2011 Military Health System Conference

Lowering Costs and Improving Quality in Health Care through Incentives

The Quadruple Aim: Working Together, Achieving Success

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The Problem

- High and rapidly rising costs in the MHS
- Want to slow cost growth without sacrificing quality
- Question: How can we use incentives to achieve this goal?

Two Types of Incentives Work in Concert

- Incentives for *providers*
  - Reward providers for lowering costs and increasing quality
  - Shared gain/loss for all providers involved in a episode of care
  - But this won't work unless we can encourage patients to use low cost/high quality providers
- Incentives for patients
  - Reward patients for using low cost/high quality providers
  - Reward patients for healthy behaviors
  - Won't work unless strong incentives for providers to lower cost/raise quality and encourage healthy behaviors

Provider Incentives

- FFS system: the butcher/steak conundrum
- Providers have patients best interests at heart – but financial incentives still play a role
- "Flat of the curve" medical care: why *not* deliver the extra medical care?
- Strong evidence
  - Introduction of Medicare PPS
  - Area variations

Provider Incentives (II)

- Other extreme: capitation
  - Turn incentives on their head by having the provider bear the spending risk
- But concern that it goes too far – doesn't reward quality care and could result in poor access
  - "de" capitation!
  - But no evidence so far that his has happened in any quasi-capitated systems

Provider Incentives (III)

- Ideal middle ground: pay for “value” – but what does this mean?
  - PMPM capitation payment to providers, with outlier adjustment
  - Reward quality metrics
    - Process based (e.g. immunizations)
    - Outcome based (e.g. mortality)
  - Commodify services where possible
    - Consider which services can be done equally well at low cost sites
    - Don’t pay a premium where unnecessary

Patient Incentives

- Flat of the curve with respect to patients also – why not get extra care?
- And strong evidence as well
- RAND HIE
  - Overall reduction in care with no impact on outcomes
  - But heterogeneity: protection for chronically ill
- Changing health behaviors is harder
  - Financial incentives matter for reducing smoking
  - But less of an effect on weight loss

Patient Incentives (II)

- Overall incentives to use care efficiently
  - Patient cost sharing
  - Value based insurance design
- Particular incentives to shop where services are commodifiable
  - Balance billing
- Experiment with incentives for healthy behavior
  - Financial incentives on smoking/weight gain
  - Employment conditions – training qualification

Experimentation Under Way in MHS

- First step is to establish Patient Centered Medical Homes (PCMH)
  - Coordinate care to lower costs and improve quality
- Next step is to Performance Planning Pilot Program (PPPP)
  - Broad system of financial incentives tied to performance
- Future steps: go further with patient & provider incentives?

PCMH

- Long-standing view that more effective coordination of care can lower costs, raise quality
- Standard model is PCMH
- Certain standards proposed by NCQA
  - 3 levels of “recognition”
  - 9 standards ➔ 30 elements ➔ 170 evaluation factors

MHS PCMH Initiative

- MHS is moving towards PCMH for clinics in MTFs
- MHS Goal is 2.5 million enrollees in a Level 2/3 PCMH by end of FY12
- More than 500 clinics expected to seek NCQA recognition

Costs of PCMH

- But PCMH is not free
- AMA finds that coordination of care raises physician costs by 20%
- Are there offsetting cost reductions elsewhere?
- Dozens of studies – many more ongoing
- So far, evidence is unclear on quality & cost impacts

PPPP

- Pilots are much more ambitious: tie financial incentives to achieving key goals – and to reducing cost growth
- Rewards for HEDIS, ORYX, PCM Continuity, Third Available, Beneficiary Satisfaction, ER Utilization, and Overall Management of PMPM
- 7 sites testing incentive design in FY11

Issues with Pilots

- Are we rewarding behavior changes?
  - Need to control for underlying trends that would have happened in absence of pilots
- Are incentives properly aligned?
  - Complicated set of incentives – have we weighted them appropriately?
- Are we setting up perverse incentives
  - Do strong incentives for cost control reduce quality of care? Do strong incentives for quality of care raise costs?

Evaluation is Key

- Given these uncertainties, it is critical for MHS to evaluate the impacts of PCMH and Pilots
  - *Ensure* that they are achieving goals
    - Careful measurement framework to assess impacts
  - *Renovate* if they are not
    - Assess components of interventions so that they can be adjusted in place
  - *Plan* for expansion if they are
    - Motivate further adoption through strong evidence base

Evaluation is Self-Fulfilling

- Problem with such initiatives: government scorers won't give them credit
- CBO: no solid evidence for cost savings from PCMH or PPPP type interventions
- They would be very receptive to carefully designed evaluation
- Could lead to scored savings that benefit MHS

First Step: Baseline Data

- Can't evaluate impacts of *change* without measuring *baseline*
- Detailed survey of all MHS sites to gather data on their compliance with NCQA standards
- Key is to gather data on each element so that we can evaluate which elements matter
  - This is an umbrella concept - if only certain elements matter, then want to target

Evaluating PCMH

- Compare MTFs which adopt PCMH standards to those that do not
- Examine broad range of outcomes
  - Medical readiness
  - Patient satisfaction
  - Process measures of health outcomes (readmission rates, screening)
  - Objective measures of health outcomes (lab values, mortality)
  - Staff satisfaction

Evaluating PCMH (II)

- Critical feature of evaluation: assess *which elements* of PCMH are responsible for changes in outcomes
- There is a wide variety of elements to PCMH, but most studies just consider yes/no
- Critical to understand *what works* so we can renovate going forward
  - Particularly since some elements may raise costs while others lower them

Evaluating PPPP

- Careful comparison of outcomes in the 7 PPPP sites to “control” sites where these incentives are not offered
- Examine responses specifically for the rewarded characteristics
- Then look more broadly at other outcomes

Renovating the PPPP

- Very innovative – as such we have little to guide us on the right incentive structure
  - Where should rewards be higher: initial patient access or continuity of care?
  - How much of cost savings to share with providers?
- We are making initial estimates based on available evidence
- But we can use the evaluation to assess where changes are having the largest effect
- Adjust incentives based on initial findings

Expanding the PPPP

- If PPPP evaluation is successful, we can plan for evidence-based expansion
  - Use what we learn to craft incentives elsewhere
- Key next step: bringing in patient incentives
  - The majority of medical spending is driven by factors under the patients control
  - What is possible here?