Defining Value in Healthcare: Environmental Scan

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Defining Components of Value

General consensus: **VALUE = Health *outcomes* achieved per *dollar* *spent***

- **Outcomes (Quality)**
  - Specific outcome measures for a patient with a given condition
  - Accounts for outcomes over the ***full cycle of care***, including ***comorbidities***
  - Includes short-term, functional, and longitudinal outcomes
    - **Short Term (Survival):** does the consumer survive and what is their degree of health or recovery
    - **Functional (Recovery):** time it takes to return to normal activities of daily living, the degree of comfort, and any adverse effects from medical treatment
    - **Longitudinal (Sustainability):** long-term consequences of treatment therapy and recovery and is health sustainable
- **Dollars Spent (Costs)**
  - Accounts for ***total costs*** involved in the full cycle of care for a medical condition
  - Reflects the full array of resources involved in caring for the condition
  - Corrects patient-costing through a ***patient-centric approach*** to accounting

$$\text{VALUE} = \frac{\text{Quality } (Outcomes\ over\ full\ cycle\ of\ care)}{\text{Costs } (Dollars\ spent\ over\ full\ cycle\ of\ care)}$$

Current State of Value: Barriers to Change

- **Incentives and Institutionalized Payment Models**
  - FFS pays for volume, not quality or appropriateness of services
  - Traditional methods of cost-accounting are crude estimates for actual costs
    - Integrated models require up-front investment (actuarial & managerial) and risk, no guarantee of reward
  - Patients not incentivized to make informed healthcare decisions
- **Fragmented Systems of Care**
  - *Multiple sites of care*: each has own financial interest in providing services
  - Duplicative services and disjointed care plans
  - Added administrative burden, lack of buy-in from C-Suite on integration initiatives
- **Health Information Technology**
  - Data collection and storage occurs in silos
  - Data not organized around the patient condition, not widely accessible
  - Lack of common definitions for data points, common data entry templates
  - Incorporation requires change in work flow processes

Current State of Value: Barriers to Change

- **Data Standardization, Measurement, and Collection**
  - *Lack of Guidance*: what data is needed for reimbursement determinations?
  - Measures are department- or entity-specific, not patient-centric (by patient condition)
    - Siloed by department, location, type of service, or type of data
  - Too many process measures, not enough true outcomes measures
  - No feedback loop to inform stakeholders on performance, engage patients
- **Educating Stakeholders**
  - Lack of training among providers in health economics, delivering cost-effective care
  - Limited patient engagement in care decisions, health literacy
  - Shared decision-making as tool for engagement
- **Government Regulation**
  - Government incentives do not encourage integration
  - Data governance policies preclude collaboration, patient-centered care
  - Up-front costs, and lack of guidance and standards inhibit easy development of technologies

Initiatives Addressing Value: Value-based Purchasing

- ***Pay for Performance (P4P)***
  - Designed to promote value through incentives by rewarding providers who deliver high-value services in cost-efficient ways and by encouraging lesser-performing providers to raise their care delivery standards
  - Common in Medicaid and HMO plans, and emerging in Medicare programs
- ***Value-based Insurance Design (VBID)***
  - Attempts to reduce or eliminate financial barriers to accessing care for patients, primarily to the access of high-value services and medications → co-payments are based on the expected clinical benefit from a drug rather than on its acquisition cost
  - Realigns the incentives faced by patients to increase utilization of and adherence to the most beneficial and valuable medications, and actively engages patients in choices that affect their health status
  - Leverages reporting data on quality and costs of high-value drugs and services

Value-based Purchasing in Diabetes Care

- In 2006, University of Michigan implemented "*M-Healthy: Focus on Diabetes*" for its 2,507 employees/dependents with diabetes
  - First prospective controlled trial of co-payment reductions targeted to high-value services for high-risk patients
    - Targeted services include drugs that affect blood sugar, blood pressure, cholesterol, and depression and that help prevent or reduce the long-term complications of diabetes
  - Maintained the tiered formulary incentives for use of less expensive medications (such as generics) - Lowers copays in a graded fashion
  - Tier 1 copays decreased by 100% (from $7 to $0); tier 2 by 50% (from $14 to $7); and tier 3 by 25% (from $24 to $18)

Value-Based Purchasing in Diabetes Care – Preliminary Findings

- Preliminary findings suggest the VBID program for diabetics is associated with:
  - self-reported reductions in cost-related non-adherence and improvements in medication adherence;
  - high levels of satisfaction among participants (virtually no dissent); and
  - strongly perceived by participants to facilitate medication utilization and self-management for diabetes

Initiatives Addressing Value: ACOs & PCMHs

- ***Accountable Care Organizations (ACO)***
  - Represents a form of P4P, where a group of providers enter into a contractual relationship to coordinate care and share the financial risks of their patient population
  - Providers agree to assume responsibility for achieving clinical outcomes and a set of risks and rewards to reduce the growth of health care spending across a defined patient population
- ***Patient Centered Medical Homes (PCMH)***
  - A comprehensive health care delivery model that provides coordinated and continuous care across an array of providers, specialists, and non-physicians to enhance the quality and value of care
  - Primary care provider facilitates the patient's care, communicating with the patient, providers, specialists, and the patient's family
  - Care is facilitated by registries, IT, and HIE to assure patients receive the indicated care when and where they need it, in the manner they need it

Initiatives Addressing Value: Global & Bundled Payments

- ***Global Payments***
  - Payers and providers agree to manage a given patient population with a set budget for a defined period
  - Budget is formed through claim and target assessments, and risk is shared across providers
  - Typically includes physician and hospital services, diagnostic tests, prescription drugs, and other services such as hospice and home health care
- ***Bundled Care Payments***
  - Package payment for the entire medical treatment
  - Includes a clear breakdown of services received, including costs, procedures, appointments, and quality metrics to ensure that the patient can assess the overall value of each bundle
  - Enables patients to make better decisions about which provider offers the most value and incentivizes providers to offer the best quality of care

Bundled Payments in Oncology Care

- In 2010, UnitedHealthcare launched a pilot involving 810 breast, colon and lung cancer patients who were treated at 5 oncology groups around the US
  - Tested the combination of an episode payment coupled with actionable use and quality data as an incentive to improve quality and reduce costs
  - Demonstrated a 34% reduction of the predicted total medical cost - a total medical cost reduction of $33 million (despite a $13 million increase in the cost for chemotherapy drugs)
  - Yielded significant savings without any measureable effect on quality

Bundled Payments in a Comprehensive Cancer Care Center

- In December 2014, the University of Texas MD Anderson Cancer Center and UnitedHealthcare launched a 3-year pilot to explore a new cancer care payment model for head and neck cancers that focuses on quality patient care and outcomes
- The bundled payment method reimburses a care provider or hospital for a defined episode of care under a single fee or payment
- The pre-priced payment provides an incentive to focus on the essential elements of care and to avoid unnecessary steps
- The new payment model is designed to bill patients just once for their cancer treatment, and they will know the cost of care of the tests, treatment and other service because the costs are priced upfront

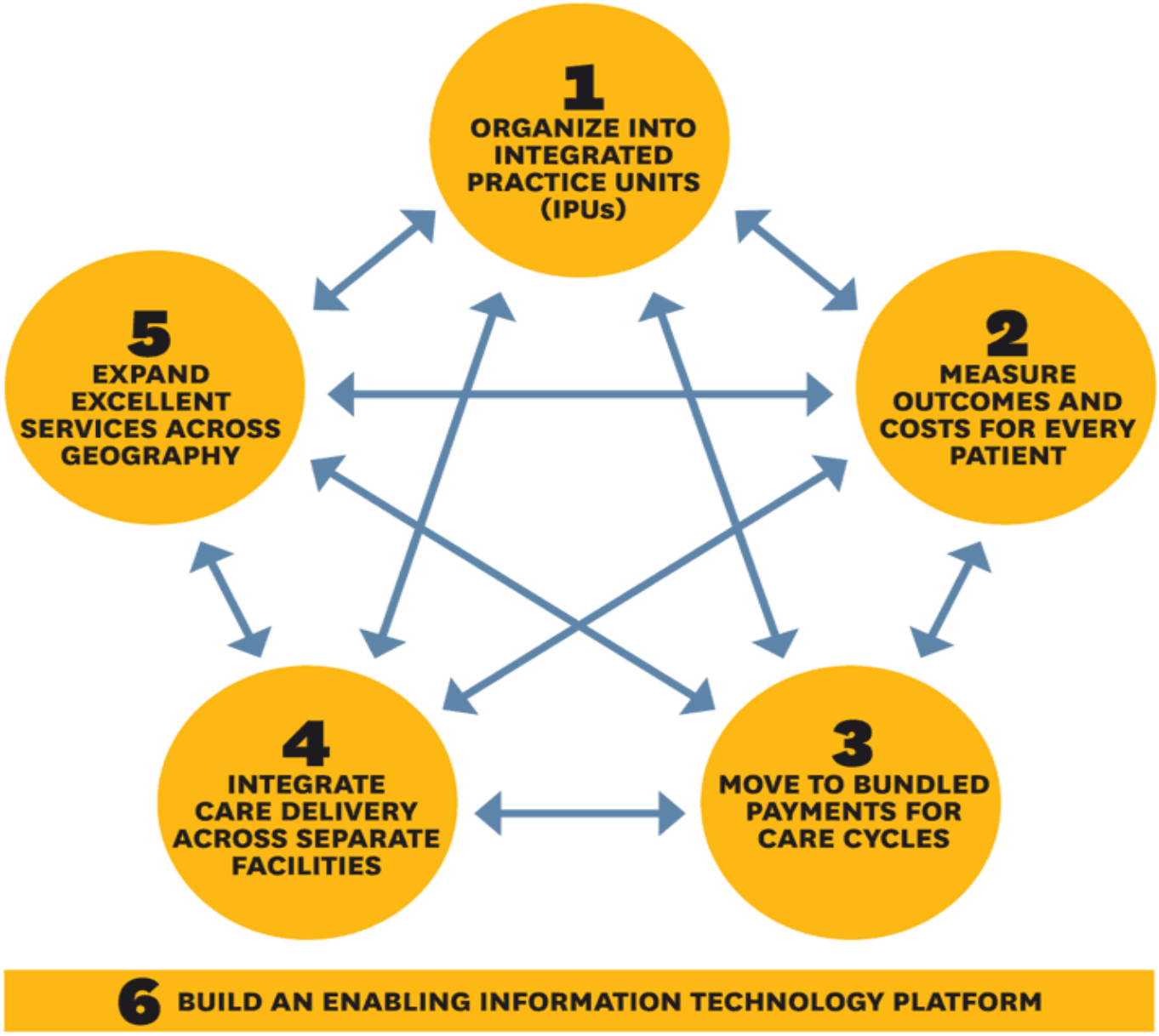
Initiatives Addressing Value: Time-driven Activity-based Costing (TDABC)

- Accounting methodology that measures costs at the medical condition level, tracking expenses for all resources involved in treating a patient's condition (and associated comorbidities)
- Enables organizations to:
  - Trace the path of a patient throughout the care continuum for a specific medical condition;
  - Identify the actual cost of each resource used in a patient's care, including personnel, facilities and equipment, as well as indirect and support costs associated with care; and
  - Document the amount of time the patient spends with each resource
- All activities are added together to measure the total cost of an entire service or episode of care and identify steps that could be consolidated, reduced, or performed with a lower cost mix of personnel

Time-driven Activity-based Costing (TDABC)

- A 2014 study reported how the Cleveland Clinic partnered with Harvard Business School to determine whether TDABC could improve the accuracy of cost information and identify value-improvement opportunities for two types of heart-value procedures
  - Using TDABC, identified steps that could be consolidated, reduced, or performed with a lower cost mix of personnel
- In 2010, the Institute for Cancer Care Innovation measured the true cost of cancer care delivery by following the patient treatment cycle from initial referral to survivorship or supportive care
  - Allowed the team to map the entire patient experience of care while capturing costs and capacity associated with each activity in the care delivery cycle

The Value Framework for the Future



Future State – Paradigm Shift to Value & Innovation

- **Integrated Practice Units (IPUs)**
  - Coordinated around patient conditions and co-morbidities
  - Services based on value-added, single billing for cycle of care, information sharing, and feedback
- **Measure Outcomes and Cost per Patient**
  - Patient-based system of reporting, costing, and billing over full cycle of care
  - Report systematic outcomes measures (3 tiers) publically to drive competition and improve performance
- **Payment Reform Across Care Continuum**
  - Using bundles to coordinate care lessens administrative burden, improves collaboration, and results in higher quality care per dollar spent
- **Integrating Care Delivery Across Locations**
  - Concentrating volume in appropriate locations for each service line of care, integration across locations
  - Expanding care to satellites and clinical affiliates, serving new geographic locations with same level of integration and quality
- **Information Technology Platform Underpinning the System**
  - Collection, monitoring, and analysis of data under a hub
  - Used for real-time decision making, public reporting, EHRs, provider and consumer education, condition management, and seamless integration across and within sites of care

Key Takeaways to Move Towards Value

- **Common characteristics across stakeholders for achieving value:**
  - A **patient-centric approach** to thinking about, delivering, managing, and paying for care at the condition level;
  - Shifting away from **fragmented fee-for-service** care systems towards more **integrated practices that cover the full cycle of care** for a condition and incentivize proper utilization and care management;
  - Utilizing **standardized measures and practices** that provide details on outcomes and costs;
  - Collecting, processing, and reporting **actionable data** to consumers and stakeholders, and educating such groups accordingly so that they may properly interpret data;
  - Integrating **comprehensive health IT infrastructures** to leverage data to enable coordination, inform choice, and improve care; and
  - Having a **shared goal** among stakeholders of achieving value in healthcare, driving value-based competition.

Questions for Consideration

- How do current payment models incentivize or disincentivize innovation?
- Are there specific “promising practices” taking place that payers and/or regulators would like to see replicated that incent innovation for the good of the patient?
- How can current government leveraged address efforts be to future innovation in a value based way? Private sector efforts?

Thank you

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