Health Care Transformation and Benefit Design: Translating Research into Policy

A. Mark Fendrick, MD
University of Michigan Center for Value-Based Insurance Design
www.vbidcenter.org
@um_vbid

Table 1: Risk factors for nodding off at lectures

Factor	Odds ratio (and 95% CI)
Environmental	
Dim lighting	1.6 (0.8–2.5)
Warm room temperature	1.4 (0.9–1.6)
Comfortable seating	1.0 (0.7–1.3)
Audiovisual	
Poor slides	1.8 (1.3–2.0)
Failure to speak into microphone	1.7 (1.3–2.1)
Circadian	
Early morning	1.3 (0.9–1.8)
Post prandial	1.7 (0.9–2.3)
Speaker-related	
Monotonous tone	6.8 (5.4–8.0)
Tweed jacket	2.1 (1.7–3.0)
Losing place in lecture	2.0 (1.5–2.6)

Note: CI = confidence interval.

Improving Care and Bending the Cost Curve
Our Goal is to Improve Health, Not Save Money

- Cost growth remains the principle focus of health care reform discussions
- Despite unequivocal evidence of clinical benefit, substantial underutilization of high-value services persists across the spectrum of clinical care

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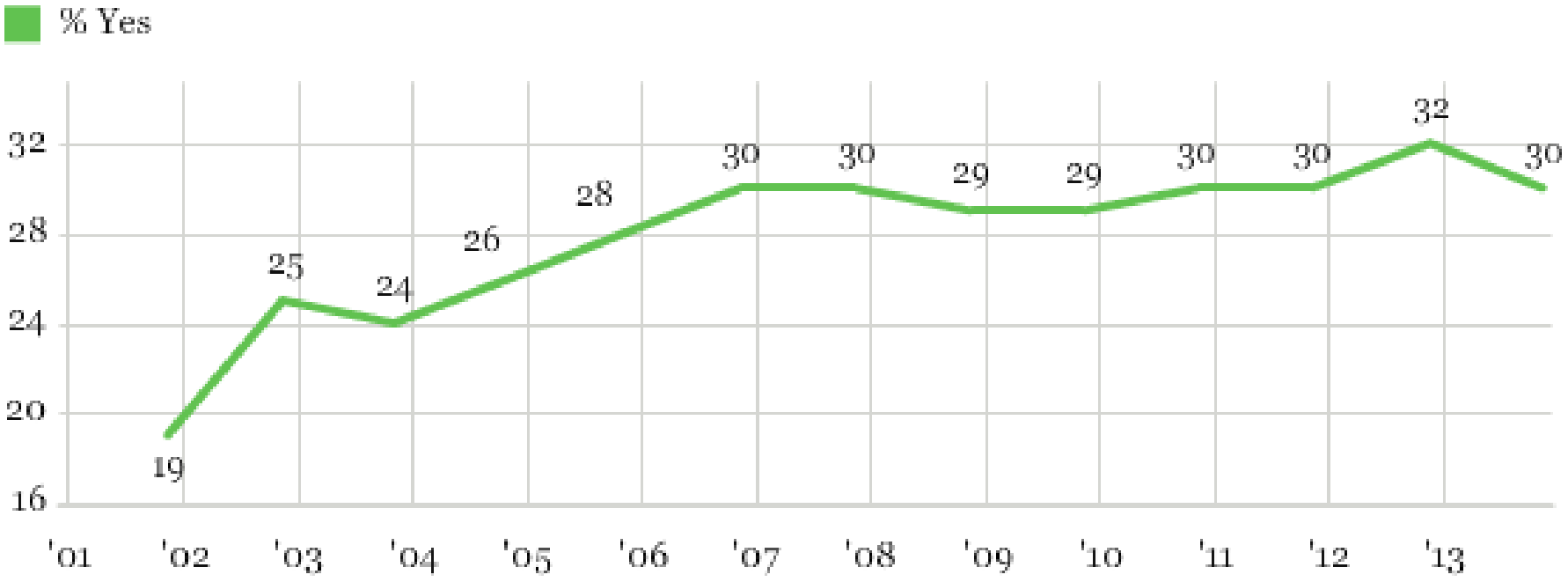
December 9, 2013

Costs Still Keep 30% of Americans From Getting Treatment

Lower-income and younger adults most likely to have delayed treatment

Percentage of Americans Putting Off Medical Treatment Because of Cost

Within the last 12 months, have you or a member of your family put off any sort of medical treatment because of the cost you would have to pay?



GALLUP

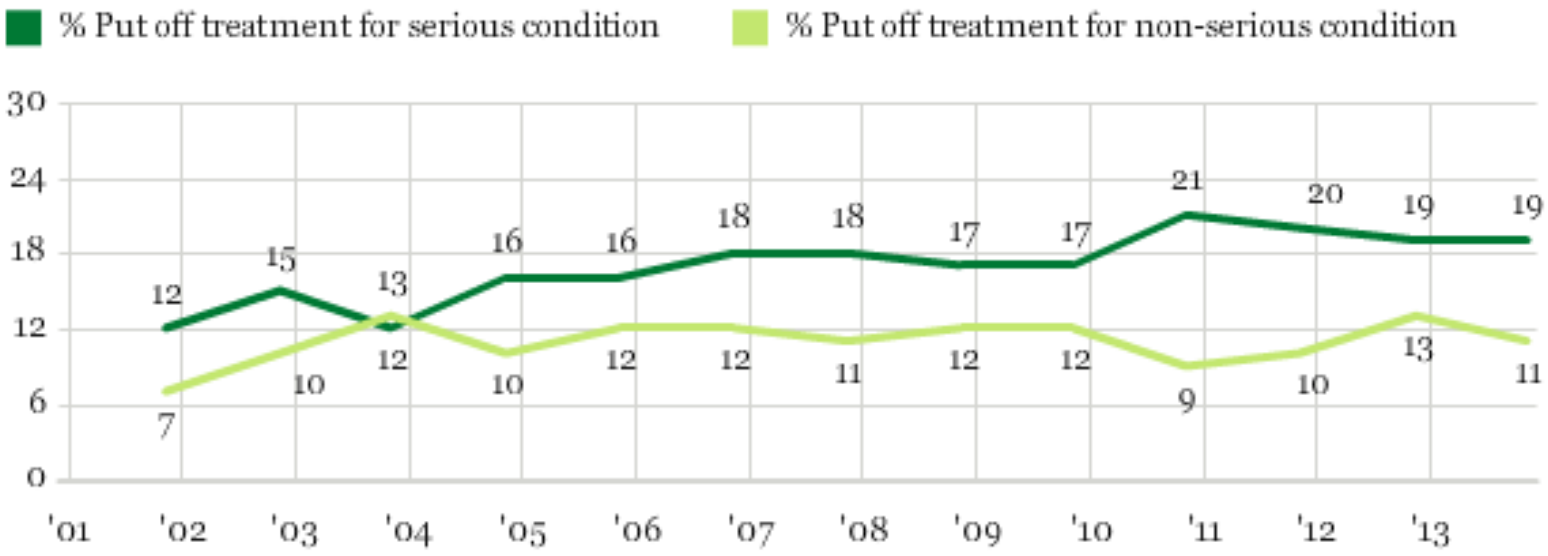
December 9, 2013

Costs Still Keep 30% of Americans From Getting Treatment

Lower-income and younger adults most likely to have delayed treatment

Putting Off Treatment For a Serious vs. Non-Serious Condition

When you put off this medical treatment, was it for a condition or illness that was -- very serious, somewhat serious, not very serious, or not at all serious?



Note: Combined question results among all Americans; % who did not put off treatment is not shown.

GALLUP

The Problem: "One Size Fits All" Cost Sharing

Cost sharing for medical services and providers are the same for...

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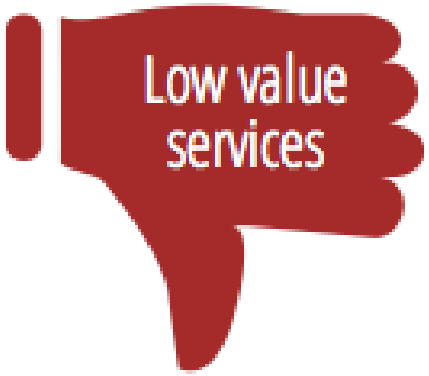

+ Strong evidence base
+ Enhance clinical outcomes
+ Increase efficiency

- Weak evidence base
- Minimal or no clinical benefit
- Increase inefficiency

...despite evidence-based differences in value.

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Patient Cost-sharing Negatively Affects Adherence to High-Value Clinical Services

- A growing body of evidence demonstrates that increased patient cost-sharing leads to decreases in non-essential and essential care which, in some cases, lead to greater overall costs

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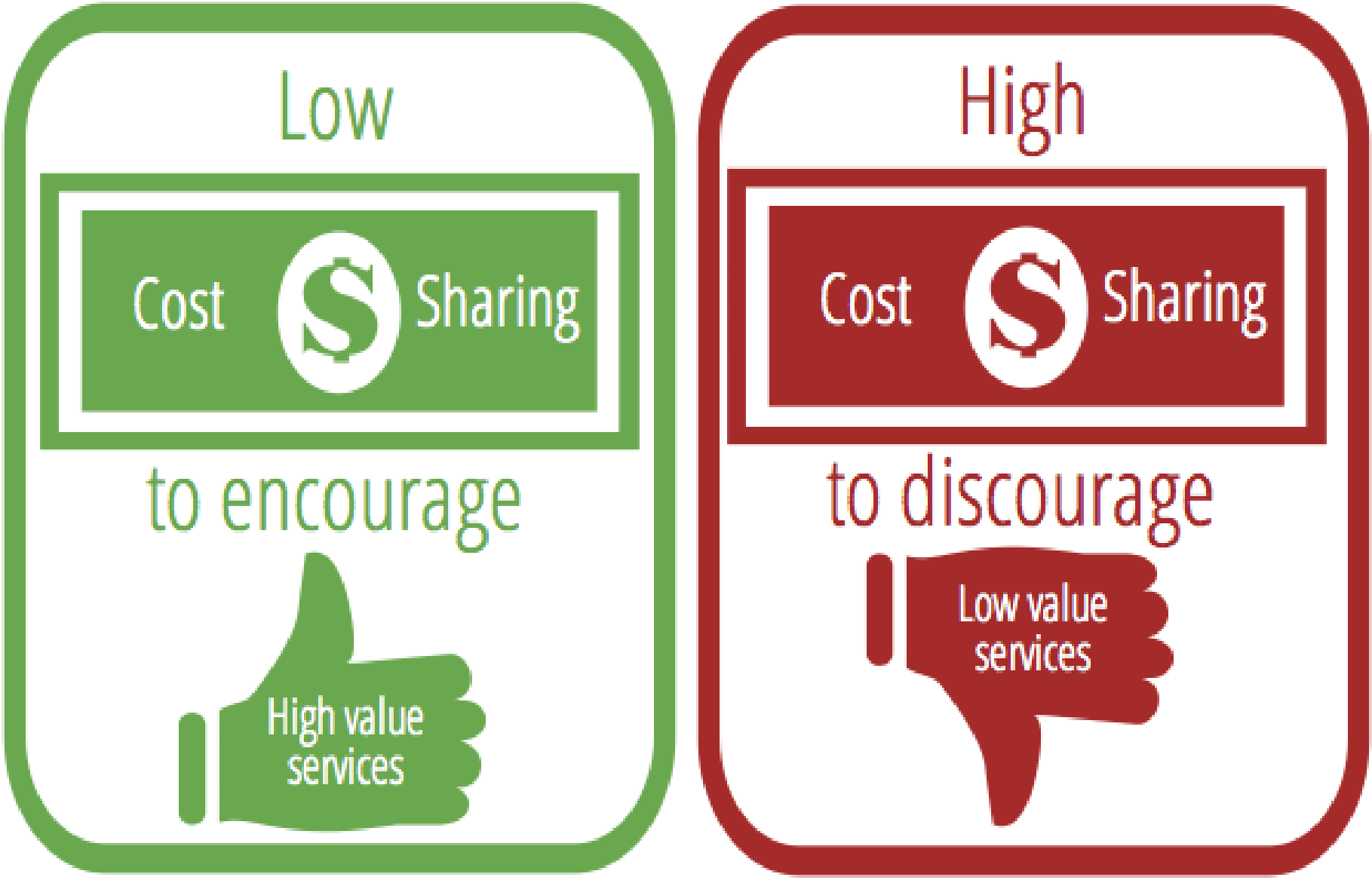
A New Approach: Clinical Nuance

1. Services differ in clinical benefit produced

2. Clinical benefits from a specific service depend on:

The Solution: Clinically-Nuanced Cost Sharing



Patient Protection and Affordable Care Act
V-BID Included

"2713(c) Valued-based Insurance Design. –The Secretary may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs."

ACA Section 2713
Selected Preventive Services be Provided without Cost Sharing

- Receiving an A or B rating from the United States Preventive Services Taskforce
- Immunizations recommended by the Advisory Committee on Immunization Practices
- Preventive care and screenings supported by the Health Resources Administration (HRSA) for infants, children and adolescents
- Additional preventive care and screenings recommended by HRSA for women

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The Results: Benefits for All Stakeholders

Consumers

Improves access to necessary services
Enhances clinical outcomes
Lowers out of pocket costs

Payers

Aligns with provider initiatives
Promotes efficient expenditures
Reduces wasteful spending

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V-BID: Implementation and Impact

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Align Payer and Consumer Incentives

V-BID

Using Clinical Nuance to Align Payer and Consumer Incentives

Many initiatives are restructuring provider incentives:

- PCMH
- ACOs
- Payment reform
  - Global budgets
  - Pay-for-performance
  - Episodes/Bundled payments
  - Reference pricing
- Tiered networks
- Health information technology

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Align Payer and Consumer Incentives

Unfortunately, “supply-side” initiatives have historically paid little attention to consumer decision-making or the “demand-side” of care-seeking behavior:

- Shared decision-making
- Literacy
- Benefit design

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Putting it All Together

- Adding clinical nuance into payment reform and consumer engagement initiatives can help ACOs attain these elusive goals.
- The alignment of supply- and demand-side incentives can improve quality and achieve savings more efficiently than either one alone

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Integrated Health Partners
Calhoun County Pathways to Health

Mary Ellen Benzik, MD

12/12/13

Formula for Success

1. (D)(V)(F) > R
   - Data (vision)(first step) > resistance
   - None can be zero
2. V = leadership x idea (my addition to above)
3. 

Journey Begins - 2006 BCBSM

(D) (V) (F) > R

- Start a registry
- Study the chronic care model – “this is going to take a community”
- Meet with key stakeholders
  - Hospital CEO
  - WK Kellogg Foundation

Calhoun County Pathways to Health is Born

- Multi-stakeholder initiative to transform care delivery utilizing the CCM
- The mission was to transform chronic care delivery, impact quality of health, and create supporting IT infrastructure to allow data analytics at the community leve
- Created three councils
  - Employer /insurer emphasis benefit redesign
  - Physician redesign care delivery
  - Patient engaging patients in their care , and in the redesign of care
- Monthly steering committee meetings with representation from all stakeholder groups

(D) (V) (F) > R

RWJF AF4Q RFP

- Data registry starting, MDCH

community quality metrics

- Leadership and vision seems in place
- Complete application which is denied

(seemed like as soon as it's received!!)

- The denial was the best thing that could have happened

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Physician Collaboratives

- Multiple waves of quality improvement work with team based care redesign
- Over 5 year period through the collaboratives,
  - 75% of primary care practices in Calhoun County have completed transformative learning collaboratives
  - leading to sustained improvements in diabetes care in six of the seven quality outcome metrics. This metrics continue to improve 24 months post collaborative
  - They have experienced spread to other chronic diseases, with coronary artery metrics improving 64% over baseline in a four year period
  - Improvements have occurred across all payer groups including Medicaid and uninsured, leading to a narrowing of disparities related to LDL and blood pressure at target

Care Management Collaborative (CMC)

- The Care Management Collaborative of the CCPTH has engaged multiple community stakeholders in improving the care delivery system across the continuum.
  - Over 20 community partners have collaborated since 2009, with a result of decreasing readmissions by 8% despite greater uninsured and access issues.
  - IHP has been named for the last two years a benchmark organization by Blue Cross Blue Shield of Michigan (BCBSM) related to Ambulatory Care Sensitive Conditions Admissions and ED utilization.(2010,2011)
  - Since 2006, there has been a steady decrease in admission rate, with a 7% decrease from baseline. (5.2% to 4.8%)

(D) (V) (F) > R for the CMC

- Physician practices were complaining about the care continuum issues, quality was still lagging
- “this is going to take a community” , gaps were still glaring at us to create the vision
- Pulling all the players first for a meeting which evolved into their own collaborative

CMC –That which doesn't kill you makes you strong!

- Data was difficult to get in cross organizational work without supporting infrastructure
- Cross organizational work is

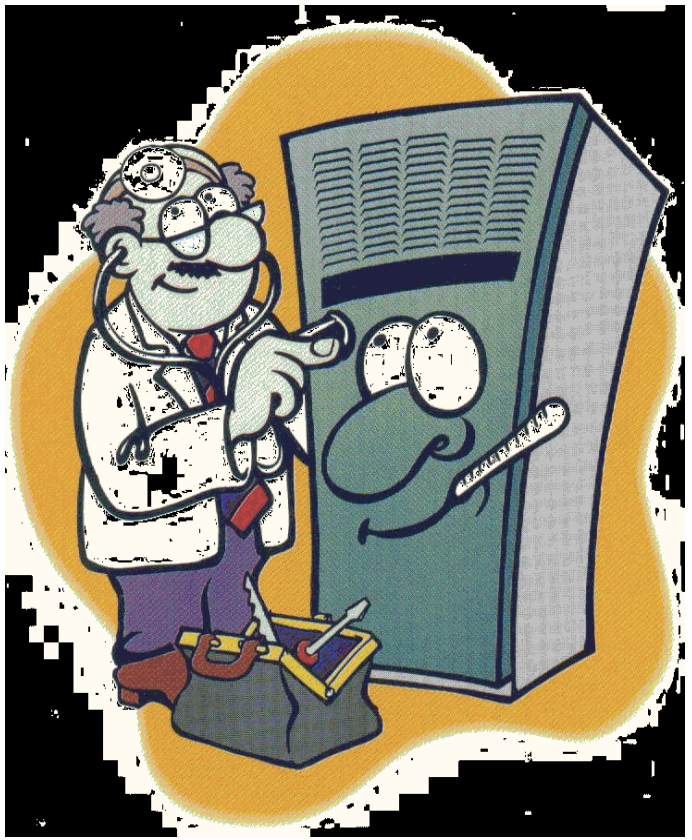
very difficult

- No funding for the work

IHP financial support

- Furnace story –
- Developed community portal

for care management



Consumer Council

- Abysmal failure
- Morphed to the consumer advisory council
- Quarterly questions to consumer stakeholders
- Aggregated to gather population Input to the work

Employer Collaborative

- Patiently waited for their role to evolve
- Developed a learning environment utilizing the framework of Dr. Eddigton “Zero Trend”
- Created synergy for multiple employers to develop aligned value based benefit models related to diabetic care
  - Kellogg Company
  - City of Battle Creek
  - Trinity Health

RWJF RFP – Third Time (almost) Magic

- Requesting proposals related to care transformation and payment reform
- Short application window
- Near missed funding

opportunity

- Thanks to all whom helped

pull it out

RWJF – We Made It!!

- Calhoun County Pathways to Health – Synergy of PCMH and VBID Determination of Component Elements to Quality

  - Analyzing the impact of patient-centered medical homes, value-based insurance design and those initiatives together on clinical outcomes
  - Begun October 2010, with completion of the data analysis in October 2012

Clinical Quality Analysis

- The impact of PCMH was analyzed for effect on quality and cost.
- This was undertaken in separate design components from the VBID the analytic team included a core team at Center for Health Research and Transformation, affiliated with the University of Michigan.
- All primary care practices involved were actively engaged with the PHO in the transformative work to PCMH. IHP had created a community registry to track patient outcomes related to chronic disease and prevention.
- Evaluation of the quality of diabetic care delivery was chosen was the area that impacted the community significantly, and was the focus of attention of the health care community since the beginning of the initiative.

Cost Analysis

- Cost analysis was much more complex than conceived in the grant
- Evolved to examining utilization data included pharmacy, professional, and inpatient and outpatient facility data.
- The analyses also include estimations of standardized costs for pharmacy data. Utilization data was analyzed for four consecutive six month intervals

(D) (V) (F) > R for the RWJF Grant

- Lots of data – just difficulty getting it all organized and useful
- The team was committed that this data could contribute to the body of knowledge - passionate to be a part of research
- Strong analytic team that knew how to create the first steps to complicated analytical processes that wasn't present in IHP skill set

Findings from the Grant

- Challenges related to small N and significant change in practices designation
  - Lower quality practice, with high volume moved to PCMH
- Failed to demonstrate statistically significant differences between PCMH and non PCMH practices on cost – pharmacy , utilization
- Due to waived IRB status , no further patient level data analytics could be undertaken. We could not further link the patient outcomes (on identified diabetic quality metrics) to their utilization /cost data

Probing the Public's View on V-BID

- Seven community- based two-hour focus group (N= 66) to discuss value-based insurance design components.

Three V-BID plan scenarios were discussed including:

- Reduced co-pays for effective treatments of chronic diseases such as diabetes. (Carrot)

- Higher co-pays for unnecessary health care such as early MRI scans for acute back pain (Stick)

- Discontinued insurance coverage for ineffective or dangerous health care such as an ineffective cancer medication with clinically indicated life-threatening side effects. (Stick)

Central Discussion Themes

Participants noted that “carrot” no co-pays for treatments known to lead to good health outcomes would be **an incentive for seeking and using health care**.

Participants favored V-BID “stick” elements of **disincentives for ineffective/unnecessary care.**

Participants favored **treatment decisions made by those with medical expertise** rather than by patients’ treatment preferences.

Participants were in favor of potential **cost savings** with this kind of health insurance.

Consumer Skepticism

Perhaps because the V-BID approaches described in the three scenarios seemed like new ideas to many of the participants, there was considerable discussion regarding:

- **Unfair health care benefit distribution**
- **Patients' personal responsibility expectations**
- **Increased costs to other employees and patients**
- **Increased out-of-pocket costs**
- **Mistrust of evidence regarding effective health care treatments**
- **Loss of individual patients' control and health care choices**
- **Mistrust of research on value-based insurance approaches**
- **Limited choices in their health plans**

Overall Findings

The results revealed a wide variety of ideas and opinions about V-BID approaches in health insurance plans.

Results suggest that the participants understood the potential advantages of V-BID approaches including incentives for effective care (e.g., no co-payments) and disincentives for ineffective care (e.g., higher co-payments).

The participants also held concerns that led them to mistrust or disagree with V-BID approaches saying that V-BID approaches encroached on some participants' sense of fairness, personal responsibility, health privacy rights, hopes for positive outcomes, and patient freedom to choose health care.

Where Do We Go from Here?

Additional consumer education/provider dialogues necessary.

The importance of consumer engagement and communication, trust, and comprehension cannot be overlooked

V-BID recommends the use of *clinical nuance* in plan design.
to shift from volume-based to value-based insurance benefits and payment models.

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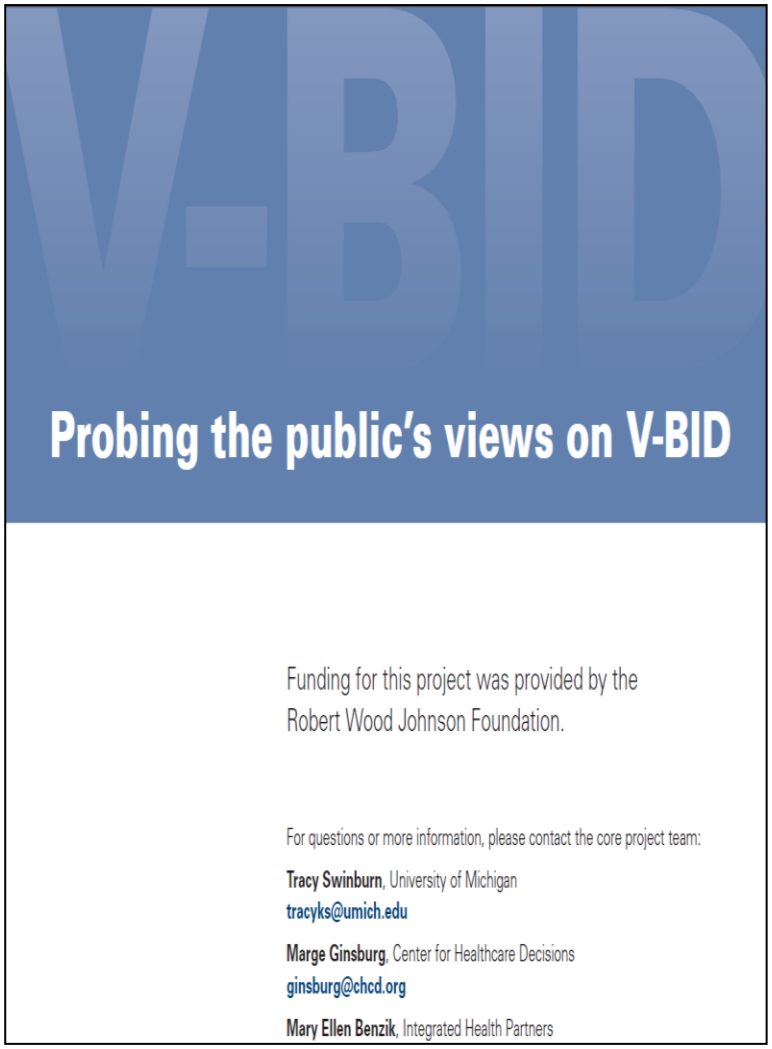
To read more…



http://www.sph.umich.edu/vbidcenter/publications/pdfs/VBID-ProbingthePublicsViewonVBID-Jun12.pdf

http://www.sph.umich.edu/vbidcenter/publications/pdfs/Probing%20the%20Public%27s%20view%20on%20VBID%20II.pdf

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Spread of CCPTH

- Care management

Collaborative to MIPCT

- Virtual Consumer

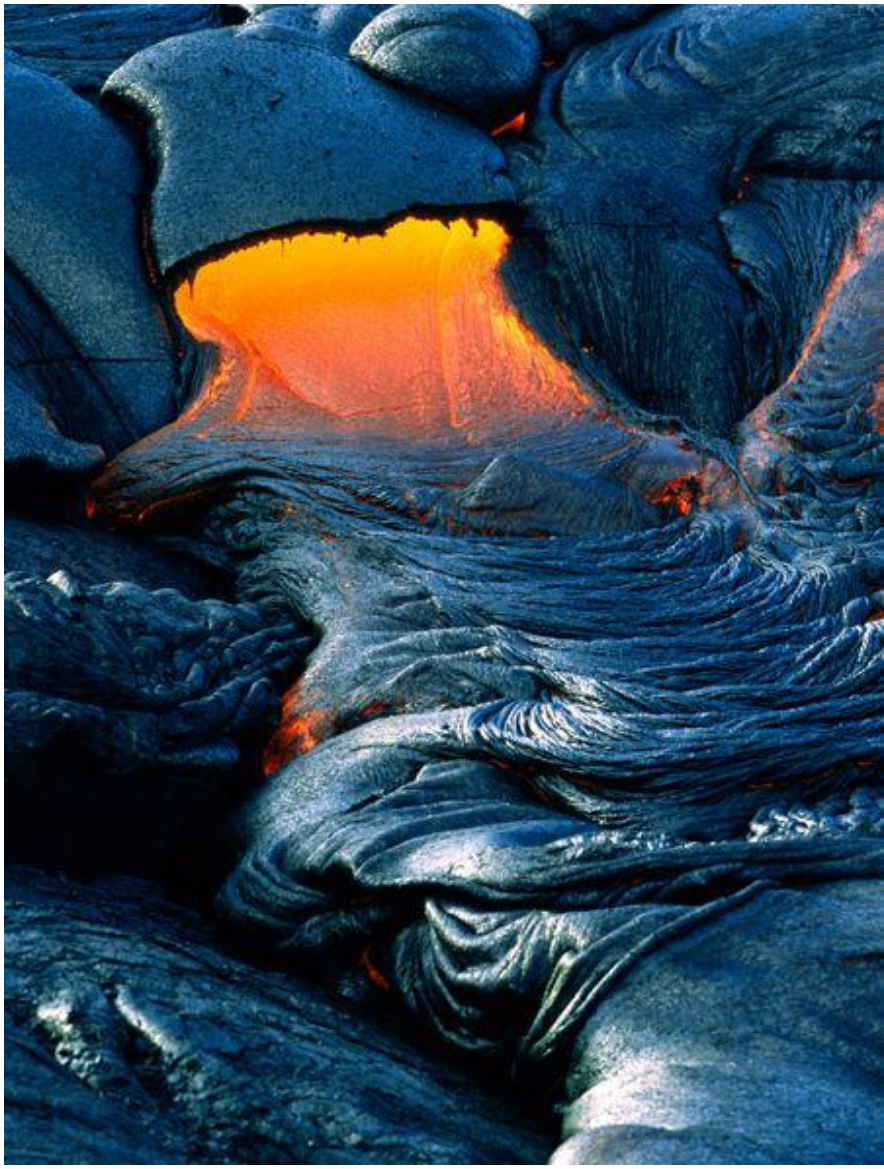
Advisory council

- Ambulatory

Learning Collaborative

Methodology for

CHE Trinity Health



Where is IHP/CCPTH Now?

- Physician Collaborative
  - Inclusion of specialist to work to create a medical neighborhood
- Care Management Collaborative
  - Continues to engage more Partners
- Employers Work
  - Delivering provider delivered care manag practices instead of vendor CM
- Creation of a “dream team”
  - Subgroup of the CCPTH to create solutions and funding streams
  - Involves IHP, mental health and community free clinic

JAMA
Proposals Unanimously Support Value-Based Payment and V-BID

Table. Policy Comparisons

Policy[a]	Organization						
	Bipartisan Policy Center	Brookings Institution	The Commonwealth Fund	Kaiser Family Foundation[b]	National Coalition on Health Care	Partnership for Sustainable Health Care	Urban Institute
Value-based payment reform	✓	✓	✓	✓	✓	✓	✓
Value-based insurance design	✓	✓	✓	✓	✓	✓	✓
Efficient administration and markets							
Administrative/information technology	✓	✓	✓	✓	✓	✓	
Antitrust	✓	✓	✓	✓		✓	
Medical malpractice	✓	✓	✓	✓	✓	✓	
Evidence-based benefits	✓			✓	✓	✓	
Work force	✓	✓	✓		✓	✓	
Broad reforms							
Medicare structural reforms	✓		✓	✓			✓
Taxes	✓	✓		✓			✓
Caps	✓	✓		✓			

[a] Value-based payment reform: rewarding quality and better outcomes over volume of unit services. Value-based insurance design: benefit designs incentivizing patient choice of higher-quality treatments, clinicians, and hospitals and choice of healthier lifestyles and adherence to effective treatment. Administrative/information technology: improvements that reduce costs. Antitrust: ensure healthy competition in local health care markets. paying for demonstrated clinical effectiveness. Work force: policies promoting provider efficiencies. Taxes: federal tax exemption changes enhancing insurance competition. Caps: total dollar limits, or targets with overspending consequences.

[b] Kaiser Family Foundation's January 2013 report presents an array of policy options without specific recommendations.

HBR Blog Network

Smarter Consumer Cost Sharing Using Clinical Nuance

by A. Mark Fendrick and John Z. Ayanian | 9:30 AM November 15, 2013

Comments (0)

Clinically Nuanced Payment and Cost Sharing
Improving Care and Bending the Cost Curve

- The ultimate test of health reform will be whether it improves health and addresses rising costs
- The use of “clinically nuanced” incentives [and disincentives] to encourage [and discourage] patient and provider behavior to redistribute medical expenditures will ultimately produce more health at any level of health expenditure

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Contact Information

- **Ruth Clark , RN**
  - Executive Director IHP
  - 269-245-3852
  - ClarkrU@bronsonhg.org

- **Mary Ellen Benzik, MD**
  - CMO Health Networks CHE Trinity Health-
  - benzikm@trinity-health.org

- **A. Mark Fendrick, MD**
  - Director, Center for Value-Based Insurance Design
  - amfen@umich.edu

- **Kaden Milkovich, MPA**
  - Manager, Center for Value-Based Insurance Design
  - kmilkovi@umich.edu
  - www.vbidcenter.org /@um_vbid
  - 734-615-9635