Enhancing Value in the Military Health System: Using 'Clinical Nuance' to Align Provider and Consumer Incentives

A. Mark Fendrick, MD
University of Michigan Center for Value-Based Insurance Design

www.vbidcenter.org
@um_vbid
<table>
<thead>
<tr>
<th>Factor</th>
<th>Odds ratio (and 95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Environmental</strong></td>
<td></td>
</tr>
<tr>
<td>Dim lighting</td>
<td>1.6 (0.8–2.5)</td>
</tr>
<tr>
<td>Warm room temperature</td>
<td>1.4 (0.9–1.6)</td>
</tr>
<tr>
<td>Comfortable seating</td>
<td>1.0 (0.7–1.3)</td>
</tr>
<tr>
<td><strong>Audiovisual</strong></td>
<td></td>
</tr>
<tr>
<td>Poor slides</td>
<td>1.8 (1.3–2.0)</td>
</tr>
<tr>
<td>Failure to speak into microphone</td>
<td>1.7 (1.3–2.1)</td>
</tr>
<tr>
<td><strong>Circadian</strong></td>
<td></td>
</tr>
<tr>
<td>Early morning</td>
<td>1.3 (0.9–1.8)</td>
</tr>
<tr>
<td>Post prandial</td>
<td>1.7 (0.9–2.3)</td>
</tr>
<tr>
<td><strong>Speaker-related</strong></td>
<td></td>
</tr>
<tr>
<td>Monotonous tone</td>
<td>6.8 (5.4–8.0)</td>
</tr>
<tr>
<td>Tweed jacket</td>
<td>2.1 (1.7–3.0)</td>
</tr>
<tr>
<td>Losing place in lecture</td>
<td>2.0 (1.5–2.6)</td>
</tr>
</tbody>
</table>

Note: CI = confidence interval.
Enhancing Value in the Military Health System: Overview

- Using Incentives to Enhance Quality of Care and Health of Beneficiaries
- New Approach: “Clinical Nuance”
- Value-Based Insurance Design
- Putting Innovation into Action
- Identifying and Removing Waste
- Synergies with Alternative Payment Models
Enhancing Value in the Military Health System: Shifting the discussion from “How much” to “How well”

- Innovations to prevent and treat disease have led to dramatic improvements in readiness and impressive reductions in morbidity and mortality
Enhancing Value in the Military Health System: Shifting the discussion from “How much” to “How well”

- Regardless of these advances, the amount of health care spending is the main focus of reform discussions.

TRICARE COSTS ARE ON THE RISE

- Innovative Therapies
- Increased Prices
- Enhanced Utilization
Enhancing Value in the Military Health System: Changes are Needed to Enhance Efficiency

- Aligning incentives for providers and beneficiaries is necessary to improve quality, enhance consumer experience and control spending
For the most part, current MHS payments are not directly tied to quality of care
Value-based incentive programs are included in 2015 NDAA (Sec. 726)

SEC. 726. PILOT PROGRAM ON INCENTIVE PROGRAMS TO IMPROVE HEALTH CARE PROVIDED UNDER THE TRICARE PROGRAM.

(a) PILOT PROGRAM.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Defense shall commence the conduct of a pilot program under section 1092 of title 10, United States Code, to assess whether a reduction in the rate of increase in health care spending by the Department of Defense and an enhancement of the operation of the military health system may be achieved by developing and implementing value-based incentive programs to encourage health care providers under the TRICARE program (including physicians, hospitals, and others involved in providing health care to patients) to improve the following:

1. The quality of health care provided to covered beneficiaries under the TRICARE program.
2. The experience of covered beneficiaries in receiving health care under the TRICARE program.
3. The health of covered beneficiaries.
Enhancing Value in the Military Health System: Align Consumer Incentives with Quality and Health

- Consumer behavior is a critical element in the decision to receive medical care
- Consumer cost-sharing has important impact on care-seeking and satisfaction
Deductibles on the rise
Percentage of covered workers with an annual deductible of $1,000 or more for single coverage

Source: Kaiser Family Foundation and Health Research and Educational Trust
“I can’t believe you had to spend a million dollars to show that if you make people pay more for something, they will buy less of it.”

Barbara Fendrick (my mother)
A growing body of evidence concludes that increases in consumer cost-sharing leads to a reduction in the use of essential services, worsens health disparities, and in some cases leads to greater overall costs.

Americans Reporting Problems Paying Medical Bills in Past Year

Source: Kaiser Family Foundation/New York Times Medical Bills Survey
Impact of Consumer Cost-Sharing on Plan Satisfaction

Lower-Deductible Health Plans
- Excellent Value: 19%
- Good Value: 49%
- Only a Fair Value: 22%
- Poor Value: 1%

High-Deductible Health Plans
- Excellent Value: 32%
- Good Value: 30%
- Only a Fair Value: 28%
- Poor Value: 3%

Source: Kaiser Family Foundation
• While important, the provision of price and quality information does not address appropriateness of care nor substantially impact provider and consumer behavior

• Health expenditures should be allocated based on the clinical benefit – not only the price – of services provided
Understanding CLINICAL NUANCE

Clinical Services Differ in the Benefit Produced

- Office Visits
- Diagnostic Tests
- Prescription Drugs
The Clinical Benefit Derived From a Service Depends On...

- Who receives it
- Who provides it
- Where it's provided
Clinical benefit depends on who receives it.

Screening for Colorectal Cancer

Screening Recipients

- First-degree relative of colon cancer sufferer: Exceptional Value
- Average risk 50 year old: High Value
- 30 year old with no family history of colon cancer: Low Value
who provides it...

High Performance

Certified

Poor Performance

- Poor
- Average
- Excellent
Clinical benefit depends on where care is provided.

- **Ambulatory Care Center**
  - Outpatient
  - $ $

- **Hospital**
  - Hospital
  - $$$$

$\text{where}$ care is provided.

Clinical benefit depends on the location where care is provided.
Implementing Clinical Nuance: Value-Based Insurance Design

Sets cost-sharing to encourage greater utilization of high-value services and providers and discourage use of low-value care.

- Successfully implemented by hundreds of public and private payers.
V-BID Momentum Continues

Source: 19th Annual Towers Watson/National Business Group on Health Employer Survey
### V-BID: Who Benefits and How?

<table>
<thead>
<tr>
<th>CONSUMERS</th>
<th>Payers</th>
<th>PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improves access</td>
<td>Promotes efficient expenditures</td>
<td>Enhances patient-centered outcomes</td>
</tr>
<tr>
<td>Lowers out-of-pocket costs</td>
<td>Reduces wasteful spending</td>
<td>Aligns with provider initiatives</td>
</tr>
</tbody>
</table>
Putting Innovation into Action
Broad Multi-Stakeholder Support

- HHS
- CBO
- SEIU
- MedPAC
- Brookings Institution
- The Commonwealth Fund
- NBCH
- PCPCC
- Families USA
- AHIP
- AARP
- National Governor’s Assoc.
- US Chamber of Commerce
- Bipartisan Policy Center
- Kaiser Family Foundation
- NBGH
- National Coalition on Health Care
- Urban Institute
- RWJF
- IOM
- PhRMA
• Patient Protection and Affordable Care Act
• Medicare
• State Health Reform
• Removing Waste
ACA Sec 2713: Selected Preventive Services be Provided without Cost-Sharing

- Receiving an A or B rating from the United States Preventive Services Taskforce (USPSTF)
- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP)
- Preventive care and screenings supported by the Health Resources and Services Administration (HRSA)

Over 137 million Americans have received expanded coverage of preventive services; over 76 million have accessed preventive services without cost-sharing
Putting Innovation into Action: Translating Research into Policy

- Patient Protection and Affordable Care Act
- Medicare
- State Health Reform
- Removing Waste
Why not lower cost-sharing on high-value services?

The anti-discrimination clause of the Social Security Act does not allow clinically nuanced consumer cost-sharing.

"providers may not deny, limit, or condition the coverage or provision of benefits"
H.R.2570/S.1396: Bipartisan “Strengthening Medicare Advantage Through Innovation and Transparency”

- Directs HHS to establish a V-BID demonstration for MA beneficiaries with chronic conditions

- Passed US House with strong bipartisan support in June 2015
CMS Announces Medicare Advantage Value-Based Insurance Design Model Test

A 5-year demonstration program will test the utility of structuring consumer cost-sharing and other health plan design elements to encourage patients to use high-value clinical services and providers.

*Red denotes states included in V-BID model test*
Putting Innovation into Action: Translating Research into Policy

- Patient Protection and Affordable Care Act
- Medicare
- State Health Reform
- Removing Waste
• State Exchanges – Encourage V-BID (CA, MD)
• Medicaid – Michigan
• State Innovation Models – NY, PA, CT, VA
• State Employee Benefit Plans
Value-Based Insurance Design
Growing Role in State Employee Plans
Connecticut’s Value-Based Insurance Plan Increased The Use Of Targeted Services And Medication Adherence
Key Features of the HEP
Align out-of-pocket costs with healthy behaviors

- **Voluntary Enrollment**
- **Full Preventive Care Coverage**
- **Reduced cost-sharing** for visits & medications to better manage specific clinical conditions
- **Increased cost-sharing** for non-emergent ED visits

Participatory Requirement:
to maintain enrollment, members must complete age-appropriate preventive care & recommended chronic disease services
HEP Impact: 2 Year Results

1. Office Visit Increases

Preventive Visits

- Year 1: 13.5%
- Year 2: 4.8%

Chronic Condition Visits

- Year 1: 1.6%
- Year 2: 1.2%

Relative change for HEP members compared to enrollees in control states
HEP Impact: 2 Year Results

[2] Preventive Care Utilization

Lipid Screening

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEP</td>
<td>50</td>
<td>70</td>
<td>90</td>
</tr>
<tr>
<td>Comparison</td>
<td>50</td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>

Mammography

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEP</td>
<td>25</td>
<td>45</td>
<td>65</td>
</tr>
<tr>
<td>Comparison</td>
<td>25</td>
<td>25</td>
<td>25</td>
</tr>
</tbody>
</table>
HEP Impact: 2 Year Results

[3] Resource Use

ED Visits per 1,000 enrollees

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEP</td>
<td>250</td>
<td>200</td>
<td>150</td>
</tr>
<tr>
<td>Comparison</td>
<td>150</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Spending - Year 2

<table>
<thead>
<tr>
<th></th>
<th>Full Sample</th>
<th>Chronic Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>US Dollars ($)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Spending</td>
<td>1000</td>
<td>900</td>
</tr>
<tr>
<td>Out-of-pocket</td>
<td>-100</td>
<td>-100</td>
</tr>
</tbody>
</table>

City overhauls health plans for municipal workers in shift toward preventive care

Changes to employees’ co-pays will make primary care cheaper while ER visits and urgent care will be pricier.

“These changes will not only secure the promised health savings, but will also promote better utilization of health care resources and improved health outcomes for City employees”
• Patient Protection and Affordable Care Act
• Medicare
• State Health Reform
• **Removing Waste**
# Identifying and Removing Waste

<table>
<thead>
<tr>
<th>Category</th>
<th>Sources</th>
<th>Estimate of Excess Costs</th>
<th>% of Waste</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unnecessary Services</strong></td>
<td>• Overuse beyond evidence-established levels&lt;br&gt;• Discretionary use beyond benchmarks&lt;br&gt;• Unnecessary choice of higher-cost services</td>
<td>$210 billion</td>
<td>27%</td>
<td>9.15%</td>
</tr>
<tr>
<td><strong>Inefficiently Delivered Services</strong></td>
<td>• Mistakes, errors, preventable complications&lt;br&gt;• Care fragmentation&lt;br&gt;• Unnecessary use of higher-cost providers&lt;br&gt;• Operational inefficiencies at care delivery sites</td>
<td>$130 billion</td>
<td>17%</td>
<td>5.66%</td>
</tr>
<tr>
<td><strong>Excess Admin Costs</strong></td>
<td>• Insurance paperwork costs beyond benchmarks&lt;br&gt;• Insurers’ administrative inefficiencies&lt;br&gt;• Inefficiencies due to care documentation requirements</td>
<td>$190 billion</td>
<td>25%</td>
<td>8.28%</td>
</tr>
<tr>
<td><strong>Prices that are too high</strong></td>
<td>• Service prices beyond competitive benchmarks&lt;br&gt;• Product prices beyond competitive benchmarks</td>
<td>$105 billion</td>
<td>14%</td>
<td>4.58%</td>
</tr>
<tr>
<td><strong>Missed Prevention Opportunities</strong></td>
<td>• Primary prevention&lt;br&gt;• Secondary prevention&lt;br&gt;• Tertiary prevention</td>
<td>$55 billion</td>
<td>7%</td>
<td>2.40%</td>
</tr>
<tr>
<td><strong>Fraud</strong></td>
<td>• All sources – payers, clinicians, patients</td>
<td>$75 billion</td>
<td>10%</td>
<td>3.27%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>$765 billion</td>
<td></td>
<td>33.33%</td>
</tr>
</tbody>
</table>

**SOURCE:** “Best Care at Lower Cost: The Path to Continuously Learning Health Care in America.” Institute of Medicine (2013)
Removing Waste
Health Waste Calculator

Software tool designed to identify wasteful medical spending:

- U.S. Preventive Services Task Force
- Choosing Wisely

Underlying algorithms process claims, billing or EMR data to identify waste

Defines services with a degree of appropriateness of care

- Necessary
- Likely to be wasteful
- Wasteful
Removing Waste
Health Waste Calculator – Sample Results Large Payer

- 20% of members exposed to 1+ wasteful service
- 36% of services were wasteful
- 2.4% or $11.94 PMPM in claims wasted
## Top 5 Measures by Cost Overall - 2014

<table>
<thead>
<tr>
<th>Measure</th>
<th>Total Services Measured</th>
<th>Waste Index (%)</th>
<th>Unnecessary Services (#)</th>
<th>Unnecessary Spending ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline laboratory studies in patients without systemic disease undergoing low-risk surgery</td>
<td>571,600</td>
<td>79%</td>
<td>453,447</td>
<td>$184,781,018</td>
</tr>
<tr>
<td>Stress cardiac or advanced non-invasive imaging in the initial evaluation of patients w/o symptoms</td>
<td>219,878</td>
<td>13%</td>
<td>27,817</td>
<td>$185,997,938</td>
</tr>
<tr>
<td>Annual electrocardiograms (EKGs) or other cardiac screening for low-risk patients without symptoms.</td>
<td>2,268,194</td>
<td>6%</td>
<td>147,423</td>
<td>$60,499,385</td>
</tr>
<tr>
<td>Routine annual cervical cytology screening (Pap tests) in women 21–65 years of age</td>
<td>199,865</td>
<td>81%</td>
<td>161,539</td>
<td>$37,558,706</td>
</tr>
<tr>
<td>PSA-based screening for prostate cancer in all men regardless of age.</td>
<td>313,011</td>
<td>42%</td>
<td>132,793</td>
<td>$31,501,675</td>
</tr>
</tbody>
</table>

*Certain measure had a waste index of 100%*
Aligning Payer and Consumer Incentives: As Easy as Peanut Butter and Jelly

Many “supply side” initiatives are restructuring provider incentives to move from volume to value:

- Medical Homes
- Accountable Care
- Bundled Payments
- Reference Pricing
- Global Budgets
- High Performing Networks
- Health Information Technology
Unfortunately, some “demand-side” initiatives – including consumer cost sharing and a lack of incentives to stay within an ACO - discourage consumers from pursuing the “Triple Aim”
Impact of Aligning Physicians and Patients: Financial Incentives to Lower Cholesterol

The alignment of clinically nuanced, provider-facing and consumer engagement initiatives is a necessary and critical step to improve quality of care, enhance patient experience, and contain cost growth.
V-BID Impact

- Bipartisan political support
- Multi-stakeholder endorsement
- Implemented by hundreds of public and private organizations
  - Enhances access to preventive care for 137 million Americans
- CMS implements MA V-BID model test in 7 states
# Implementing V-BID in TRICARE

<table>
<thead>
<tr>
<th>TRICARE plans...</th>
<th>V-BID plans...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase out-of-pocket costs</td>
<td>Promote efficient expenditures</td>
</tr>
<tr>
<td>Offer one-size-fits-all cost-sharing</td>
<td>Increase use of high-value services and providers</td>
</tr>
<tr>
<td>Limit provider access</td>
<td>Enhance clinical outcomes</td>
</tr>
<tr>
<td>Misalign consumer and provider incentives</td>
<td>Align with provider initiatives</td>
</tr>
</tbody>
</table>
Discussion

Slides and additional resources may be accessed at:  www.vbidcenter.org