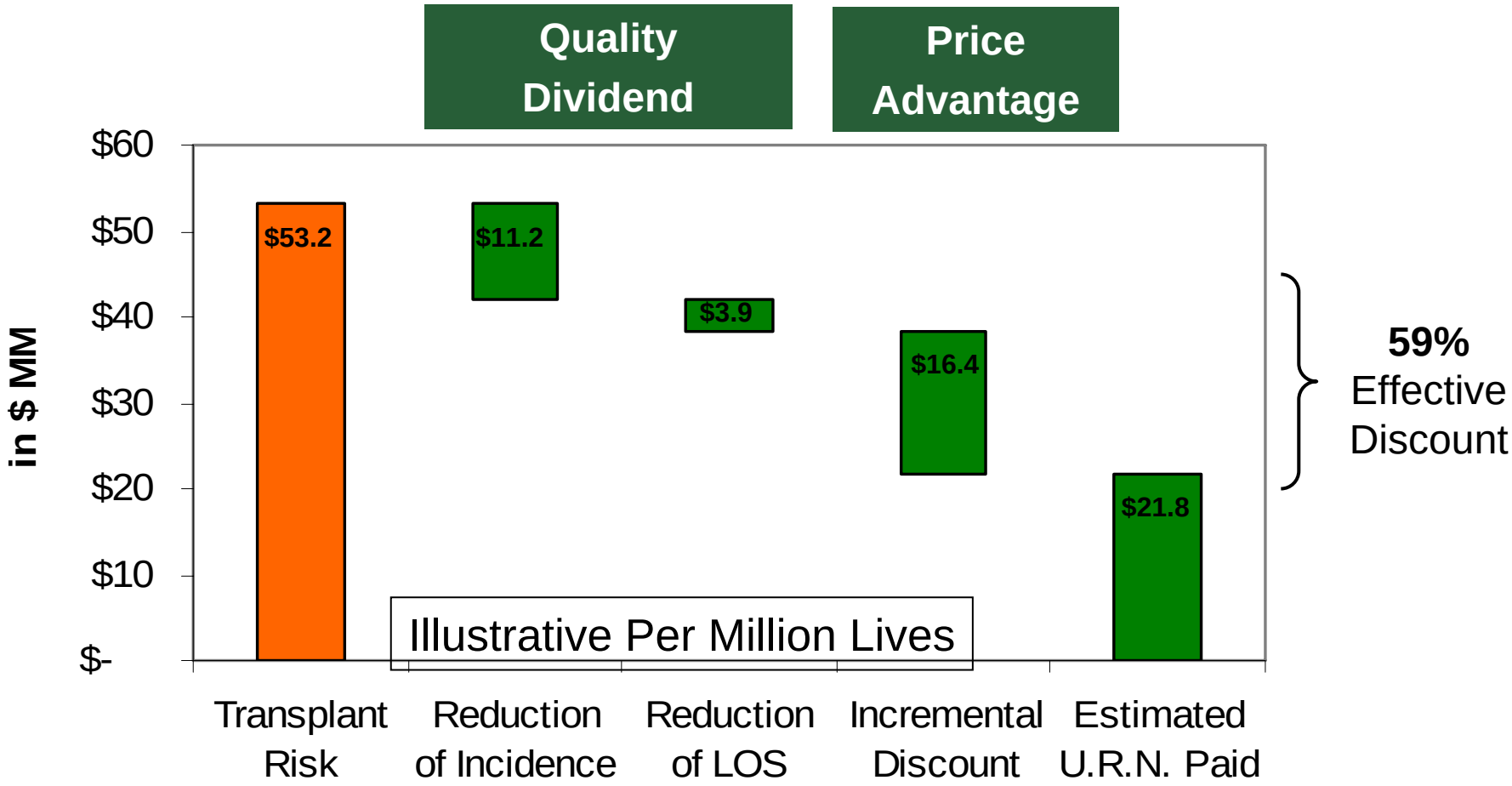
- Industry first – began in 1986
- Largest network of its kind
- Utilized by other insurance companies, health plans, and governments across the country
- Through United Resource Networks, we offer services in:
  - Transplant
  - Congenital Heart Disease
  - Complex Cancer
  - NICU
  - ESRD/CKD
  - Bariatric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

Quality/Cost Dividends from Transplant COEs

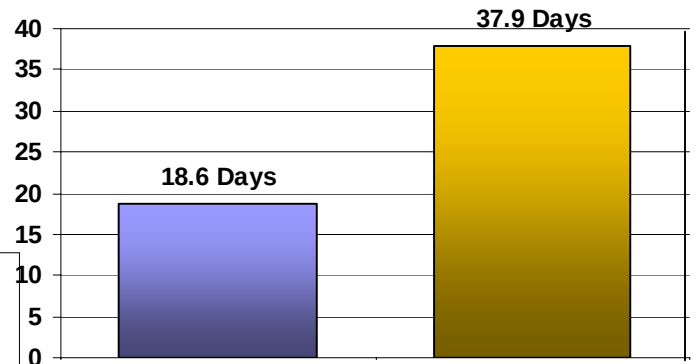


Transplant Risk based on Milliman 2006 projections, including Evaluation, Procurement, Hospital, Physician, 365-days of follow-up, Immuno-suppressants. OptumHealth average paid charges based on 3,682 transplants over 2005, per Milliman methodology.

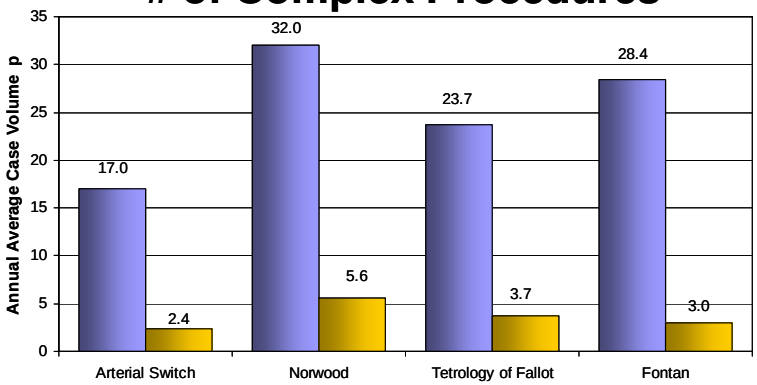
CHD Network-Higher Volume, Better Outcomes

CHDRS Network programs perform more complex CHD procedures and have better outcomes than non-Network programs

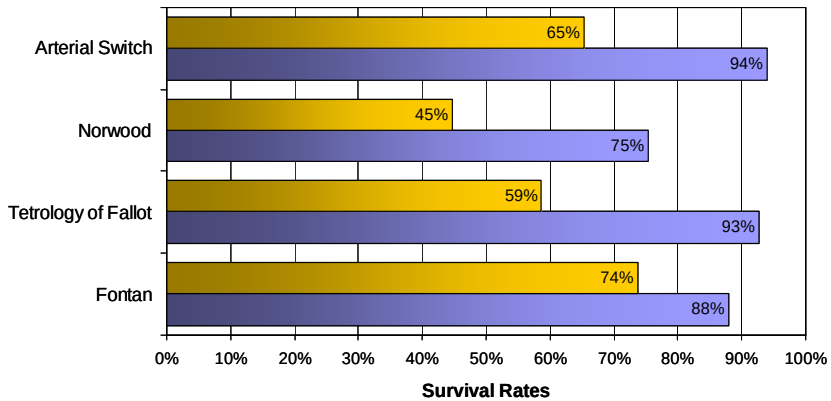
Length of Stay



of Complex Procedures

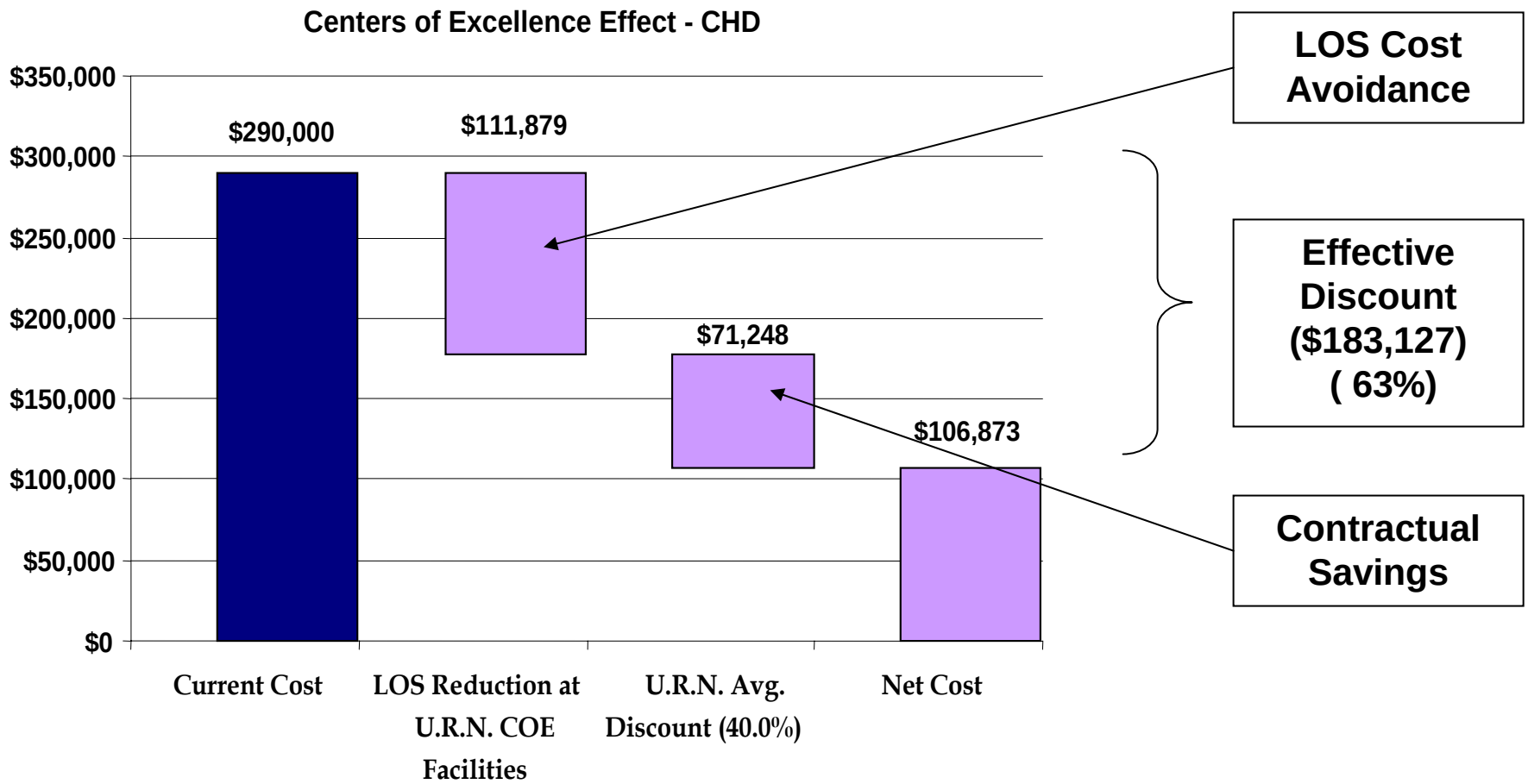


Survival Rates



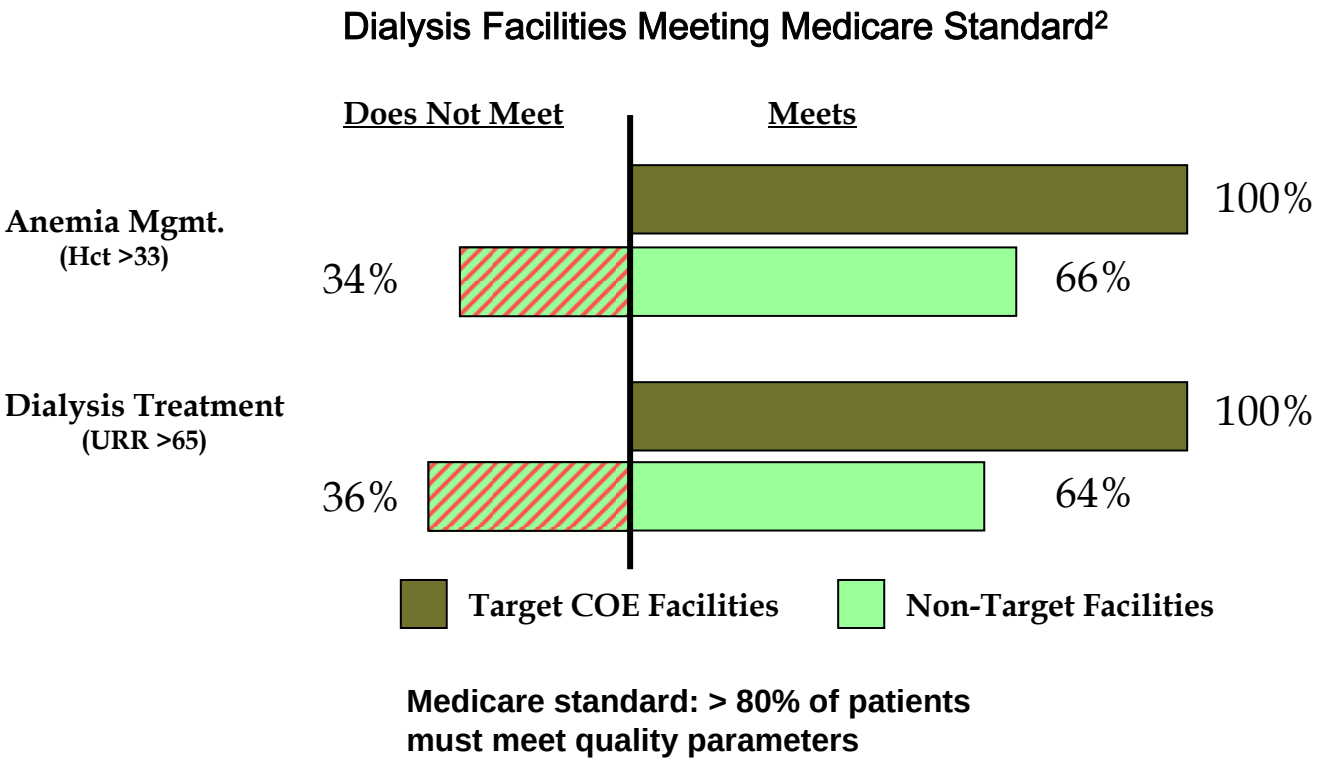
CHD Network-More Patient-Centered, Better Costs

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



Quality of Care Variation Across Dialysis Centers

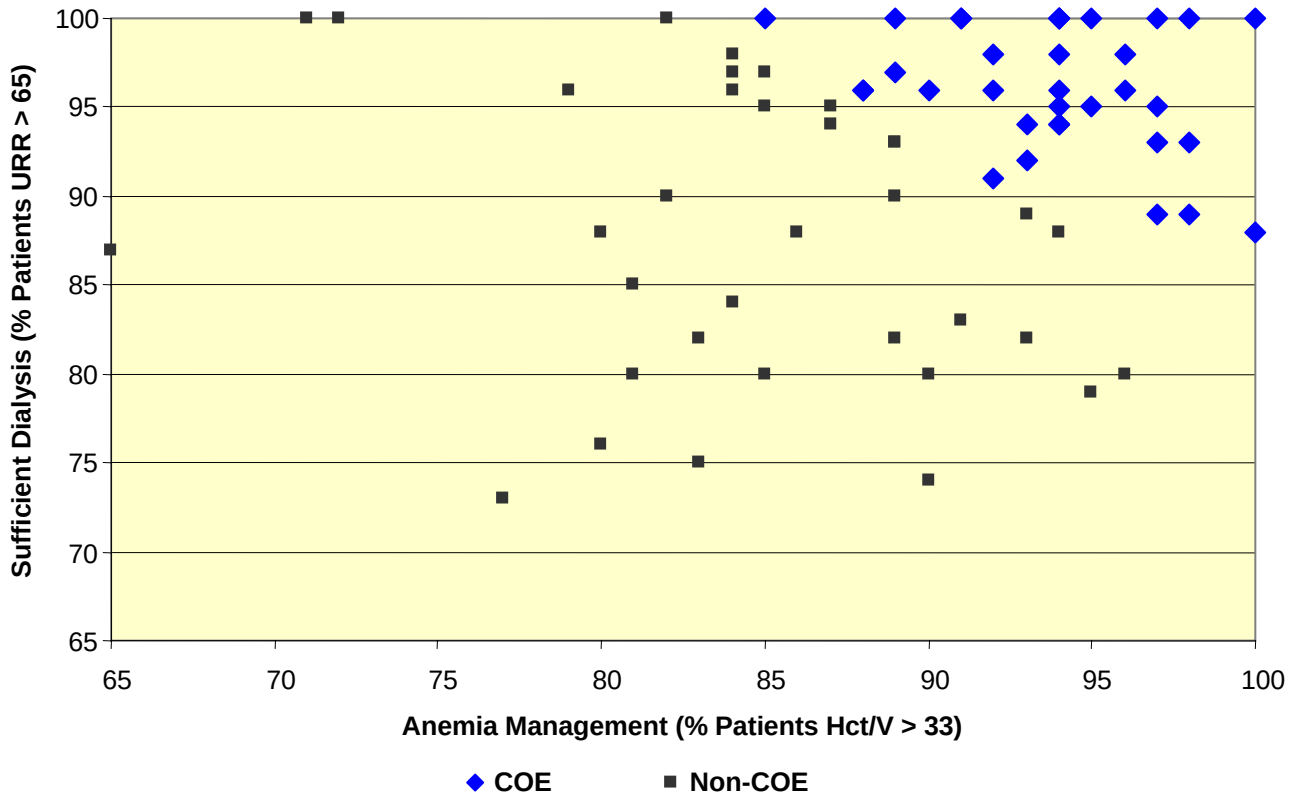
The quality of care measurably differs between dialysis centers.[1] Many Medicare-certified facilities do not even meet the minimum standards of care for a significant portion of their patients.



(1) Fink, et al., J Am Soc Neph, Sep 2002.
(2) U.S. GAO, Dialysis Facilities, GAO-04-63, Oct 2003
Note: COEs are credentialed along these as well as other dimensions of quality.

Market-Level Variation- ESRD

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.

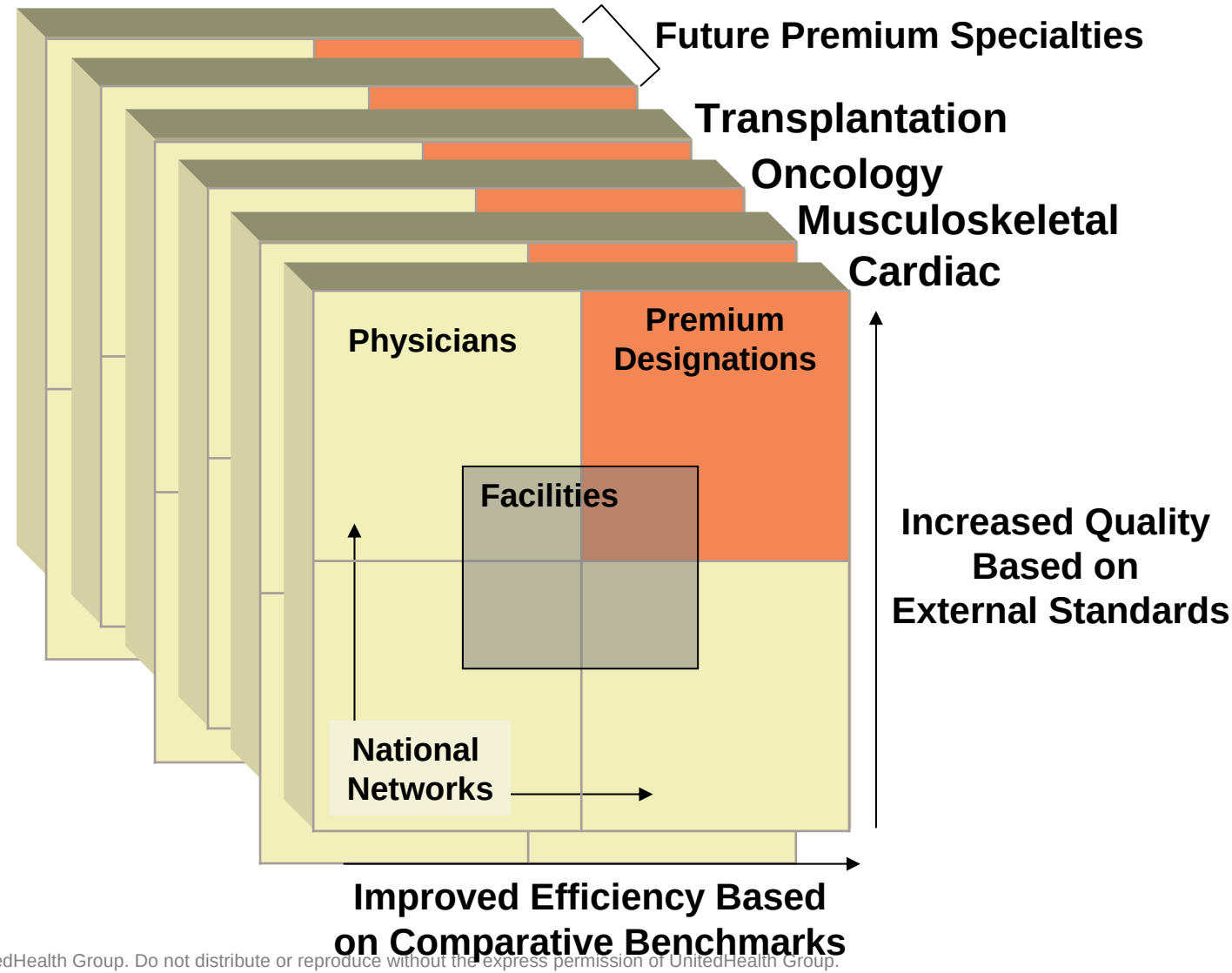
Centers of Excellence-Lessons:

- “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

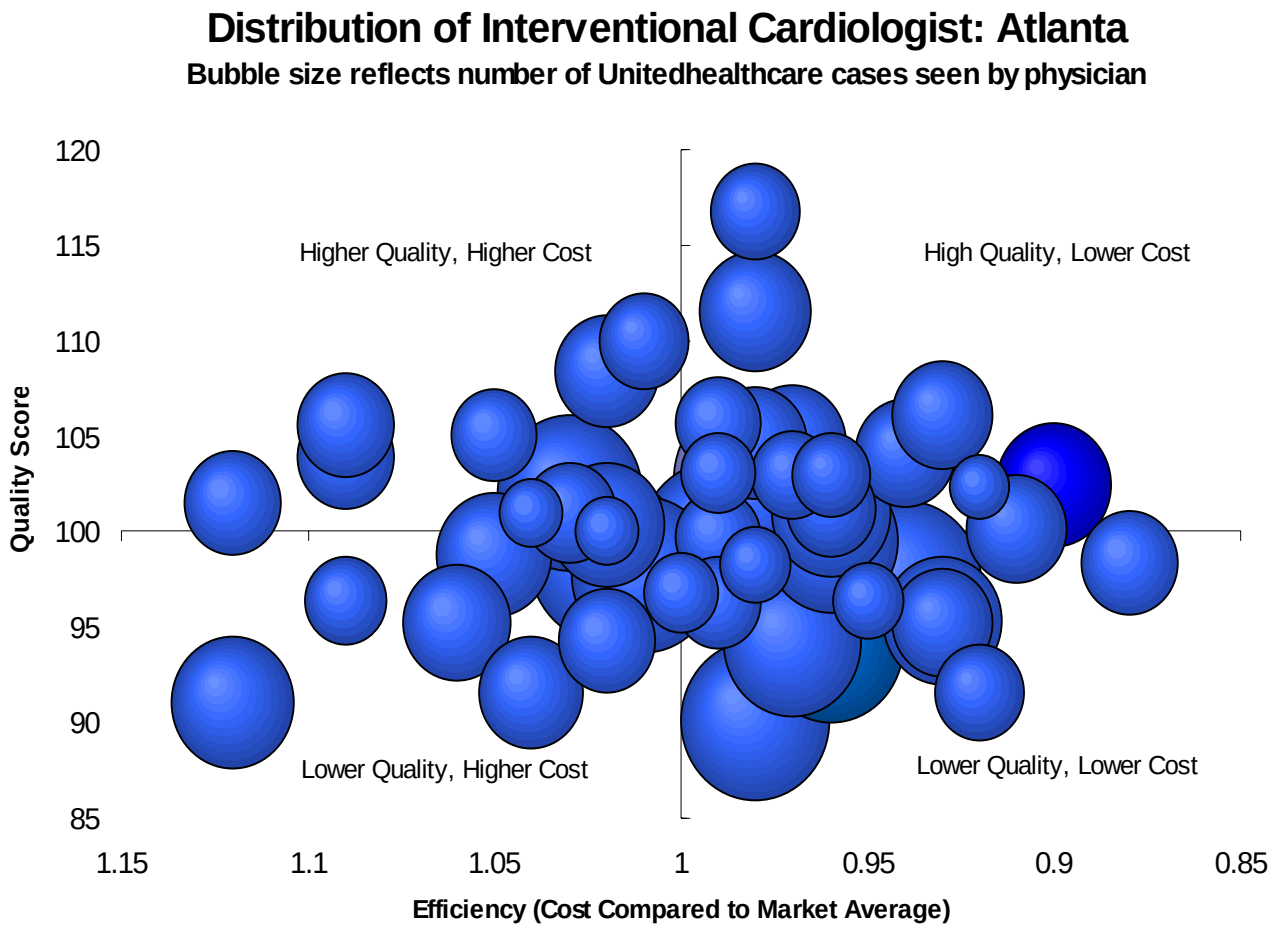
Design Considerations for Scaleable Payment Reform

- 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



Performance Assessment: Empirical View



How the Program Works:

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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 and Efficiency of Care Designation

Quality Only 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

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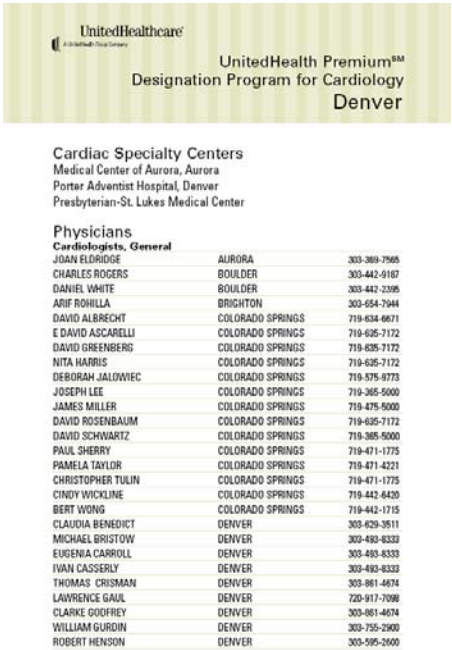

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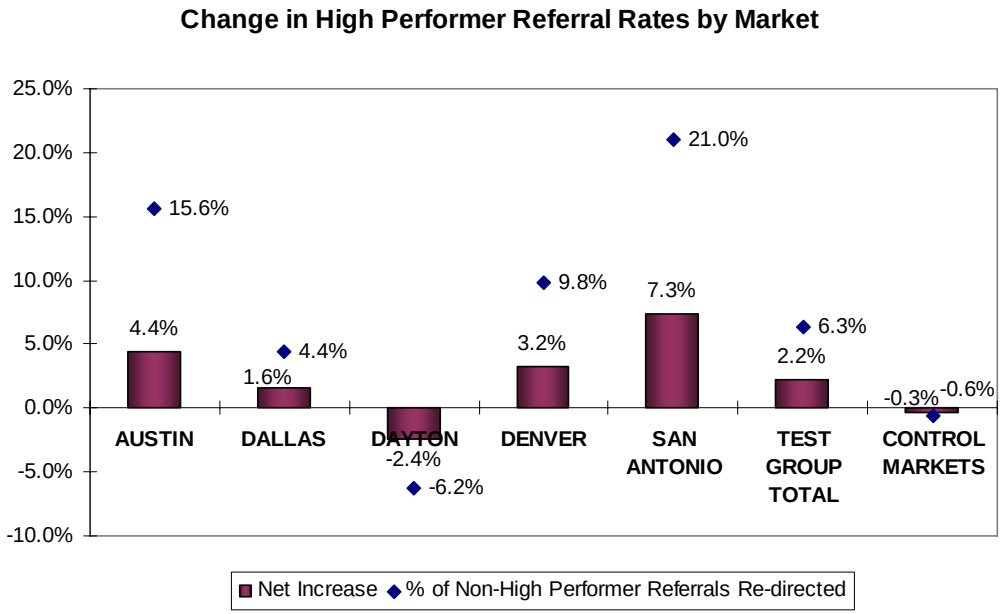
UnitedHealth Premium℠
Designation Program for Cardiology
Denver

Cardiac Specialty Centers
Medical Center of Aurora, Aurora
Porter Adventist Hospital, Denver
Presbyterian-St. Lukes Medical Center

Physicians
Cardiologists, General

JOAN ELDRIDGE	AURORA	303-369-7565
CHARLES ROGERS	BOULDER	303-442-9187
DANIEL WHITE	BOULDER	303-442-2395
ARIF ROHILLA	BRIGHTON	303-654-7944
DAVID ALBRECHT	COLORADO SPRINGS	719-634-6671
E DAVID ASCARELLI	COLORADO SPRINGS	719-635-7172
DAVID GREENBERG	COLORADO SPRINGS	719-635-7172
NITA HARRIS	COLORADO SPRINGS	719-635-7172
DEBORAH JALOWIEC	COLORADO SPRINGS	719-575-6773
JOSEPH LEE	COLORADO SPRINGS	719-365-5000
JAMES MILLER	COLORADO SPRINGS	719-475-5000
DAVID ROSENBAUM	COLORADO SPRINGS	719-635-7172
DAVID SCHWARTZ	COLORADO SPRINGS	719-365-5000
PAUL SHERRY	COLORADO SPRINGS	719-471-1775
PAMELA TAYLOR	COLORADO SPRINGS	719-471-4221
CHRISTOPHER TULIN	COLORADO SPRINGS	719-471-1775
CINDY WICKLINE	COLORADO SPRINGS	719-442-6420
BERT WONG	COLORADO SPRINGS	719-442-1715
CLAUDIA BENEDICT	DENVER	303-629-3511
MICHAEL BRISTOW	DENVER	303-493-8333
EUGENIA CARROLL	DENVER	303-493-8333
IVAN CASSERLY	DENVER	303-493-8333
THOMAS CRISMAN	DENVER	303-861-4674
LAWRENCE GAUL	DENVER	720-917-7098
CLARKE GODFREY	DENVER	303-861-4674
WILLIAM GURDIN	DENVER	303-755-2900
ROBERT HENSON	DENVER	303-595-2600



- Piloted in 5 markets – May 2006: Denver, Dallas, San Antonio, Austin, Dayton.
- 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

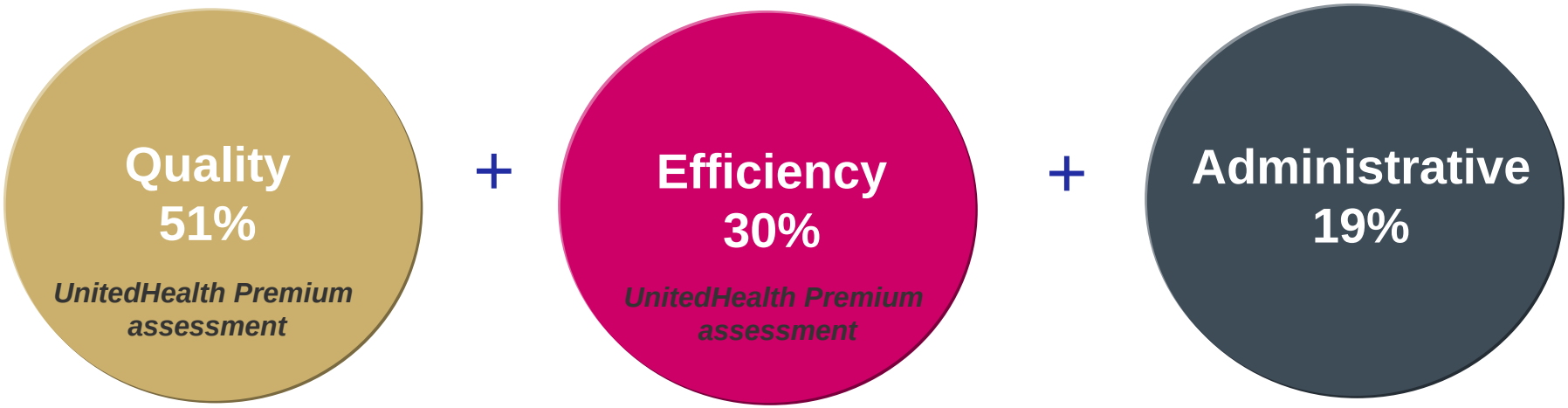
UnitedHealth Practice Rewards is a financial recognition program for solo practitioners and medical groups who have:

- 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)

Practice Rewards: Program Criteria



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.

The Patient-Centered Medical Home: Integrated Delivery and Payment Innovation

N E W S R E L E A S E

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American Academy of Family Physicians

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

ACP
American College of Physicians
INTERNAL MEDICINE | *Doctors for Adults*

UNITEDHEALTH GROUP, AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN ACADEMY OF PEDIATRICS, AND AMERICAN COLLEGE OF PHYSICIANS JOIN TO ADVANCE INNOVATIVE PRIMARY CARE MODEL

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

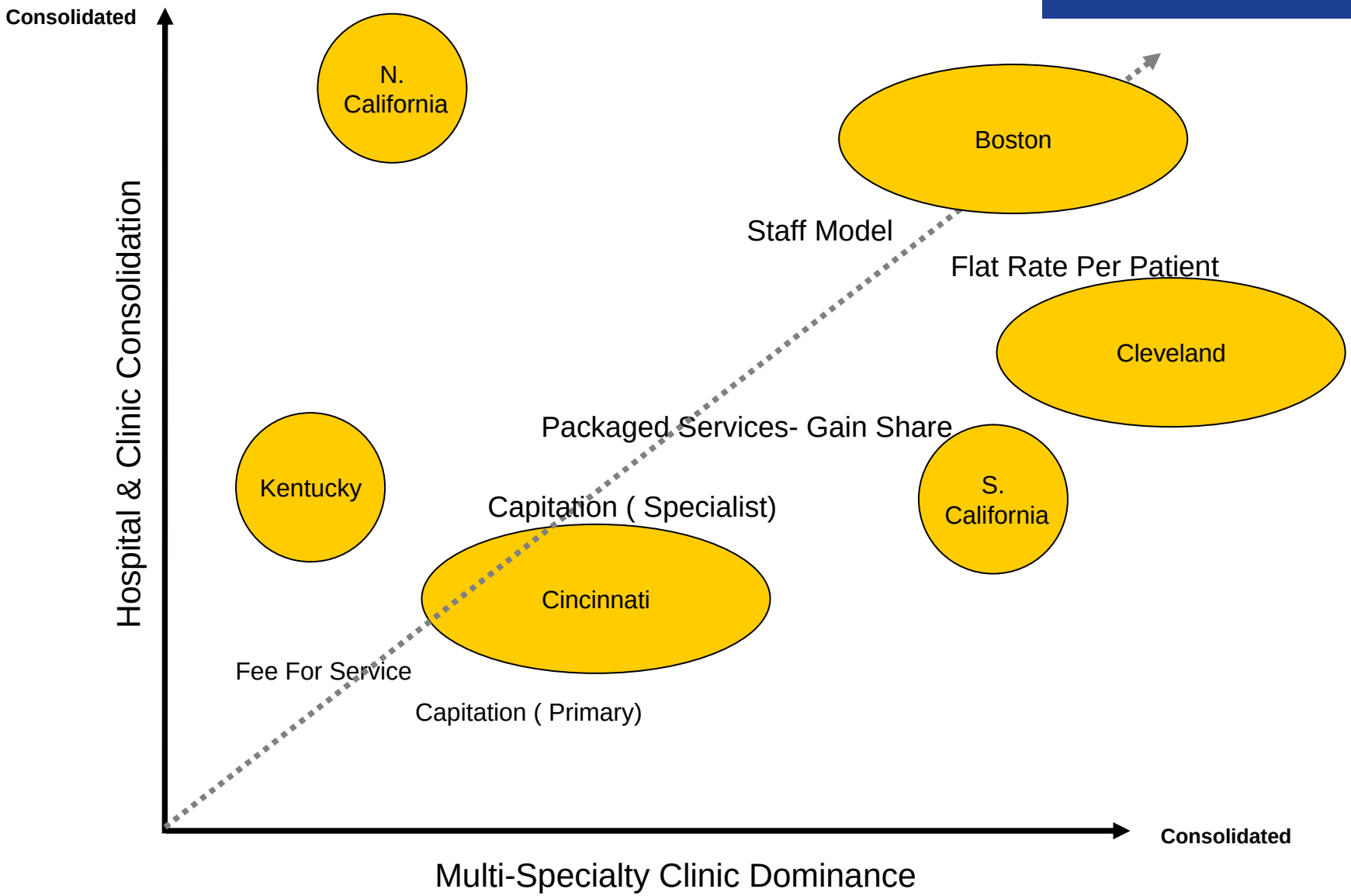
Reimbursement will be a combined Fee for Service (FFS) and PMPM Fee for all attributed practice patients.

- 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

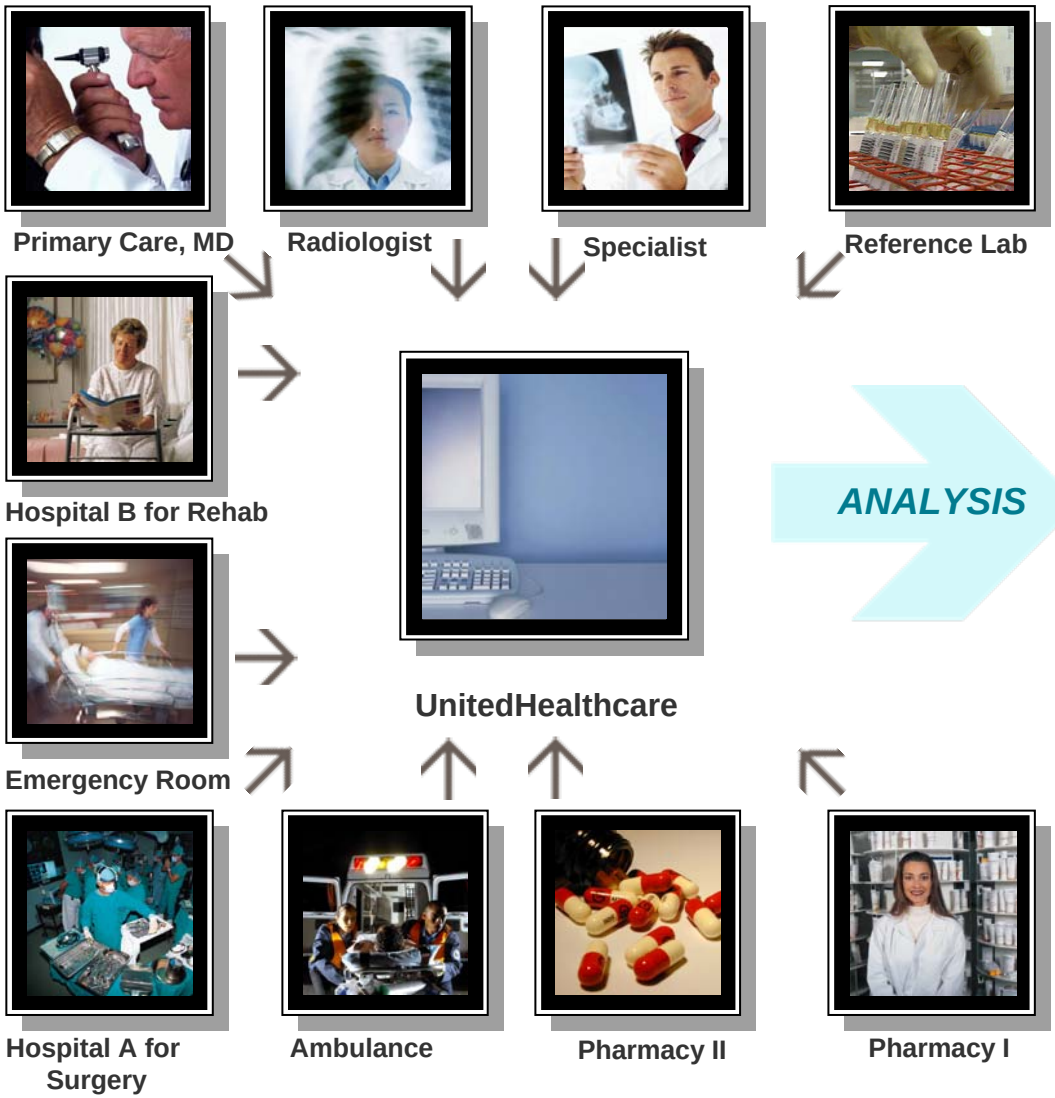
Payment Models Must Account for Local Delivery "Ecosystem"



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, Supply, and Organization-Summary Thoughts

- 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?