

National Consumer Driven Healthcare Summit

**Achieving a Sustainable ROI Using a Breakthrough Consumer
Centric, Pay-for-Performance Program Featuring Interactive
Doctor-Patient Rewards**

**Jeff Greene
September 27, 2007**

Mede^encentive

Med*e*ncentive

*e*vidence-based rewards for a healthier world.



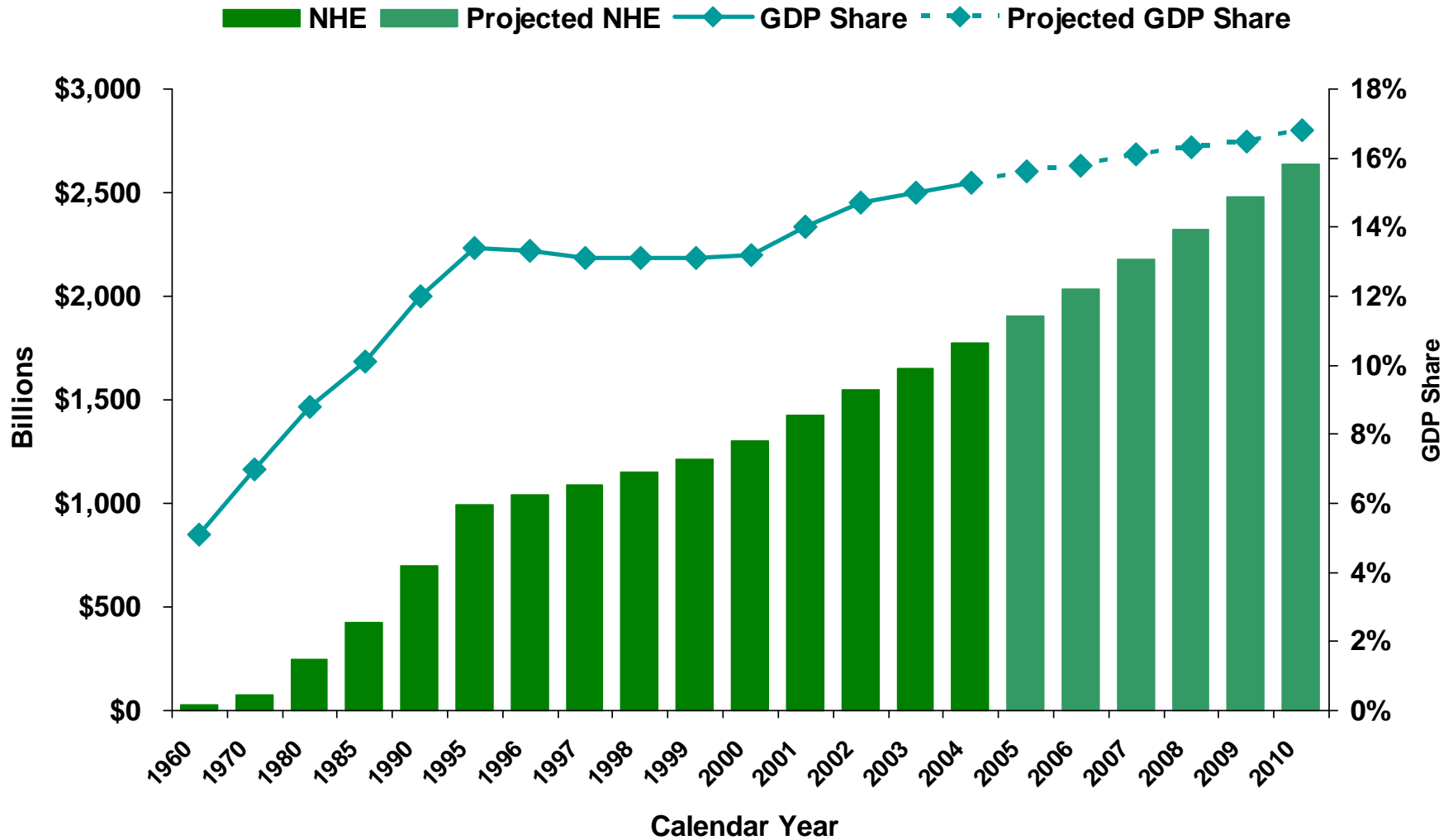
**Presbyterian Health
Foundation
Research Park**

Oklahoma City

The Problem...

Inflation

U.S. healthcare delivery is broken and needs dramatic solutions...



America's Health Statistics Rank Poorly

- We spend more on health care per capita than any country on earth, yet...
- U.S. infant mortality ranks 41st in the world, below Cuba and Costa Rica
- U.S. life expectancy ranks 42nd in the world, down from 11th two decades ago
- The number of physicians per capita ranks 43rd in the world
- We cannot keep manufacturing jobs in America due to health care cost

We are simply not getting our money's worth...

Underlying causes of high healthcare costs

1. Poor quality of care

- Recommended care delivered only **55%** of the time (RAND Corp 2004 study)
- Errors in hospital is 4th lead cause of preventable deaths

2. Patient medical illiteracy Poor physician-patient communications

- Doctors interrupt patients within the **first 23 seconds**
- **15%** of patients fully understand their doctor
- **50%** of patients comply with doctors' orders
- Causes misdiagnosis, inferior clinical outcomes, malpractice, and higher costs

3. Misaligned provider and patient incentives

- Incentives to provide **more** care not **better** care
- Defensive medicine increases cost by **10%**
- There are few patient incentives to comply with care recommendations or to lead healthy lifestyles

4. American's (**The “Drivers”**) bad health habits

- Preventable maladies such as obesity, diabetes and cardiopulmonary diseases are at epidemic rates

What do we know about these Drivers?

- Each Driver is systemic and related to human behavior
- Therefore, the solution to health care cost containment must involve changing the system and shaping human behavior

The Solutions...

The ABCs of Healthcare Cost Containment

- A. Given: Evidence-based medicine (EBM)** , by definition, has been proven to work...
- B. Given:** A 2005 RAND Corp study determined that dispensing health information or **information therapy (ix)** has been proven to work...
- C. Given and the Challenge:** The federal government and major private purchasers are 100% committed to **reforming provider compensation (P4P)** but it has not been proven to work...

Health Access, Quality Improvement and Cost Containment Initiatives - Past, Present and Future

- **Nationalize the System/Single Payer**
- **HMOs**
- **Economic Credentialing Providers**
- **Gatekeeping**
- **Disease Management**
- **Consumer-driven Healthcare (HSAs and HRAs)**
- **Pre-certification**
- **Tort Reform**
- **Diagnostic Related Groups (DRGs)**
- **Digitized Medical Record (EHRs and PHRs)**
- **Wellness and Prevention Programs**
- **Pay-for-Performance (P4P)**

Why Health Care Reforms Fail

- Some solutions suggest a major overhaul of the health care delivery system

This task is simply too daunting and risky.

Why Health Care Reforms Fail

- Many of solutions rely on a strategy of **winners and losers**
- As a result, these solutions do not adequately **align the interests** of the 3 primary health care stakeholders:
 - the patient (consumer)
 - the provider (physicians and hospitals)
 - the purchaser/payer (self-insured employers, insurance companies, and governments)

The Key to Health Care Cost Containment

No health care cost containment solution can be affected or sustained without balancing the interests of the essential stakeholders in a simple and effective manner...like a three-legged stool



Consumers/Patients



Physicians



Purchasers/Payers

Alignment-of-interests™ to create a win-win-win proposition

Mede^encentive

Let's try the **Alignment-of-Interests** test on...

- HMOs – Purchaser/payer and provider win...consumer loses
- P4P – Consumer wins...providers feel they lose...purchaser/payers are losing
- CDHC – Purchaser/payer wins...consumer and provider loses...



What is P4P?

- A movement in its early stages with 100-150 programs being tested nationwide
- It is principally directed toward transforming the provider (doctor and hospital) reimbursement system from volume-based to value-based
- Also referred to as value-based health care

What is P4P?

- Involves the principles of quality and pricing transparency, which is referred to as pay-for-reporting
- Involves providers agreeing to meet criteria such as:
 - treatment protocols
 - wellness and prevention
 - patient satisfaction surveys
 - the use of electronic health records
- Sometimes involves patient clinical outcomes
- Rarely or ever involves patient performance

What is P4P?

- Performance is almost always judged by a third-party against the third parties' criteria (insurance company, managed care plan, governments)
- Often involves doctor stratification or de-selection
- If any additional compensation is made to providers, it is typically:
 - 1% to 5% of base pay
 - paid in lump sums at the end of a quarter or annually

Who are the P4P player?

- California P4P Consortium (IHA)
- Bridges to Excellence and Prometheus
- Leapfrog
- National Business Coalition on Health
- The British P4P system
- Medicare's self-reporting programs

How are P4P programs doing?

Not well...



NATIONAL PAY FOR PERFORMANCE SUMMIT

The Leading National Forum on Pay for Performance to Enhance Healthcare Access, Quality and Efficiency

**Beverly Hilton
Los Angeles, CA**

February 14 - 16

KEYNOTE SPEAKER

Arnold Schwarzenegger
38th Governor of California



So what's wrong with P4P?

- Providers are against P4P for legitimate reasons
 - The parties who pass judgment on provider performance are objectionable to providers
 - The provider measurements will be argued endlessly – which will lead to gaming or the Physicians Bill of Rights or both...
- Without provider enthusiasm, P4P is doomed
- Consumers are not engaged
- P4P is not producing a return-on-investment for the purchaser/payer

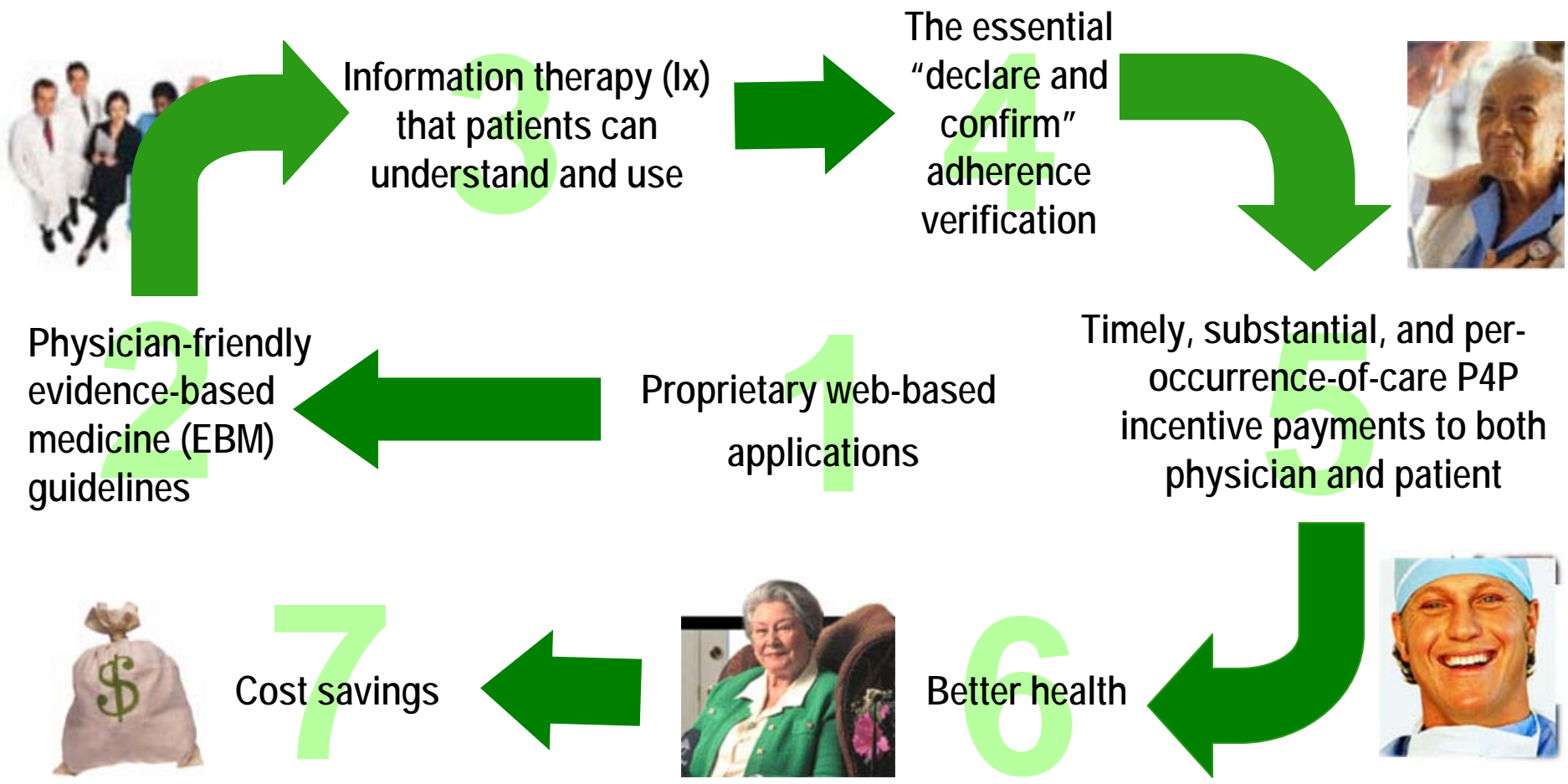
The MedEncentive Solution...

What is MedEncentive?

- A web-based incentive system that:
 - “bolts-on” to any health plan to...
 - reward both doctors and patients, interactively, to...
 - control healthcare costs by...
 - incorporating evidence-based medicine (EBM) treatment guidelines and information therapy (IX[®])...
 - ...that alleviate the impact of the Drivers on health

In other words, MedEncentive controls health care costs through a system of incentives...

Med^encentive Information Therapy Program



How does MedEncentive Program work?

Some Program basics...

- Program participation is voluntary for both doctors and patients
- Doctors and patients can earn financial rewards immediately for each office visit
- Physician compensation is approximately 20% more for each office visit for additional effort and responsibility, not for merely doing what they are already being paid to do
- Patient financial rewards are in the form of office co-pay rebates ranging from \$10 to \$30, depending upon the employer

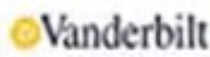
Doctors can practice the Ix Program in two ways...

- Real-time while the patient is in-office or shortly thereafter, or...
- After-the-fact...
 - As a result normal insurance claim, MedEncentive sends an email
 - Time limits to respond
 - MedEncentive also sends a fax reminder

The Physician Log-in Screen

The screenshot shows a web browser window titled "MedEncentive - Provider Portal - Windows Internet Explorer". The address bar displays "http://www.medencentive.com/Docs/Providers/Default.aspx". The browser interface includes a search bar with "Live Search" and a toolbar with various icons. The main content area features a banner with a smiling male physician in blue scrubs and a surgical cap. The banner text reads "MedEncentive" in a large, stylized font, followed by the tagline "Evidence-based rewards for a healthier world." Below the banner, there are navigation links: "Home | About Us | Contact Us" and "Product Description | News & Press Releases | Providers | Patients | Employers | Administrators". The URL "WWW.MEDENCENTIVE.COM" is displayed below the banner. The main heading is "MedEncentive Provider Portal" with a "Back" link. A list of instructions follows: "If you are a first time user [click here](#) (To enroll in the MedEncentive Program)", "If you are an enrolled provider please login", and "If you are a group administrator and need to create a group login [click here](#)". The login section includes a "Username:" field, a "Password:" field, and a "Login" button. A link "Forgot your username/password? [Click here](#)" is provided below the password field. On the right side, there is a "NEWSLETTER" section with a "City of Yukon Adopts MedEncentive" article. The article text states: "In September, the City of Yukon, Oklahoma signed an agreement to adopt the MedEncentive Program. The current implementation date is set for Nov. 1, 2006. During the presentation to the City Council, one council member kept repeating the cost-benefit analysis and concluded that the Council's decision was a 'no-brainer.' Jim Dempster concurred by noting this is the case for all employers." At the bottom left, there is a logo for "innovator OF THE YEAR" with the text "A 2005 and 2006 Innovator of the Year Award Winner". The browser status bar at the bottom shows "Done", "Internet", and "100%".

MedEncentive's physician website takes only seconds to complete...



Address: http://locainost/EMPHYSICIAN/DOCS/WORKCLAIM.aspx

Patient: Test Patient
Date of Service: 2004-10-05 To 2004-10-05

Instructions: All questions associated with each diagnosis in the left column appropriately answered to be eligible for higher payment on this claim. A "no" response will require a listed or typed explanation. Refer to "No" options under each question. Only the primary diagnosis requires your response, however you can prescribe additional information therapy to your patient by clicking on other listed guidelines and diagnoses. When completed click the "Done" button. Click "Help" for expanded instructions.

Print Guideline

Hypertension Decision Tree

```
graph TD
    A{Hypertensive Crisis?} -- No --> B[If not Hypertensive Crisis Begin Lifestyle Modification :  
Lose weight, limit alcohol, increase activity, reduce sodium, maintain potassium calcium and magnesium, stop smoking, reduce saturated fat and cholesterol]
    B --> C{Not at Goal BP}
    C --> D{Initial Drug Choices}
    D -- Specific Indications --> E[ACE Inhibitors  
Angiotensin II Receptor-blockers  
Alpha-blockers  
Alpha-beta-blockers  
Beta-blockers  
calcium antagonists  
Diuretics]
    D -- Compelling Indications --> F[Heart Failure: ACE inhibitors, diuretics  
Myocardial Infarction: Beta-blockers (non-ISA), ACE inhibitors  
Diabetes Mellitus (type I w/proteinuria): ACE inhibitors  
Isolated systolic HTN (elderly): Diuretics preferred, long-acting dihydropyridine CA antagonists]
    D -- Uncomplicated --> G[Diuretics  
Beta-Blockers]
    G --> H{Still not at Goal BP?}
    H --> I[Substitute another drug from a different class]
    H --> J[Add second agent from different class (diuretic if not already used)]
    I --> K[Still not at goal BP while]
    J --> K
```

1. 401.1 (P) BENIGN HYPERTENSION

Hypertension

Are you following this guideline for this patient?

Yes
 No

[Click here for 'no' options](#)

Do you wish to prescribe information therapy to this patient?

Yes
 No

[Click here for 'no' options](#)

Please rate your patient's compliance for this diagnosis.

Compliant
 Compliance is a non-factor
 No Response

[Help](#) [Done](#)

- Flow chart hyperlinks allow physician interaction with guideline including decision support
- 2 or 3 simple questions makes application fast and easy to use, yet answers allow patient to validate physician compliance to the guideline and program

MedEncentive's anti-cookbook medicine feature is key to physician acceptance ...

Address: http://localhost/ePPOPHYSICIAN/Docs/WorkClaim.aspx

Patient: Test Patient
Date of Service: 2004-10-05 To 2004-10-05

Instructions: All questions associated with each diagnosis in the left column must be appropriately answered to be eligible for higher payment on this claim. A "no" response will require a listed or typed explanation. Refer to "No" options under each question. Only the primary diagnosis requires your response, however you can prescribe additional information therapy to your patient by clicking on other listed guidelines and diagnoses. When completed click the "Done" button. Click "Help" for expanded instructions.

1 . 401.1 (P)
BENIGN HYPERTENSION

Hypertension Decision Tree

Are you following this guideline for this patient?
 Yes
 No

Do you wish to prescribe information therapy to this patient?
 Yes
 No

Please rate your patient's compliance for this diagnosis.
 Compliant
 Compliance is a non-factor
 No Response

Help Done

Hypertensive Crisis?
No

If not hypertensive crisis:
Close:

- Co-morbidity
- Emergent condition
- Pending lab or other test results
- Contraindicated because:
- Patient declines for financial reasons
- Patient declines for other reasons:

Drug Choices:
Calcium antagonists
Diuretics

Compelling Indications:
Heart Failure: ACE inhibitors, diuretics
Myocardial Infarction: Beta-blockers (non-ISA), ACE inhibitors
Diabetes Mellitus (type I w/proteinuria): ACE inhibitors
Isolated systolic HTN (elderly): Diuretics preferred, long-acting dihydropyridine CA antagonists

Uncomplicated:
Diuretics
Beta-Blockers

Still not at Goal BP?
Substitute another drug from a different class
Add second agent from different class (diuretic if not already used)

Still not at goal BP while

- Allows the flexibility for physicians to deviate from the guideline (the "anti-cookbook medicine" feature)

The physician's response automatically triggers the patient prescription for "information therapy"



Jane Doe
123 Test ST
Oklahoma City, OK 73127

Dear Jane,

Welcome to the MedEncentive Program sponsored by your health plan. This letter is an information therapy prescription from **Dr. Doright** to services rendered on **01/01/2005**.

The purpose of this prescription is to provide you with important medical information to help you self-manage your condition and to help you maintain good health. This letter also serves the purpose of initiating the process that will financially reward you when you indicate your compliance with your doctor's instructions and with treatment guidelines compiled by leading medical schools.

To receive your information therapy you must have access to the Internet. If you have Internet access at home, this is ideal. If not, we recommend contacting your employer about Internet access at your place of work. You may also consider accessing the Internet at your doctor's office or at the public library.

You will find your information therapy by going to <http://www.medencentive.com/DemoPatient/> on the Internet. This Web site will ask you for a user id and a password.

Your user id is: **Jane**
Your password is: **Doe**

This website provides helpful instructions for you to successfully receive your information therapy. One important instruction worth noting is **the two week time limit** for you to successfully complete the information therapy questionnaires in order to be eligible for any financial rewards associated with this notification. Also, be aware that failure to actively participate in this self-management program may result in increased health care cost to you. Your participation may earn you a financial reward of **\$25.00**.

Contact your doctor if you have medical questions. Contact Patient Services at 405-947-7410 ext. 123 if you have operational or financial rewards questions.

- Provides alternative web access options so all can participate
- Log-on instructions with the URL and User ID/Password
- Allows 2-week timeframe to complete instructional course
- Offers financial incentive to participate in the program
- Initially sent by mail, but after log-on patient communications can be done electronically

Patients are educated with the same guideline as their doctor - specific to their diagnosis

http://www.medcentive.com - _1stDiagnosis - Microsoft Internet Explorer

Step 2 of 7

Review medical information related to this diagnosis and answer the questions at the bottom of each article

401.1 / BENIGN HYPERTENSION

Note: Your doctor has deviated from the recommended guideline for this diagnosis for the following reason:

Co-morbidity

High Blood Pressure - Key Points

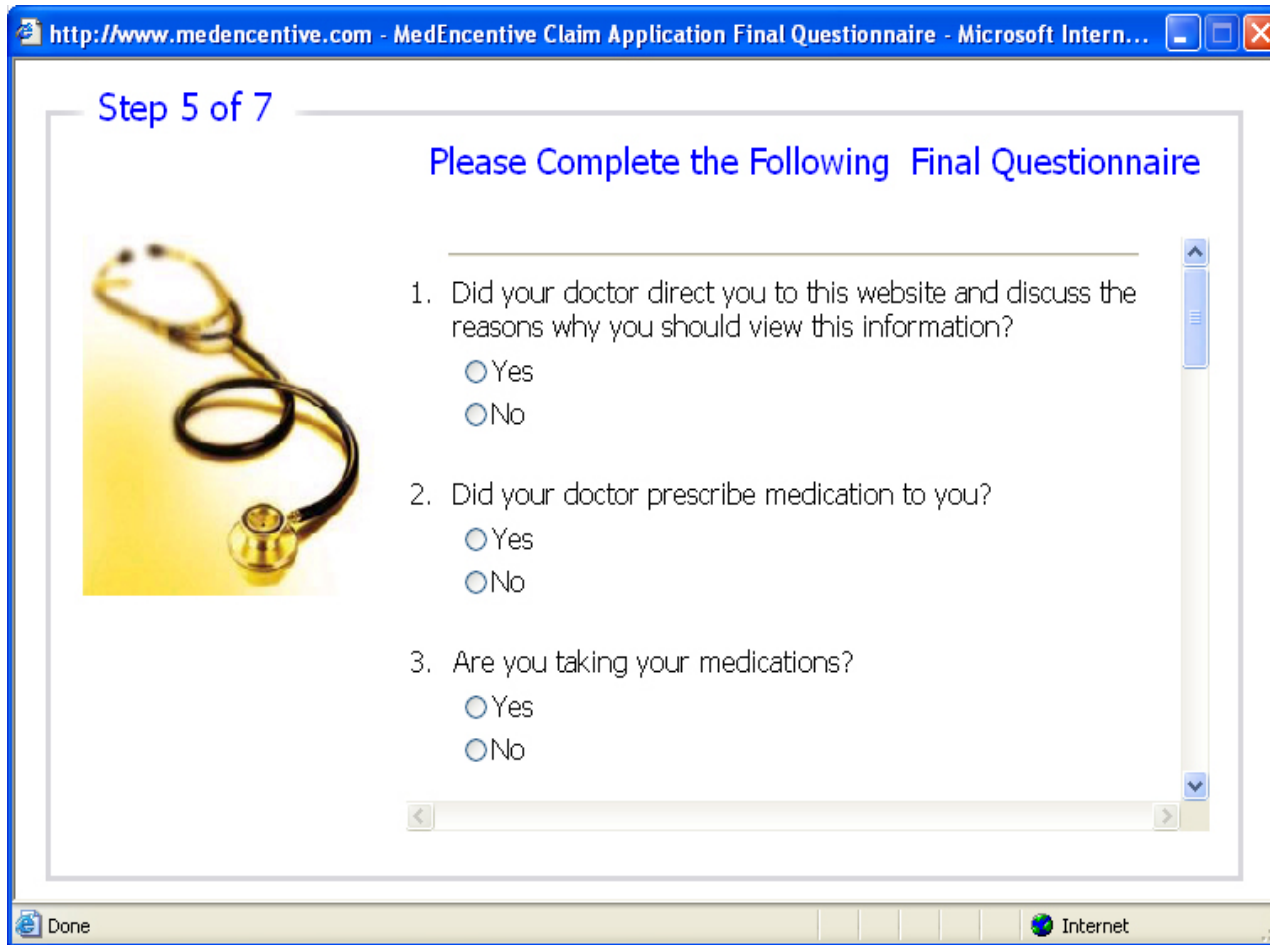
KEY POINTS

- Hypertension is the same thing as high blood pressure. It is often called "the silent killer." It affects nearly 50 million Americans. It is a major cause of stroke, heart attack, sudden unexpected death, heart failure, and kidney failure. High blood pressure is a serious disease.

MedCentive's patient interface provides:


- Information in easy-to-understand language (8th grade level)
- An evaluation to make sure the patient understood the material presented

The patient questionnaire provides “checks and balances” to the physician’s input and vice-versa when:



Step 5 of 7

Please Complete the Following Final Questionnaire

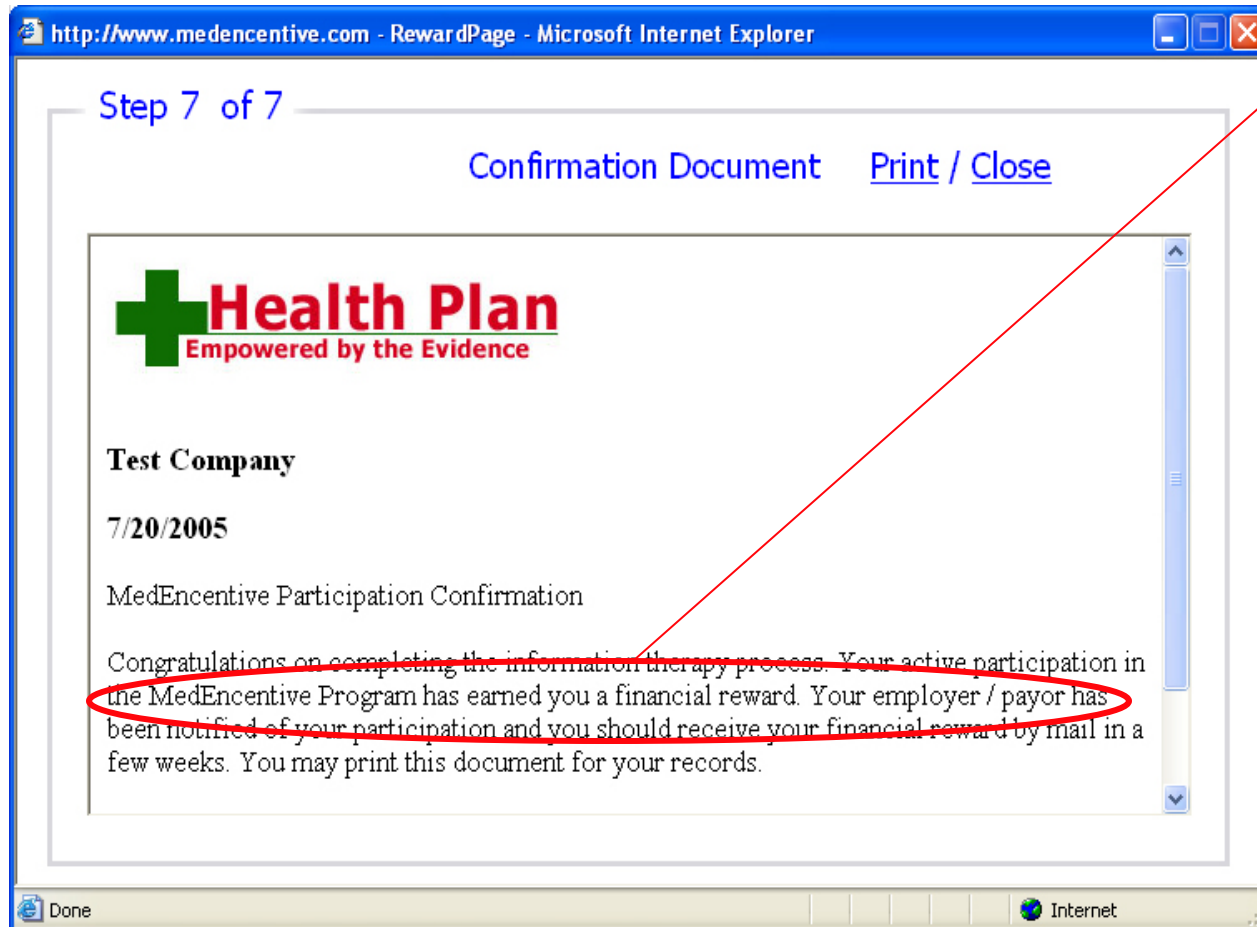


1. Did your doctor direct you to this website and discuss the reasons why you should view this information?
 Yes
 No
2. Did your doctor prescribe medication to you?
 Yes
 No
3. Are you taking your medications?
 Yes
 No

Done Internet

- Patient demonstrates knowledge
- Patient records health status
- Patient declares compliance to EBM
- Patient rates physician against EBM
- Patient’s responses are shared with their physician, creating a powerful compliance motivator

Timely completion of “information therapy” results in immediate financial reward to patients for compliance



- MedEncentive triggers an automatic transaction notifying the TPA to generate a patient payment
- The voucher serves as another co-branding opportunity and a vehicle for other patient communications

System implementation is easy...

- Employers can implement the Program in as little as 30 days
- Physicians enroll on-line or through their licensing organizations
- Employees are oriented through Member Kits

Employee-Member Kit is Like a Gift from the Employer



Unlike Any Other Health Care Reform Concept

*Mede*ncentive

- **Triangulates™ the interests of:**

- **the medical provider**



- **the consumer/patient, and**



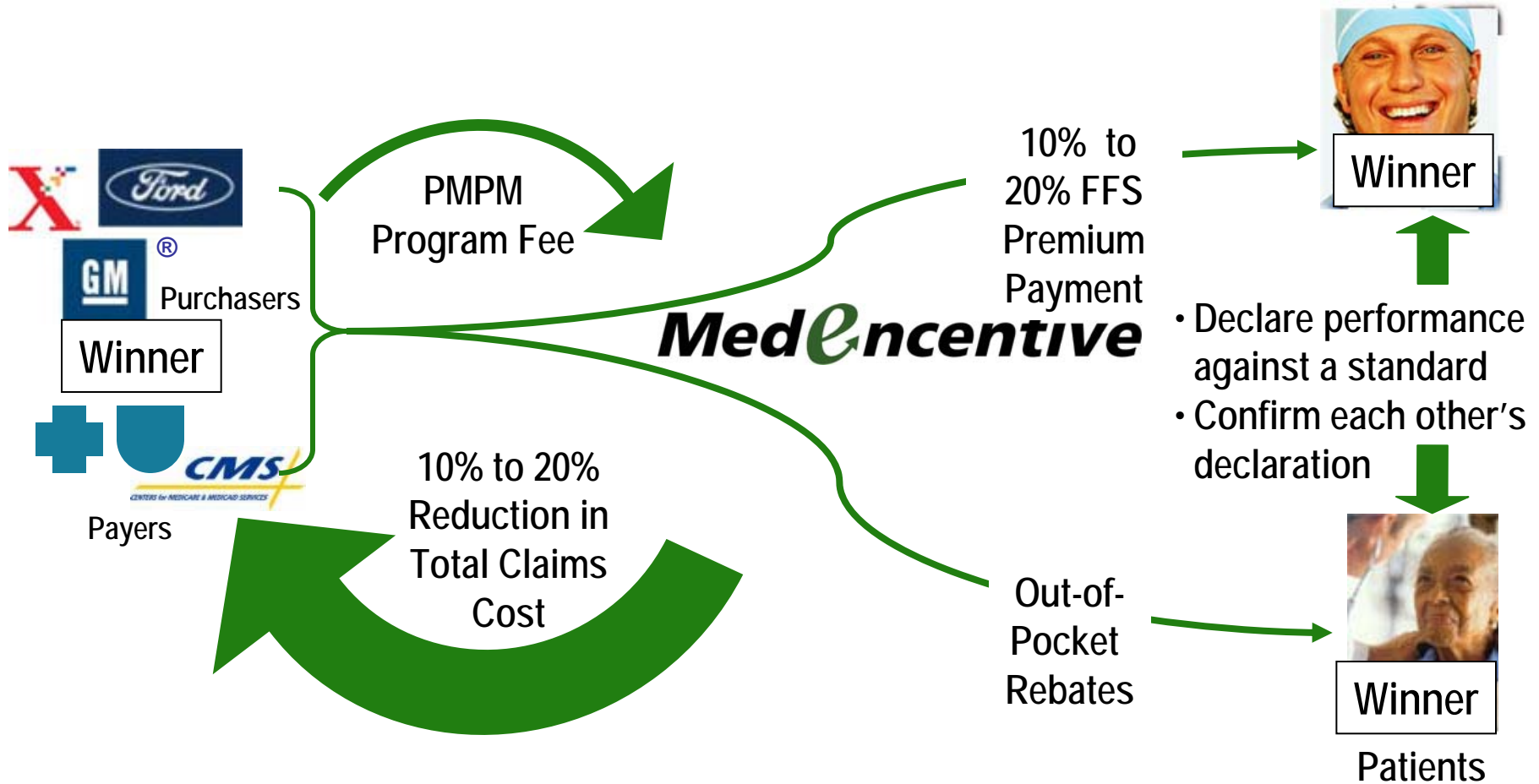
- **the purchaser/payer**



...to create a win-win-win solution

Med^encentive Web-based Solution

MedEncentive functions as an “Informediary” to...



...create a “Triangulation” that produces a Win-Win-Win

There is a significant difference

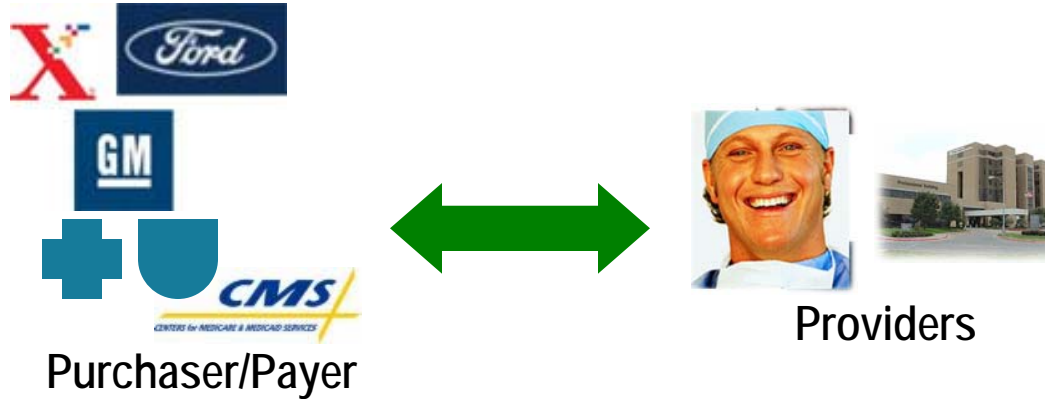
Alignment of Interest or “AOI”

versus

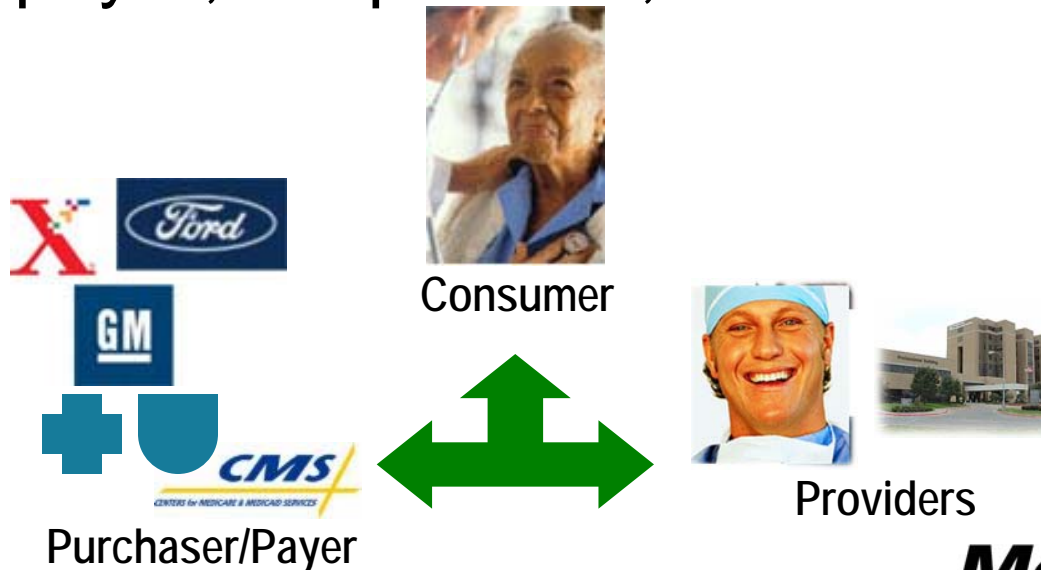
Pay for Performance or “P4P”

The difference between AOI and P4P...

P4P is bilateral between the purchaser/payer and the provider



AOI is trilateral and interactive between the purchaser/payer, the provider, and the consumer



Reason's Why Physicians Endorse MedEncentive

- **Alignment-of-Interests™ vs. Pay-for-Performance**
 - Physicians are rated by their patients (after their patients are qualified) against objective criteria as opposed to other P4P programs that have third parties, such as insurance companies or the government, rate physicians using controversial methods such as claims data, self-reporting, or patient satisfaction surveys.
 - Physicians get a chance to measure their patients' performance
 - Purchaser/payers are willing to reward both physicians and patients because they are working together to improve health care and healthiness, that leads to cost containment

Reason's Why Physicians Endorse MedEncentive

- **Alignment-of-Interests™ vs. Pay-for-Performance**
 - MedEncentive is purely voluntary for physicians
 - Offers 10% to 20% increase in compensation as opposed to 1% to 5% offered by other P4P programs;
 - It is designed to be very fast and easy to practice;
 - Helps physicians provide a higher standard of care to their patients;
 - Financially rewards the patient for being compliant, thus providing physicians with a powerful means to encourage patients to be healthier, unlike other P4P programs;
 - Is “anti-cook” by encouraging physicians to indicate adherence or provide a reason for non-adherence to evidence-base medicine guidelines, unlike other P4P programs

Reason's Why Physicians Endorse MedEncentive

- **Alignment-of-Interests™ vs. Pay-for-Performance**
 - Is web-based for convenience, but can be practiced in high-tech and low-tech medical practices;
 - Can increase physician productivity:
 - by providing a means for the physician to educate patients through information therapy prescriptions as opposed to time-consuming face-to-face instruction;
 - by allowing physicians to direct care as opposed to having patients misdirect care with “Google” searches; and
 - by reducing patients’ telephone calls.
 - Improves doctor-patient communications and patient medical literacy:
 - by having patients read and be queried about their condition; and
 - by providing a means for physicians to confirm their patients’ understanding and commitment to compliance;

Reason's Why Physicians Endorse MedEncentive

- **Alignment-of-Interests™ vs. Pay-for-Performance**
 - Financial rewards are more immediate than other P4P programs;
 - Does not tie physician compensation to patient performance behavior like some P4P programs;
 - Encourages due process through licensed medical associations before physician rankings/performance are published like some P4P programs;
 - Does not use complicated formulas to determine physician compensation like some P4P programs;
 - MedEncentive's means of measurement is much more objective and relevant than other P4P programs;

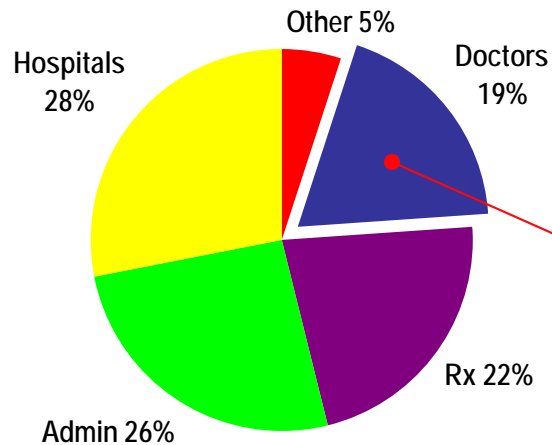
Reason's Why Physicians Endorse MedEncentive

- **Alignment-of-Interests™ vs. Pay-for-Performance**
 - Can offer a means to achieve clinical integration to negotiate with managed care plans;
 - Provides convenient access to evidence-based medicine treatment guidelines;
 - Helps physicians keep current on recommended treatments;
 - Provides a degree of malpractice risk management;
 - Can provide continuing medical education and CME credits;
 - Improves the overall quality of healthcare;
 - And last but not least, has been proven to control overall healthcare costs.

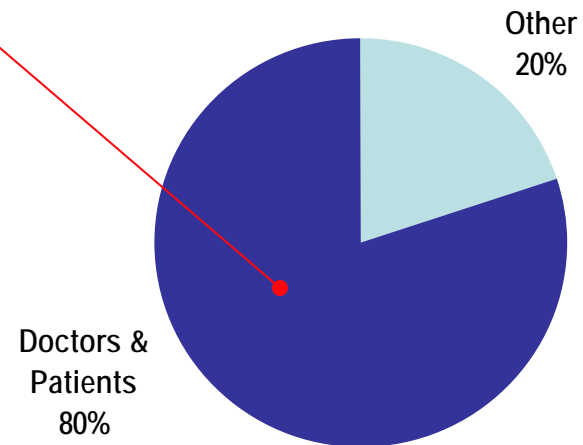
The MedEncentive Ix Program leverages doctor and patient influence on total costs by increasing their financial incentives

- physicians and patients have a significant influence on the total cost of care

Allocation of Health Premium



Influence on Healthcare Costs



- but the physician slice of the health care pie is relatively small (and shrinking) when compared with this influence

What can we conclude about disparity between who controls utilization/consumption versus who gets paid for medical services?

- It is an economic imperative that we invest in doctors and patients to improve the standard of care and encourage healthiness
- MedEncentive has proven that the best way to invest in doctors and patients is through web-based, interactive incentive systems that incorporate evidence-based standards, information therapy and other performance standards

Physicians Endorse MedEncentive and Vice Versa

Med*e*ncentive

*e*vidence-based rewards for a healthier world.

Certificate of Achievement

For demonstrating a commitment to Evidence-based Medicine
and Information Therapy in the care of patients

Michael Morgan, M.D.

is designated by MedEncentive as

A Patient First Champion

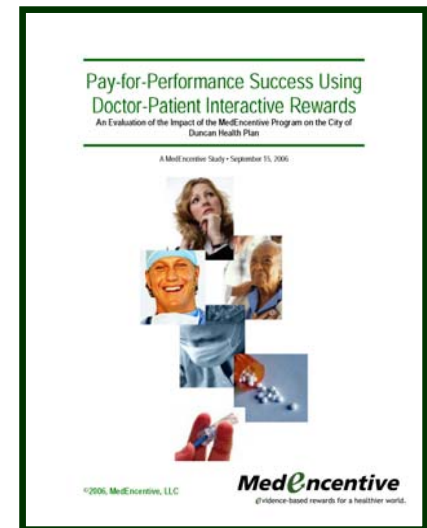
July 1, 2006

P. Lloyd Hildebrand, M.D.
Chief Medical Officer

**How well does MedEncentive
work?**

For over three years, MedEncentive's performance capabilities have been tested and validated

- Three separate pilot implementations involving 1,100 covered lives
- After a year-long trial, all three test employers experienced significant health care cost reductions
- The principal test site, City of Duncan, has been the subject of an in-depth analysis and a recently released study entitled: ***Pay-for-Performance Success Using Interactive Doctor-Patient Rewards***



The City of Duncan faced a budget crisis because of three consecutive years of double digit increases in health costs

- **About Duncan, OK**

- located in south central Oklahoma
- population 22,000, median income \$31,000
- oil & gas discovery in 1921
- major Halliburton installation



- **The City of Duncan**

- uses a self-insured, self-funded health plan
- faced a budget crisis because of growing health costs
- forced to cut health benefits; faced employee union discontent
- elected to try the MedEncentive Program to control costs

Implementation was inexpensive and fast

- Implemented in less than 60 days
- Health fair was conducted to officially launch the program and orient plan members
- Provider network addendum was negotiated with physician leadership
- Doctors and office staff received one orientation session, instructional videos/printed materials and registration assistance
- Plan members and the City's management received instructional videos/printed materials
- The City's TPA and re-pricer made moderate modifications to automate processes

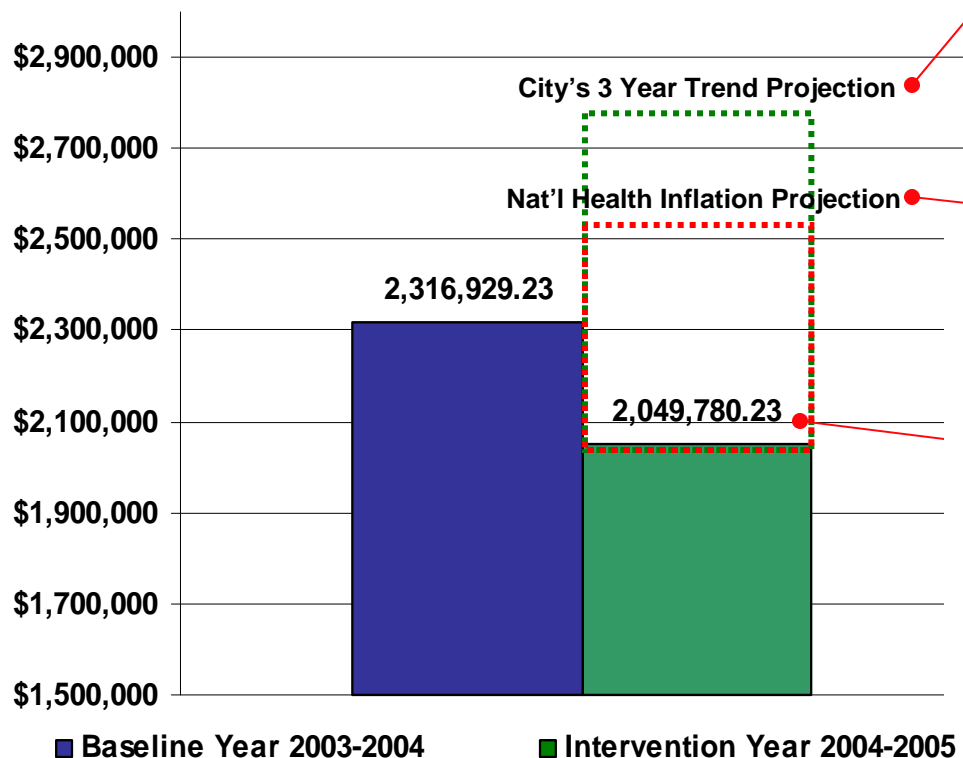
The following hypotheses were tested against the first year results:

- 1 Global healthcare costs would be contained in the first year of implementation
- 2 Expenditures among cost categories would be re-distributed in favor of physicians and administration
- 3 Defensive medicine would be abated
- 4 Patients would perceive a benefit in physician prescribed Ix

**In-depth study confirmed
all four predictions**

Prediction #1: In spite of increases in prices (hospital and doctor) and admin, costs would decrease

City of Duncan
Global Healthcare Expenditures
2003-2004 vs 2004-2005



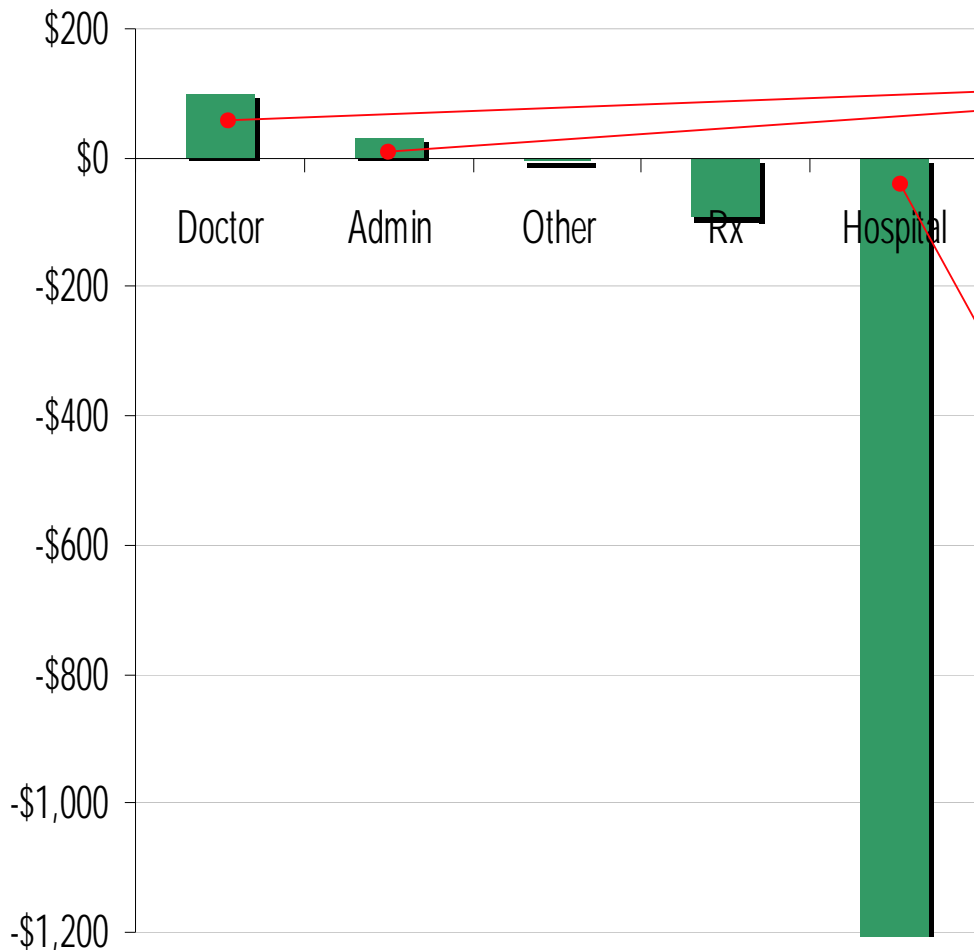
The annual expenditures were projected to increase 20%.

The national inflation rate


Prediction # 1
Confirmed

Prediction 2: There would be a re-distribution among the categories of cost

Net Change by Provider Type



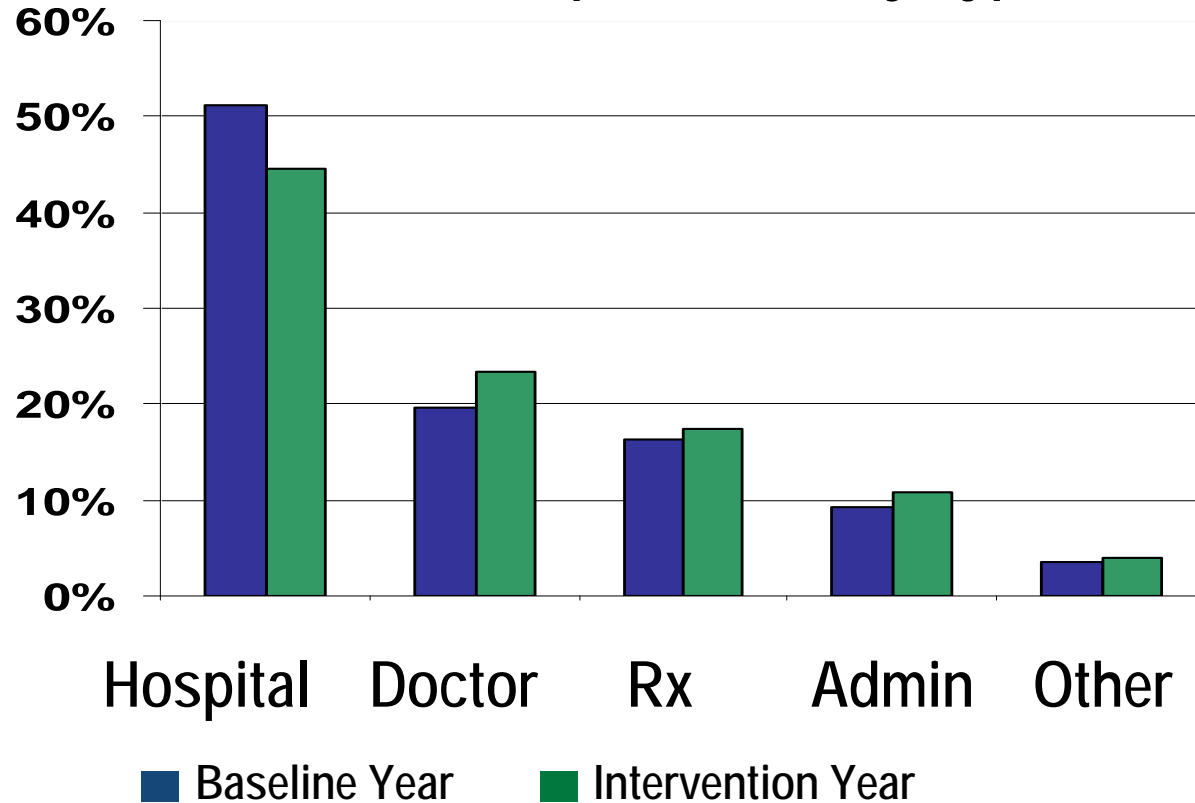
• As designed, MedEncentive caused physician and admin costs (including MedEncentive program access fees) to

 Prediction # 2
Confirmed

Prediction #2: A redistribution of revenues to physicians...

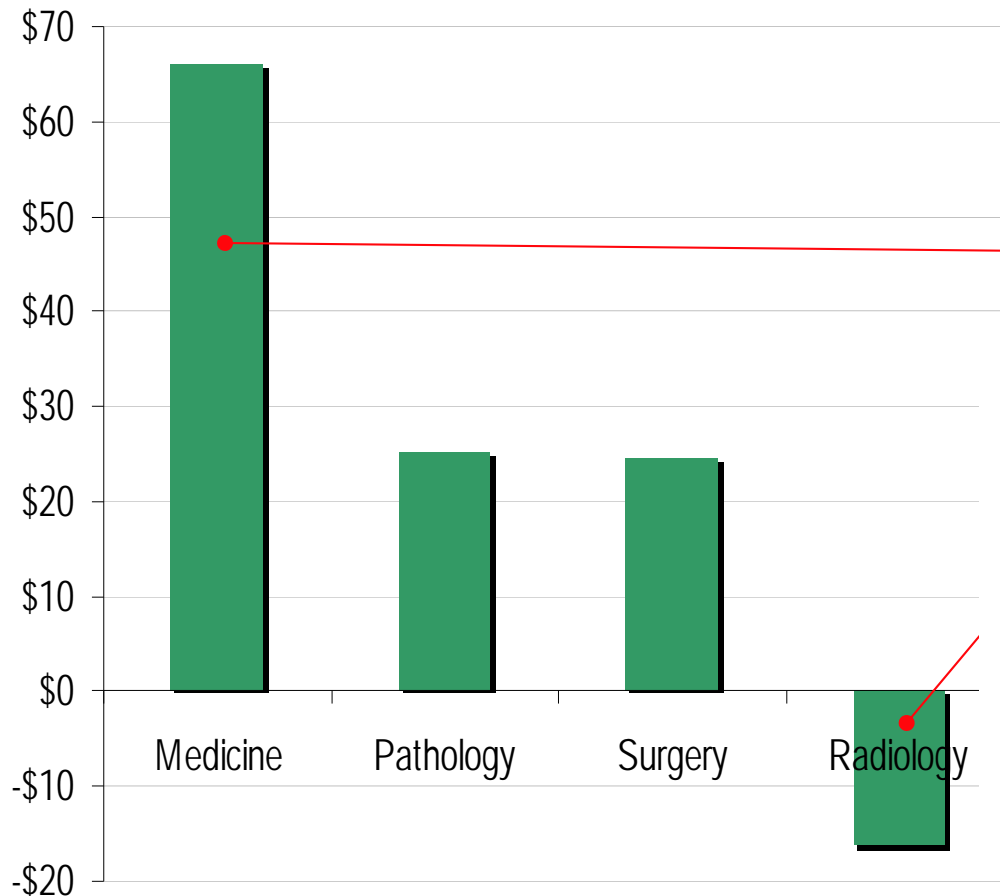


% Distribution of Expenditures by Type Service



Prediction #3: A reduction in defensive medicine would occur...

Change in Physician Costs by Service Type



- The increase in physician service costs were allocated by medical specialty type based on CPT codes
- As expected, Medicine services including office visits

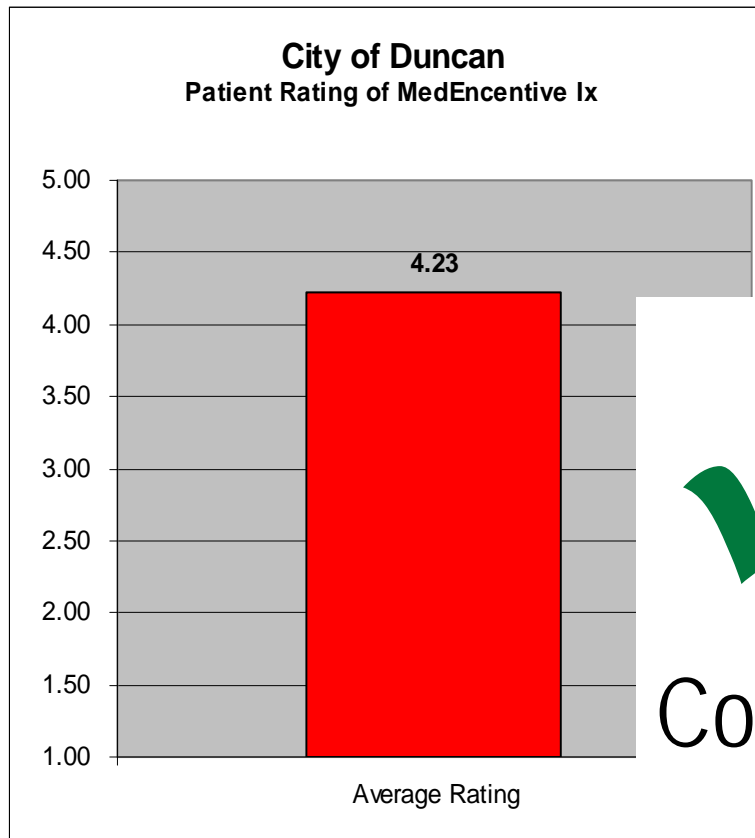


Prediction # 3
Confirmed

adherence to guidelines

Prediction #4: Patients would perceive a benefit

On a scale from 1 - 5, how helpful has this information been to you in managing your disease or condition? (1 being not at all helpful and 5 being very helpful)

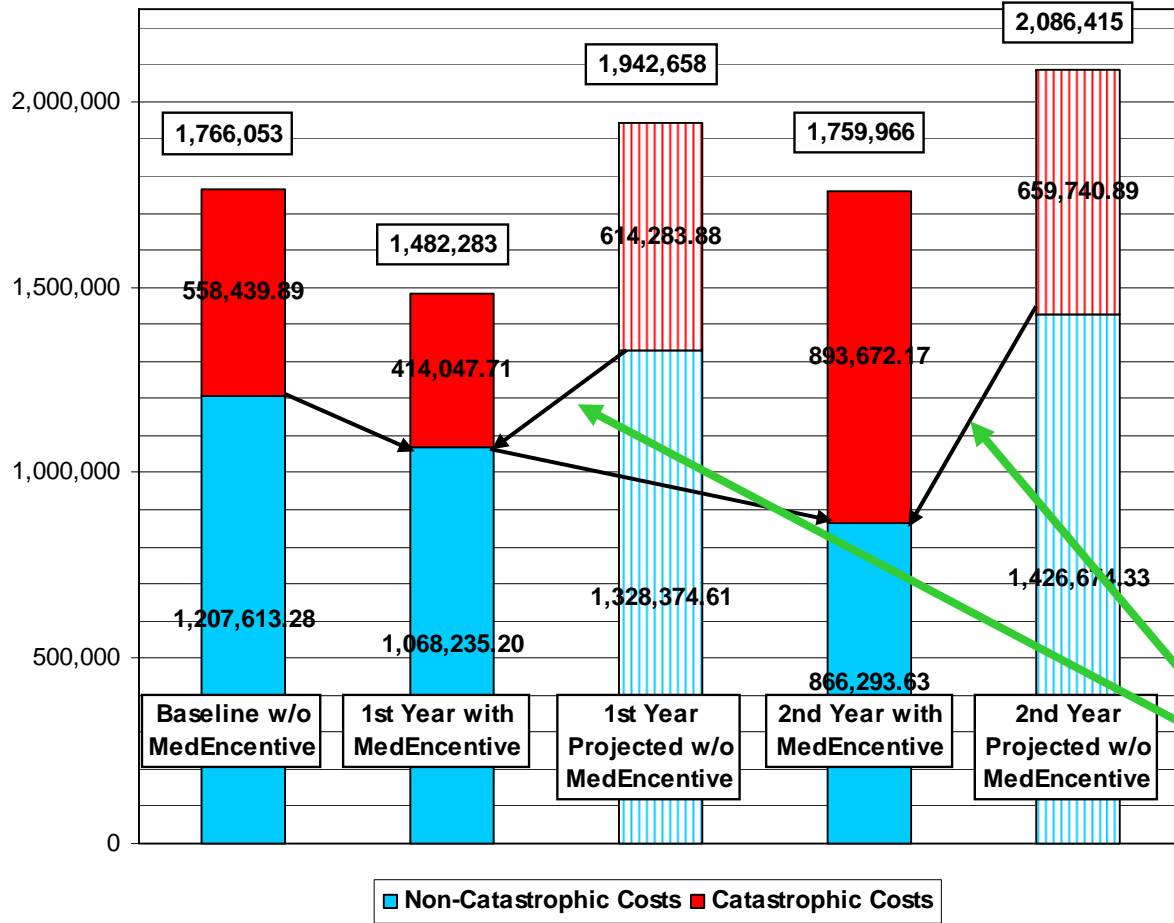



Prediction # 4
Confirmed

**Trial's second year of positive
results further validates the
MedEncentive Program...**

2nd Year's Results Even Better than the 1st Year's

City of Duncan
Actual Net Charges for Last 3 Years Plus Projection w/o MedEntensive



- The Program is currently most effective controlling non-catastrophic costs, which decreased more in the second year than the first year, for a total savings of **\$480,698** from the baseline year.
- Assuming the nat'l health inflation rate, the actual 2 year cumulative non-catastrophic costs were **\$820,520** or **29.8%** less than projected

The City of Duncan realized a significant ROI

Two year program investment vs. non-catastrophic claims cost

Physician Compensation*	\$21,144
Patient Rewards*	\$27,835
MedEncentive Fees	<u>\$25,978</u>
Total Investment	\$74,957
Two Year Savings vs. Projection	\$820,520
Return on Investment	995%

* Conservative approximations

- The City has been handsomely rewarded in the first 2 years of the program.
- Most recent year's spike in catastrophic cases is accelerating MedEncentive's pre-certification/hospitalization product.

Confirmation By Northwestern and Emory Universities Research Team

What You Don't Understand Could Kill You

By LINDSEY TANNER – CHICAGO - July 23 2007

Plenty of evidence suggests that having trouble understanding medical information is bad for your health. Now new research says it could even be deadly.

“Inability to understand medical information and instructions makes it hard to manage chronic illnesses from asthma to diabetes to heart disease,” said lead author Dr. David Baker, chief of general internal medicine at Northwestern University's Feinberg School of Medicine. “That in turn can lead to declining health, frequent hospitalizations and ultimately death, especially in older patients whose health may be more precarious to begin with,” he said.

Almost 40 percent of those deemed medically illiterate died during the study, compared with 19 percent of those who were literate. Factoring in health at the outset and other variables, medically illiterate patients were 50 percent more likely to die than the others.

The difference in death rates "was much higher than we expected," Baker said.

Confirmation By Medicare Trial

Shift in Health-Cost Focus Is Said to Show Promise

July 12, 2007

REED ABELSON

New York Times




By coordinating care and keeping their patients out of the hospital, doctors can help reduce overall health care spending, Medicare officials said yesterday in announcing the results of an experiment that allowed doctors to share in the cost savings.

"The real driving force of change needs to occur in a physician office," said Dr. Karl Ulrich, the president and chief executive of the Marshfield Clinic.




So how does MedEncentive do against the Drivers?

1. Poor quality of care ✓
2. Poor doctor-patient communication and patient medical illiteracy ✓
3. Misaligned provider and patient incentives ✓
4. American's deteriorating health due to bad health habits ✓

How does MedEncentive perform against the P4P issues...

1. **Physician enthusiasm** 
2. **Consumer enthusiasm with accountability and empowerment** 
3. **Purchaser/payers ROI** 

How does MedEncentive do against the ABCs of healthcare cost containment

- A. Given: Evidence-based medicine (EBM)**, by definition, has been proven to work... 
- B. Given:** A 2005 RAND Corp study determined that dispensing health information or **information therapy (ix)** has been proven to work... 
- C. Given and the Challenge:** The federal government and major private purchasers are 100% committed to **reforming provider compensation (P4P)** but it has not been proven to work... 

Program is designed to be adjusted to achieve cost containment...

- “Precision-guided rewards and performance standards” allow customer to focus on specific problems and intended outcomes
- Take note of City of Duncan and INTEGRIS Health’s second and third year Program modifications and subsequent results...

What is coming?

- To more effectively address catastrophic costs, MedEncentive's performance standards will expand to “triangulate” the following:
 - A pharmacy benefit manager (PBM) feature involving e-prescribing and Rx-Ix
 - Wellness and prevention
 - Pre-certification
 - A hospitalization method
 - The adoption of personal health records (PHRs)

Summary - A compelling value proposition

“Employer, how would you like an employee benefit program that:

- 1 allows you to offer a unique benefit enhancement to attract and retain employees;
- 2 helps your employees to be healthier, happier and more productive;
- 3 is endorsed by leading physicians;
- 4 is very simple to implement and maintain; and
- 5 best of all, has been proven to control health care costs?”

“Your employees will elevate you to hero status.”

The Team

- **Jeff Greene**
 - founder, CEO, Director, MedEncentive; co-founder, CEO, CompONE Services
- **Susan Chambers, MD**
 - co-founder, Director, MedEncentive; co-Founder and Officer, ObGyn of OKC; Oklahoma's 2003 Woman of the Year, Past President; World Neighbors; President, COPA
- **David Parke, MD**
 - co-founder, Director, MedEncentive; President, Dean McGee Eye Institute; Chairman Dept of Ophthalmology University of Oklahoma; 2007 President-elect, American Academy of Ophthalmology; Chairman Medem; Director, Ophthalmic Mutual Insurance Company

The Team

- **Cliff Winburn, CPA, JD**
 - co-founder, CFO, Director, MedEncentive; co-founder and CFO, CompONE Services; CFO Cotton Petroleum Company
- **Jim Dempster**
 - Executive Director, Sales and Support, MedEncentive; co-founder of Physician Direct; Board Member and Past President, Oklahoma Underwriters Association

What must CDHC and consumerism do to be successful?

Align the interests of the purchaser/payer, provider and consumer using interactive incentives to triangulate™ a win-win-win...

Q&A

Jeff Greene
jgreene@medcentive.com
405-319-8450
www.medcentive.com