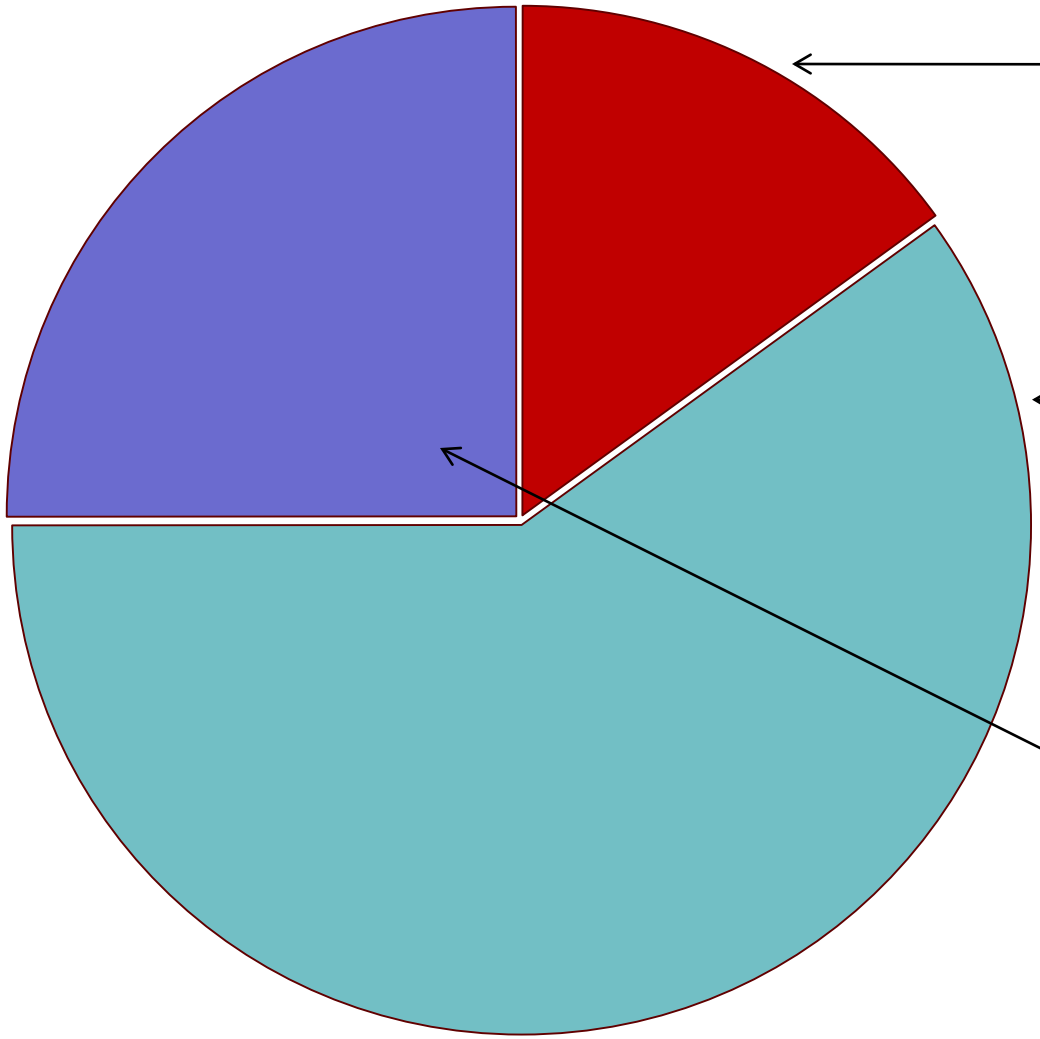
Getting Better Value for the Healthcare Dollar

Key points

- **Transparency initiatives and value-based purchasing are common across payers**
- **Sometimes public programs lead, other times they follow**
- **Medicare has unique leverage, data**
- **Public-private alignment can be very effective in moving initiatives**
- **Greater push behind common quality and cost measures can get us out of the doldrums**

Conceptual framework



Effective care (15%)
Making health plans and delivery system accountable, rewarding results

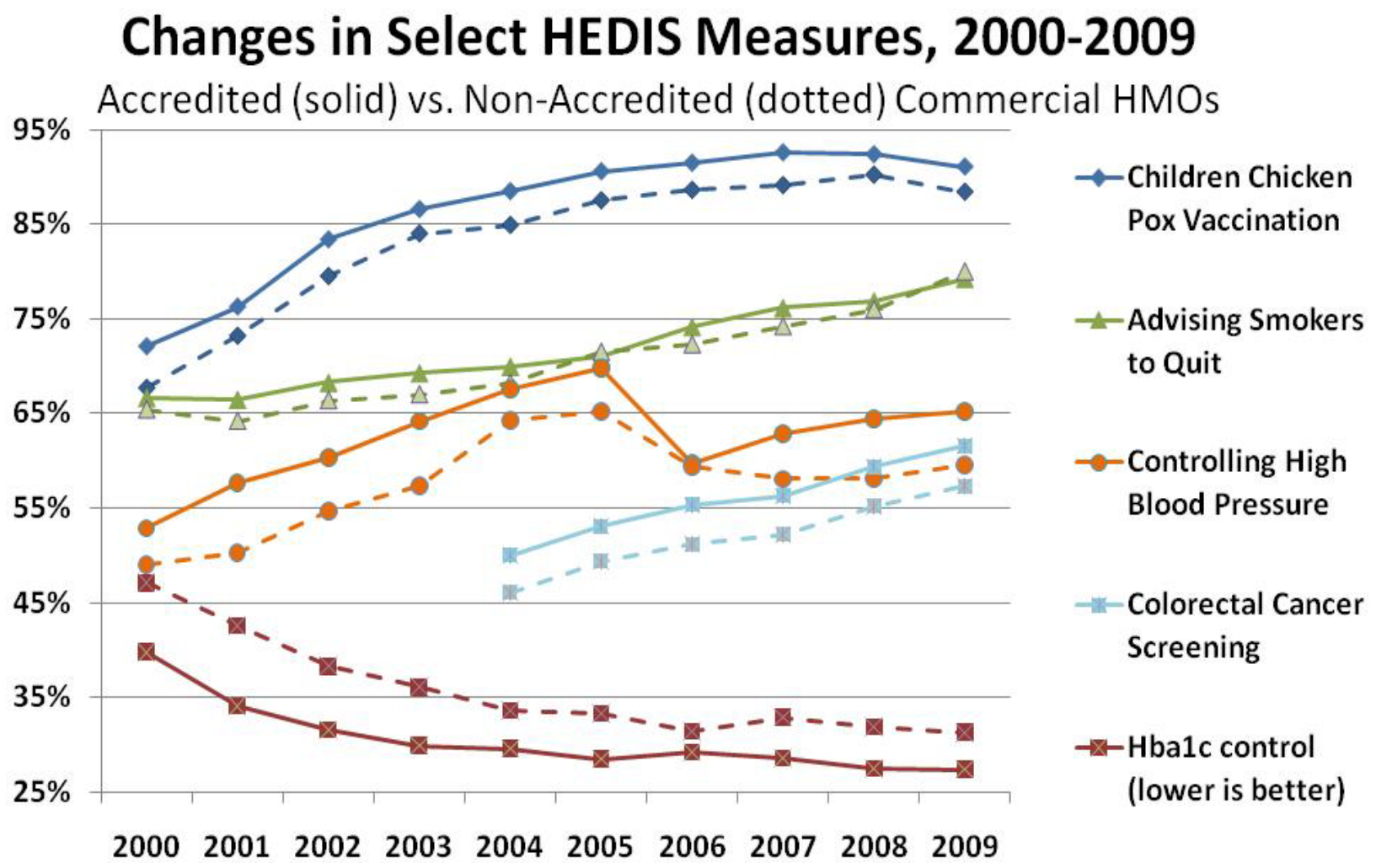
Supply-sensitive care (60%)
Accountability mechanisms at the delivery system level, use incentives to drive results

Preference-sensitive care (25%)
Comparative effectiveness research, shared decision making and patient activation

Source: Wennberg estimates based on Medicare claims

PUBLIC REPORTING AND VALUE-BASED PURCHASING FOR HEALTH PLANS

What Gets Measured Gets Improved



Relative Resource Use (RRU) Measures

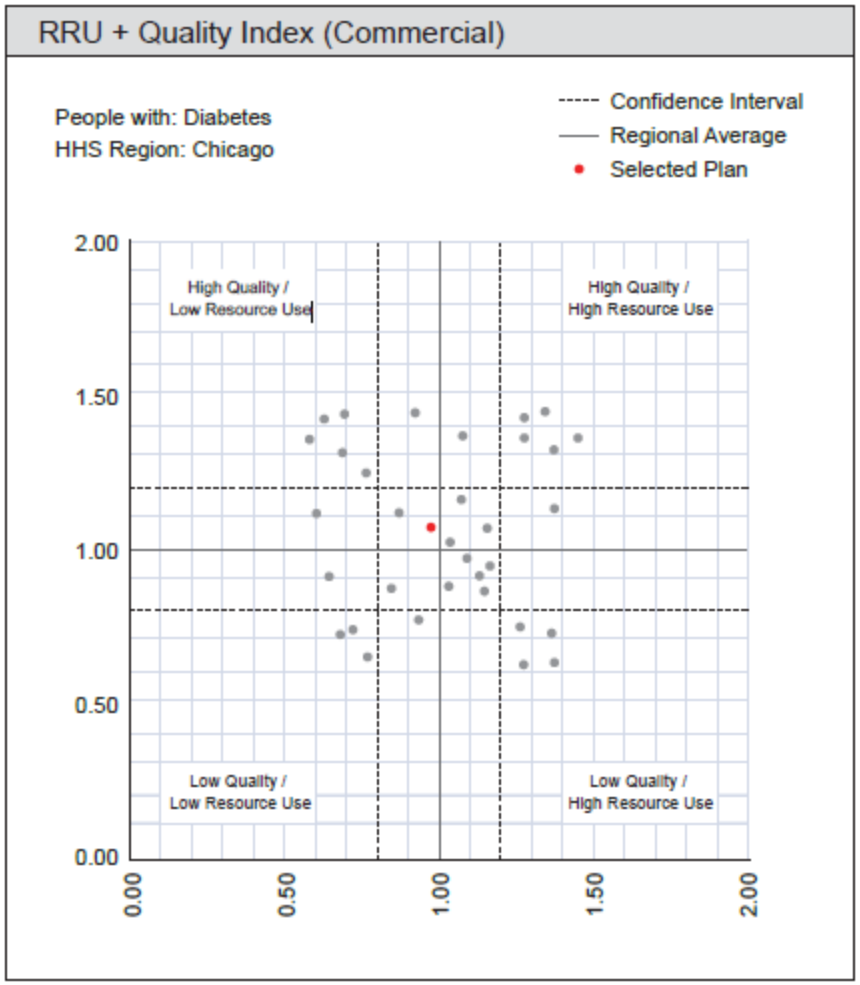
- **Indicate how intensely physician, hospital other resources are used vs. similar plans**

Focus on 6 high-cost chronic conditions that total over 50% of costs: diabetes, asthma, COPD, cardiac care, hypertension, low back pain

- **With HEDIS, RRUs let us talk about quality and cost together: the *value* plans offer, not merely unit price and discount**
- **Can be used at plan *and* large group level**

RRU Results

Combining the Index ratio together with the quality index will provide critical information to purchasers of health plan services on comparative cost and quality of care to select health plans and providers



Resource Use and Quality Results

Plan D Achieves the Highest Quality with Low Resource Use

Sample Diabetes Relative Resource Use in a Single State – HEDIS 2008:

Plan	Diabetes Quality Composite	Diabetes Medical Components Resource Use				Pharmacy Resource Use
		Combined Medical	Inpatient Facility	Eval & Mngmt	Surgery & Procedures	
Plan A	**1.06**	**1.14**	1.32	1.00	0.89	**1.14**
Plan B	**1.10**	**0.85**	0.96	0.74	0.73	**1.12**
Plan C	**1.10**	**0.80**	0.84	0.79	0.71	**1.16**
Plan D	**1.14**	**0.74**	**0.77**	**0.85**	**0.56**	**1.13**
Plan E	**0.97**	**0.73**	0.79	0.76	0.54	**1.19**

Note: 1.00 = average, Less than 1.00 = below average, Greater than 1.00 = above average

Medicare Advantage Star Ratings

- **Summarizes clinical and patient experience data into easy-to-use stars**
- **Significant detail on individual plans**
- **Plans working much harder to improve now that:**
  - **Only 4+ star plans get bonuses that let them offer better benefits/cost sharing**
    - **Temporary demo gives bonus to 3+ plans thru 2014**
  - **5 star plans can have continuous enrollment**
  - **New flag highlights low performers**

How Exchanges Can Promote Value

1. **Choice architecture**
   - "Nudge" consumers towards best value
2. **Benefit design**
   - Foster value-based designs that steer people to better treatment options
   - Integrate patient activation tools
3. **Network design**
   - Tier providers based on quality and cost data
4. **Health plans as "market makers"**
   - Health plans can be change agents, supporting (with data) and driving (with payment) improvements in care delivery

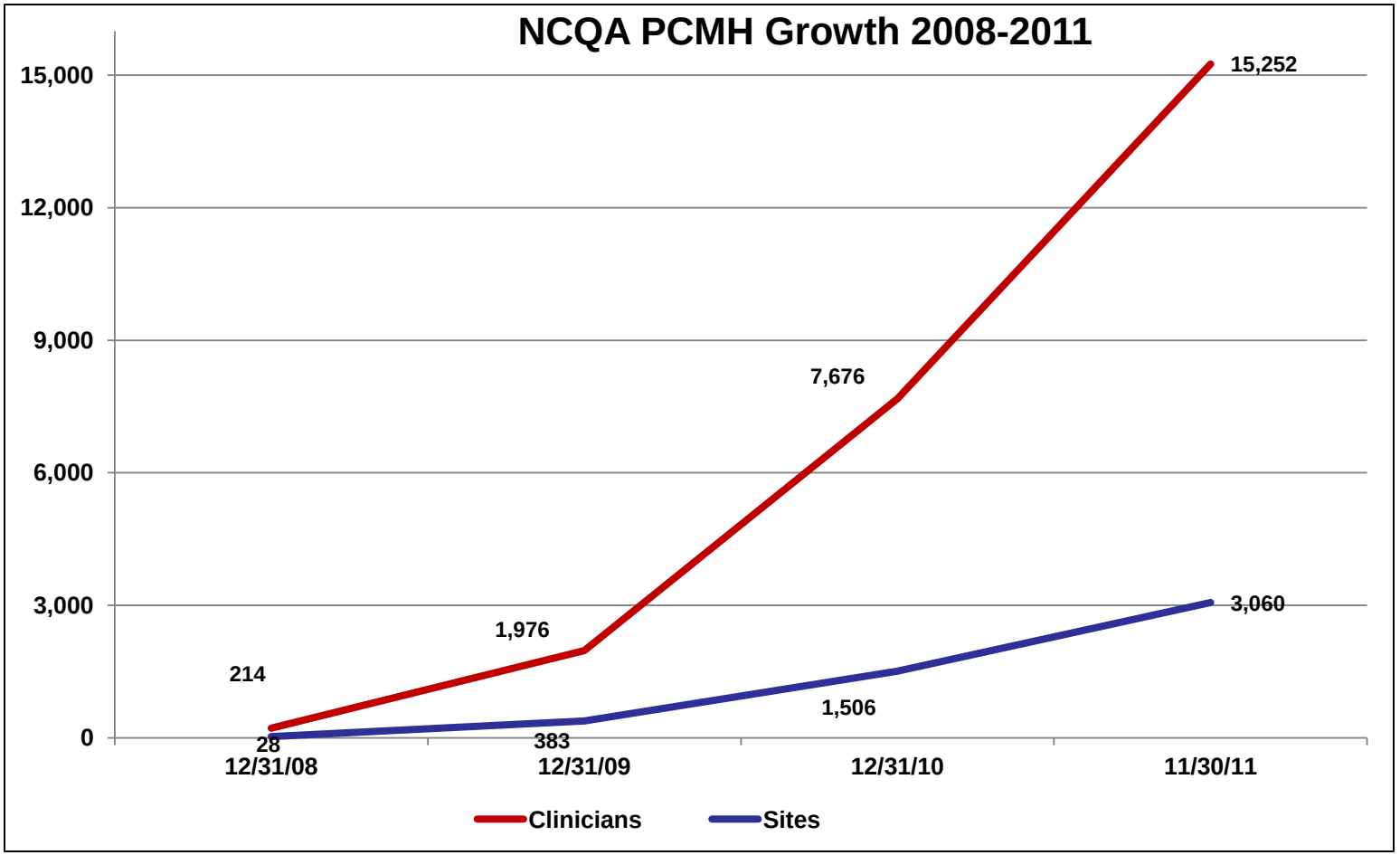
Summary – Health Plan initiatives

- **Accountable entity – has been the first place for measurement**
  - **Quality – long trends (PPO more recent)**
  - **New cost measures – RRU and readmissions have potential to engage**
  - **Medicare Advantage, Medicaid plans innovators in value-based purchasing**
  - **Exchanges a great new opportunity**
- **But many purchasers want to get below the health plan level**

DELIVERY SYSTEM REFORM

NCQA Patient-Centered Medical Homes

America's #1 program; an essential start for ACOs



Research Shows: Medical Homes *Work*

- ***Medicaid Pilots: Improved access, reduced costs, decreased ER/inpatient utilization, more evidence-based primary care (Takach, 2011)***
- **Higher quality, reduced cost (Patient-Centered Primary Care Collaborative, 2010)**
- **Reduced hospitalization and ER visits, overall savings (Fields, Leshen, Patel, 2010)**
- **Integrated group practice: improved quality, patient and provider experiences (Reid, 2009)**
- **Decreased inpatient and emergency care by diabetic patients (Flottemesch, under review)**

Policy goals with ACO accreditation program

- **Public/private alignment around incentives to transform for multiple payers and operational program elements**
  - **Clear roadmap to achieving goals, focus on care coordination, use of data, organizational competence**
  - **Confident in our expertise**
  - **Competitive advantage to organizations**
- **Alignment/support for Patient-Centered Medical Home, Meaningful Use**
- **Consumer and purchaser comfort**

NCQA Evaluates Capabilities in 7 Key Areas

1. ACO Structure & Operations
2. Access to Needed Providers
3. Patient-Centered Primary Care
4. Care Management
5. Care Coordination and Transitions
6. Patient Rights and Responsibilities
7. Performance Reporting and Quality Improvement

Summary – Delivery System

- **Making headway in primary care**
- **ACO has potential but still early days**
- **Challenge to build accountabilty frameworks giving measurement challenges, incentives to participate/change, capital**
- **Will need health plan and delivery system changes to accommodate multiple markets, leverage points**