Putting Episode of Care Variability To Work

Bundled Payment Summit
Pre-Conference
June 3rd, 2015

About HCI^3

- Not-for-profit that designs and implements programs to improve the quality and affordability of health care in the US by modifying the current incentives driving provider and consumer behaviors.

Agenda and Presenters

- Introduction – Francois de Brantes
- Episode Variability as Opportunity for Health Plans – Stacey Eccleston
- Episode Variability as Opportunity for Providers – Dr. Amita Rastogi and Andrew Wilson
- Episode Variability as Opportunity for Consumers – Douglas Emery

Understanding Manageable Variability

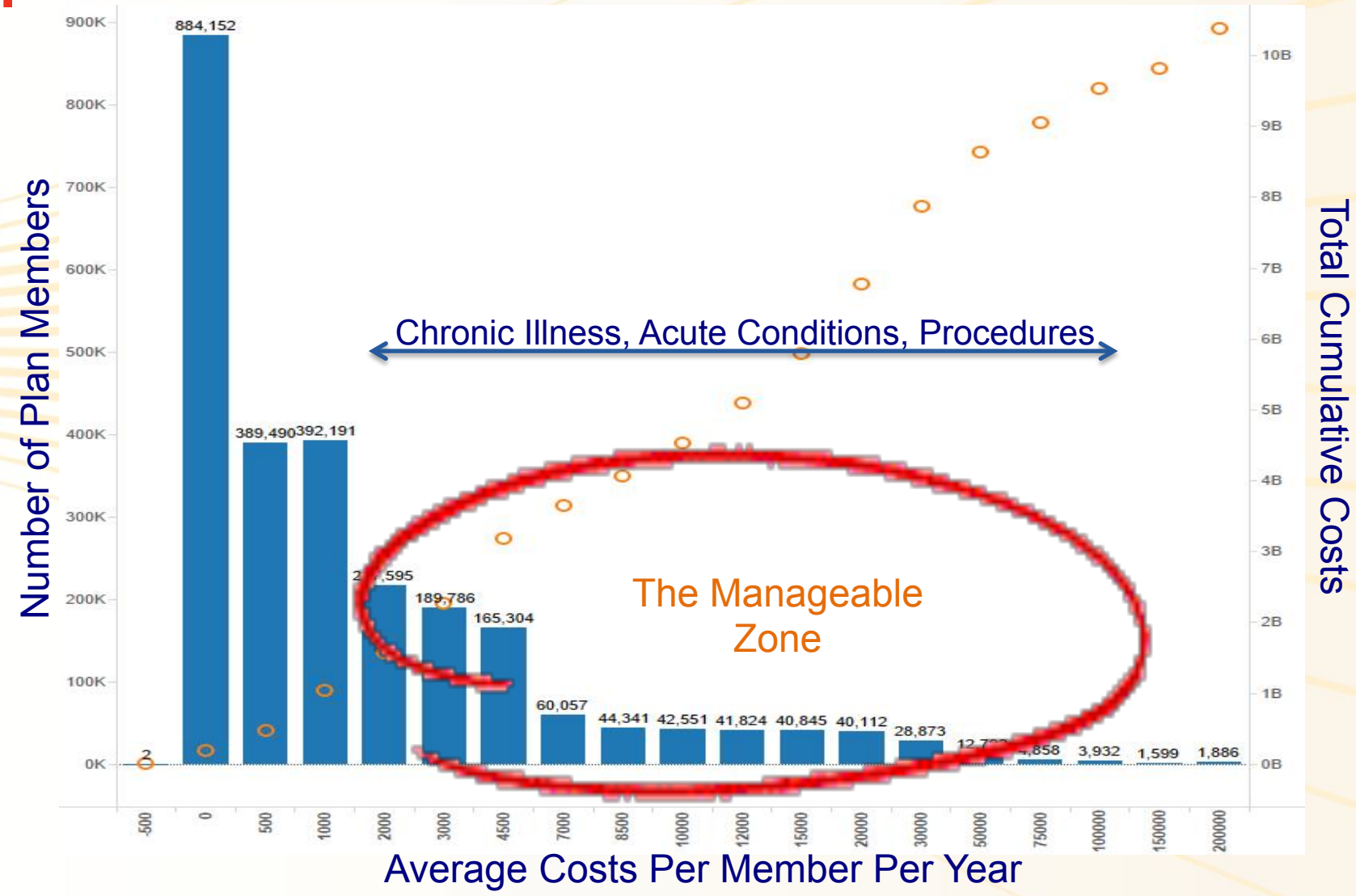
5th Bundled Payment Summit

June 3rd 2015

Agenda

- HCI^3 – Who we are and what we do
- The basics of medical episodes and bundles
- Methodological and policy considerations

What Is Manageable Variability?



What is an Episode of Medical Care?

- Components of an Episode
  - Starts with one or more signals – triggers
  - Time delimited
  - Includes all services deemed relevant to that episode
    - Defined and vetted by clinicians
    - Based on evidence informed practice guidelines or expert opinion
    - Modifiable based on empirical analysis

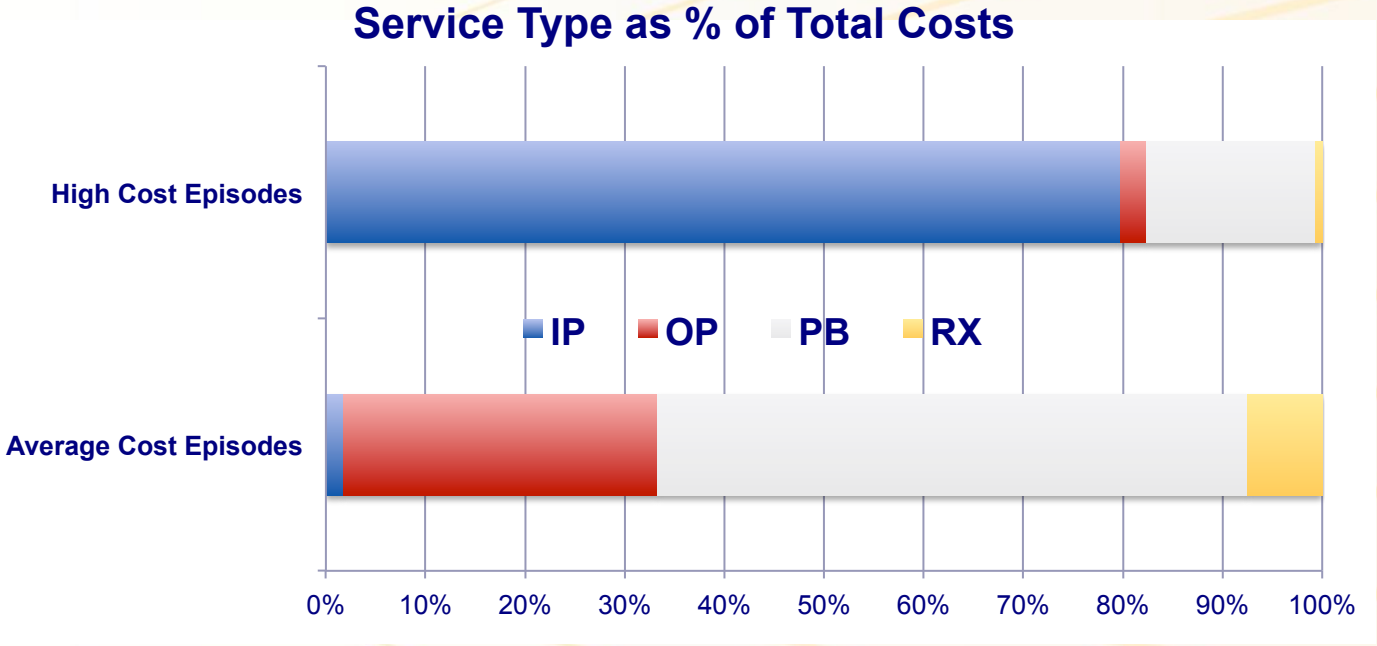
The Basics

- A bundled payment is (usually) a prospective *budget* for a group of services that define a specific episode of medical care
- The budget can be paid up front, or simply act as a target against which actual is compared in an account reconciliation
  - Either way, the risk of a variable episode cost is transferred
- A consumer-transparent bundled price can become the unit of accounting and accountability for health care services around which a market can form

Important Considerations in Building Episodes/Bundles

- Adjusting for patient severity
- Minimizing false positives and false negatives
- Balancing "lumping" v. "splitting"
- Keeping the focus on provider locus of control
- Determining the boundaries of upstream and downstream accountability

Is This Variability Manageable?



Ratio of High Cost Episodes (Top Quintile) to Avg Cost Episodes (Median Quintile)

Service Type	Ratio
IP	426.20
OP	0.77
PB	2.68
RX	0.88

Important Truisms

- The more you split episodes into smaller fragments (e.g. an acute phase of a chronic condition, or the post-acute phase of a procedure), the less variability in total episode costs
  - You end up in a price war
- The more you aggregate heterogeneous patients and episodes into a global payment, the more total cost is dependent on the right tail of the distribution
  - You end up in an insurance game

What You'll Learn Today

- Why potentially avoidable complications are often the reason for excessive episode cost variability
- How to understand the relative contribution of price, use and mix of services to total cost variability
- How manageable variation can be converted to financial opportunity

Putting Variability To Work For A Health Plan

Stacey Eccleston

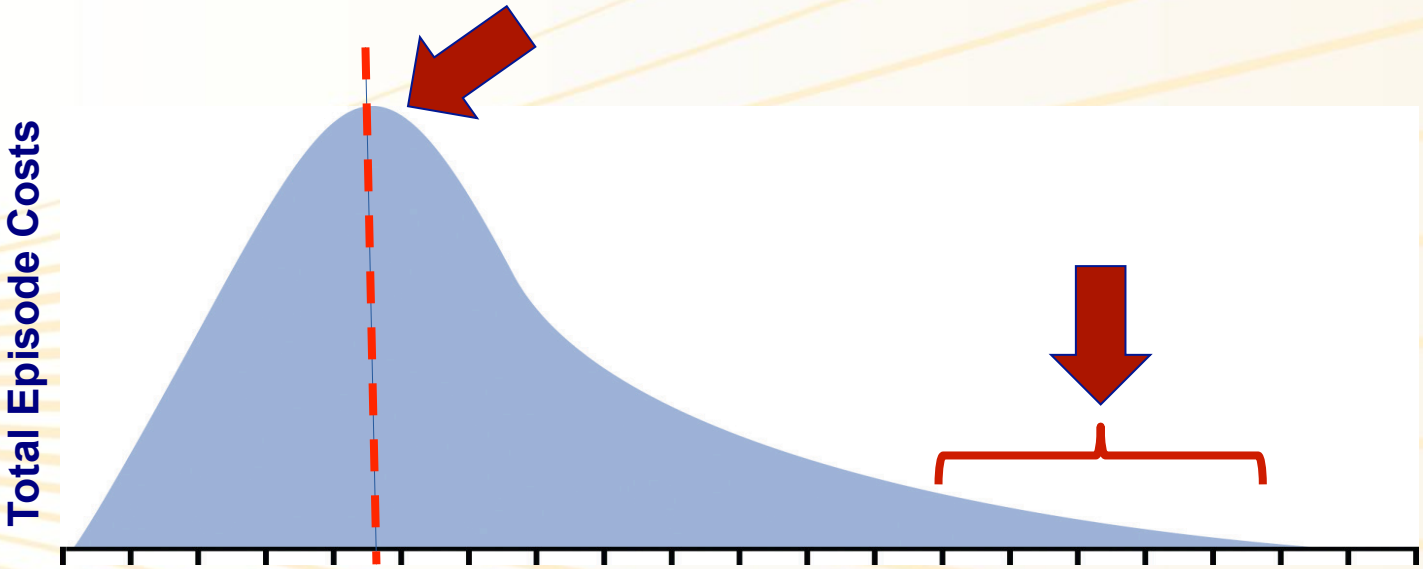
Why Measure Episode Cost Variation?

- Unwarranted variation in episode costs is an indicator that incentives aren't working:
  - Lack of compliance from plan members – manifests in volume and mix of services
  - Lack of adherence to clinical guidelines from providers – manifests in service mix
  - No transparency in price leading to excess variation in prices of services

What Metrics Inform Health Plan Policy Decisions?

- Compare episode costs and potentially avoidable complication (PAC) rates
  - Where are opportunities
- Evaluate the potential savings from reducing variation
  - Know potential yield
- Analyze additional drivers of cost variation—Is it price, volume or service mix?
  - Target your efforts

Understanding Cost Variation

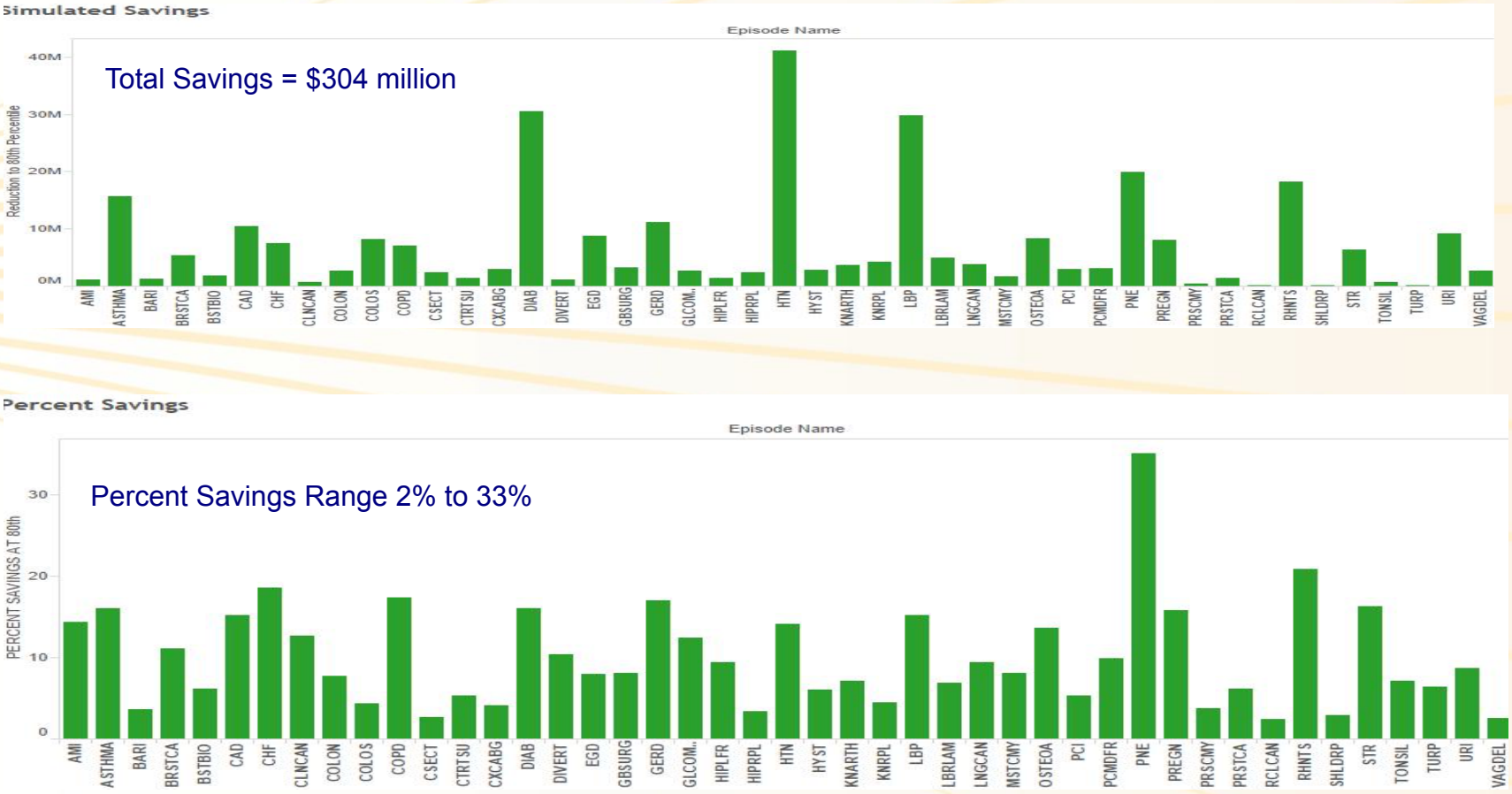


What makes costs in the tail different from "average" episodes??

- Prices
- Overuse
- Financial incentives
- Misuse
- Intensity of services
- Unnecessary services
- Patient severity
- Fragmentation
- Etc.

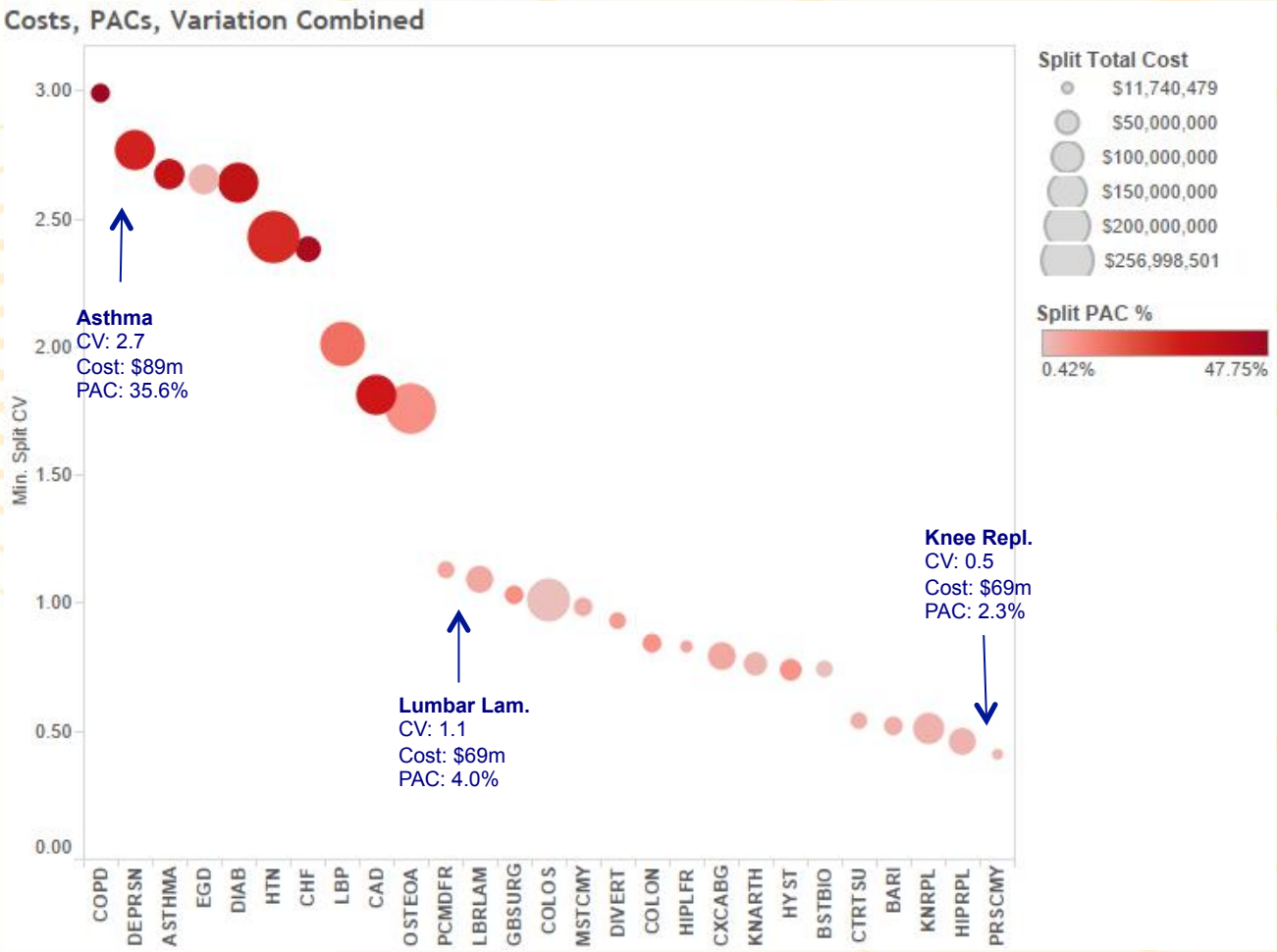
Savings Simulation Across All Episodes Yields Substantial Savings

Reduce episode costs down to X% above expected*



**set at 80th percentile of ratio of actual to expected for each episode-assume stop loss at 98th percentile.*

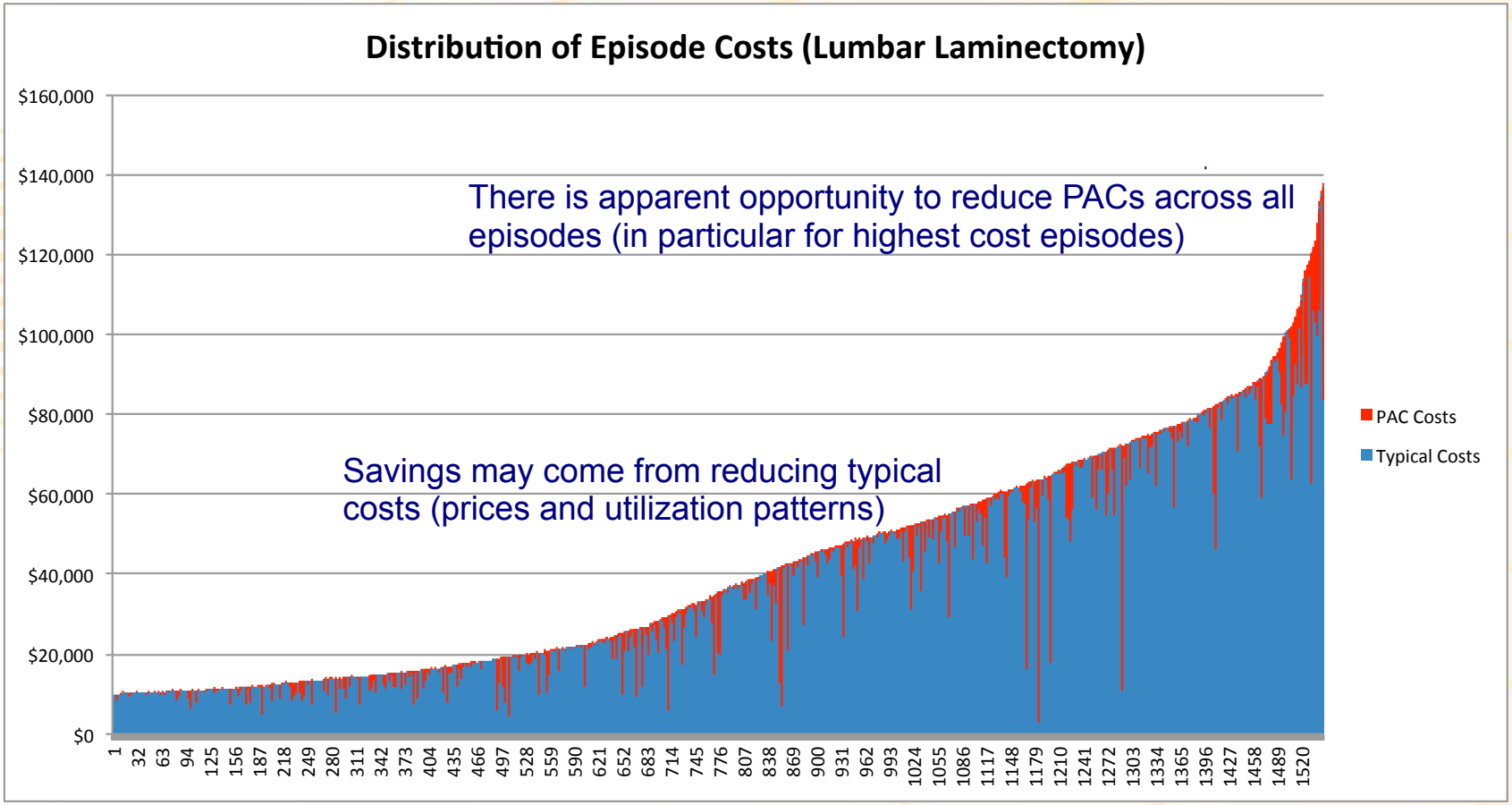
Combining Costs, Variation and PACs to Target Opportunity



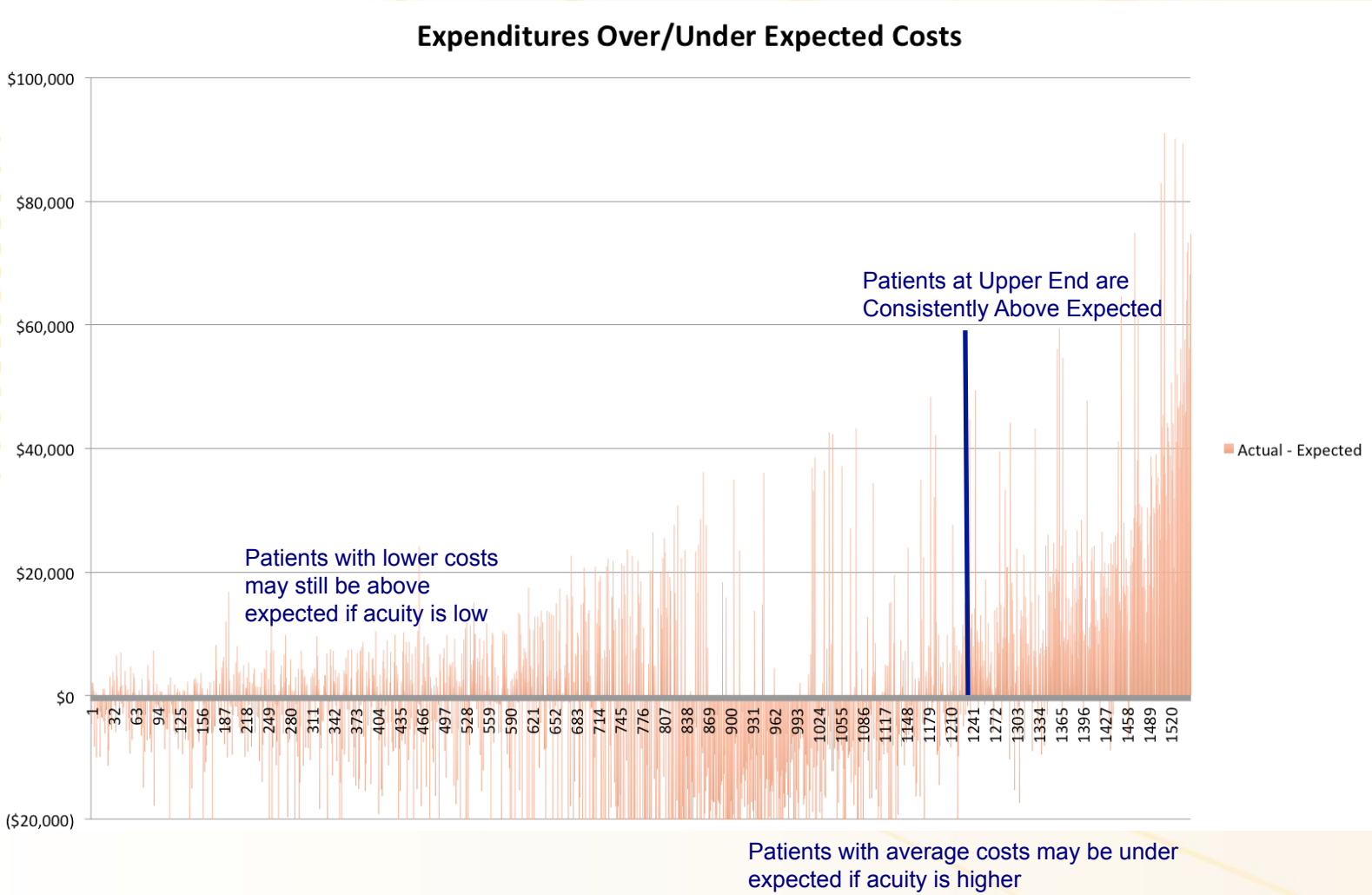
Observing Variation In Lumbar Laminectomy

- Savings can come from reducing price and/or use of resources and manifest in typical costs and complications
- Comparison of risk adjusted expected costs to actual quantifies the opportunity to do both
- Assume that well targeted interventions can reduce costs of episodes that are well above expected cost
  - E.g. 80th percentile ratio of actual to expected costs

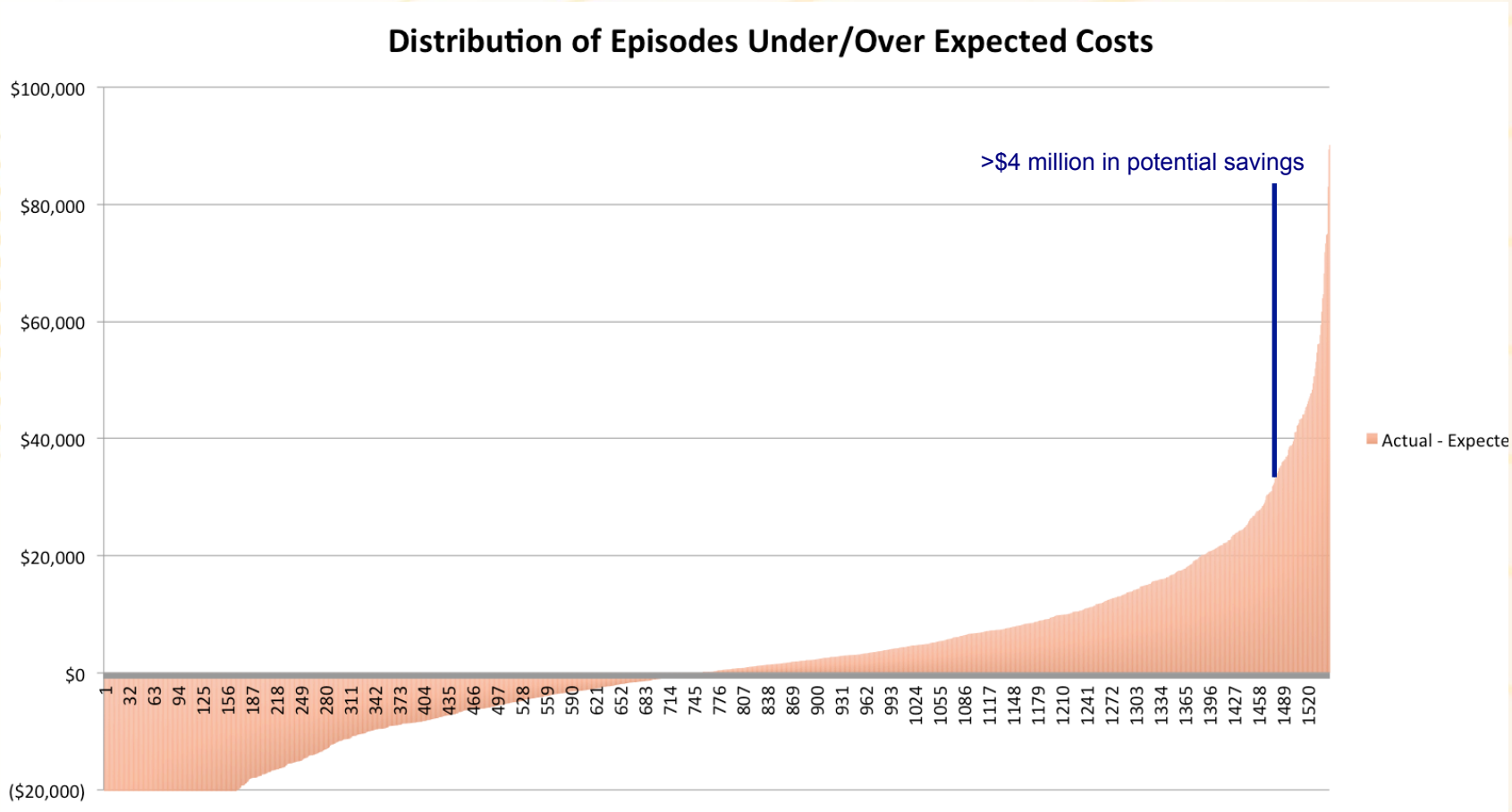
Episode Costs Range from $10k to $140k



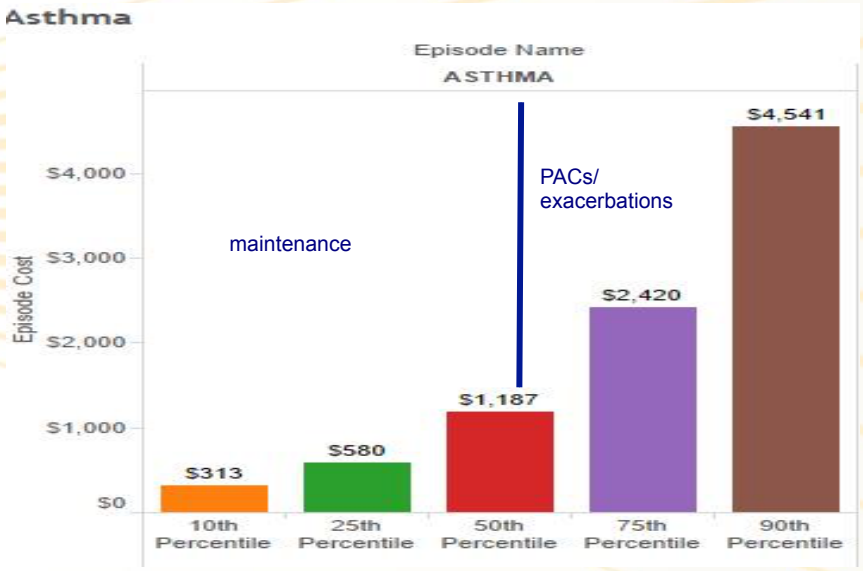
Variation is Not Driven by Patient Acuity

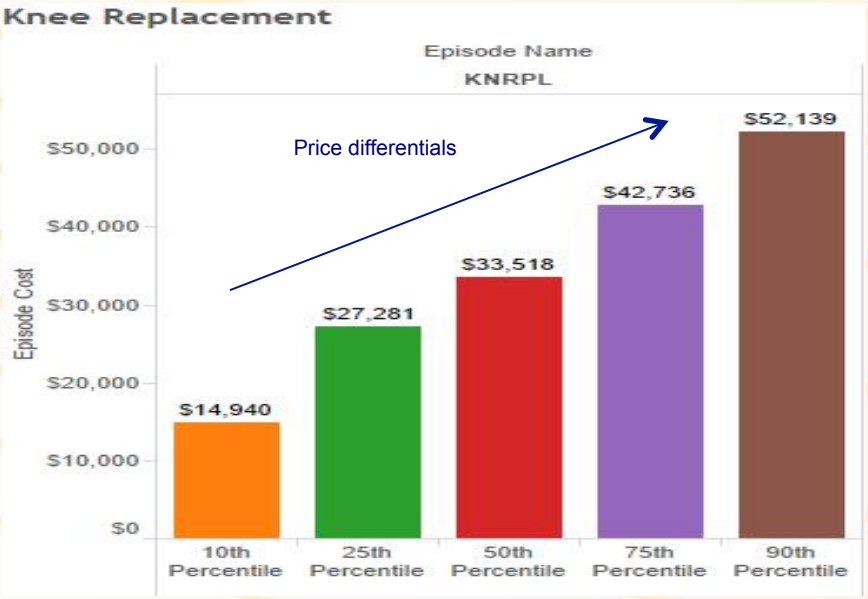


Focus on Episodes Well Over Expected Costs



Variation Can Be Caused By Different Factors





Intra-Episode Variability Analysis (IEVA)

- A method for decomposing variation in a given episode (AMI, CHF, etc.) into three broad categories:
  - Price
  - Volume
  - Service-Mix
- Across episodes and within types of service
  - IP, OP, PB, RX
- Trace drivers down to the level of the individual service
- Provides a basis for deeper investigation and develop of highly targeted interventions

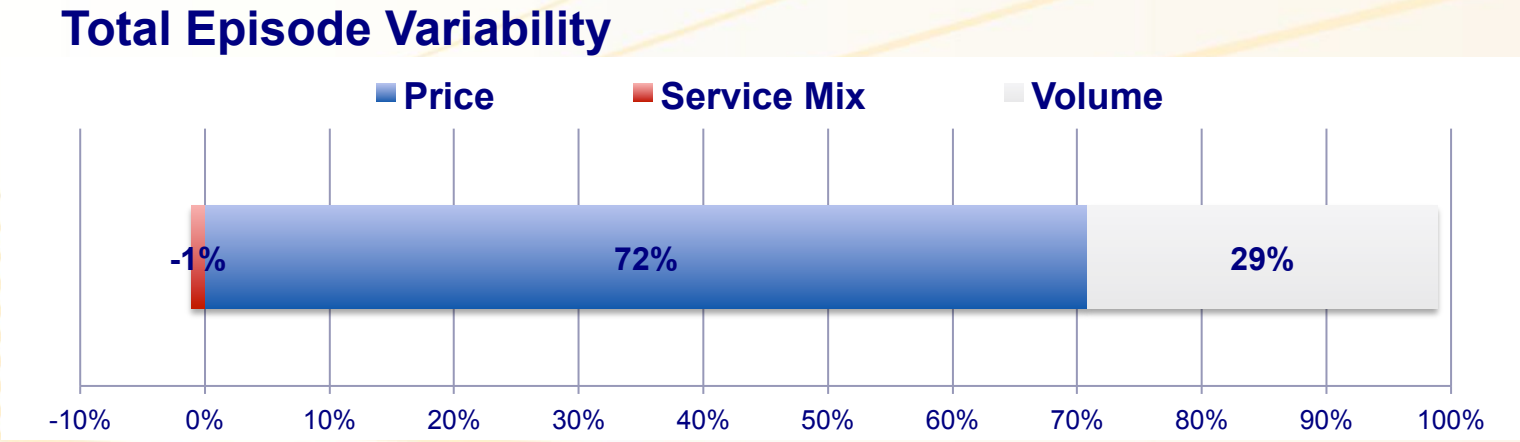
Overview of IEVA Process

1. Compare episodes in 3rd (median) and 5th (high cost) quintiles, arranged total by episode costs
2. Examine services and claims within "market basket"
   - Most costly services common to each group
   - 80% of total costs within each service type
3. Compare median price and quantity in each group for every service
4. Decompose contribution of price, volume, and mix to cost difference between the groups
   - Within each individual service type
   - Across all services by weighting individual service type level contributions by % of total cost difference between high and median cost group

Price and Quantity Definitions

Type of Service	Servicer Identifier	Quantity Definition	Price Definition
IP	Bed type revenue codes	Total hospital days	Per diem cost
PB	CPT code	# of claims	Allowed amount on claim
OP	Revenue, HCPCS code		
RX	National Drug Code (NDC)	# of claims on	30-day standardized costs

Drivers of Variability for Knee Replacement Procedures



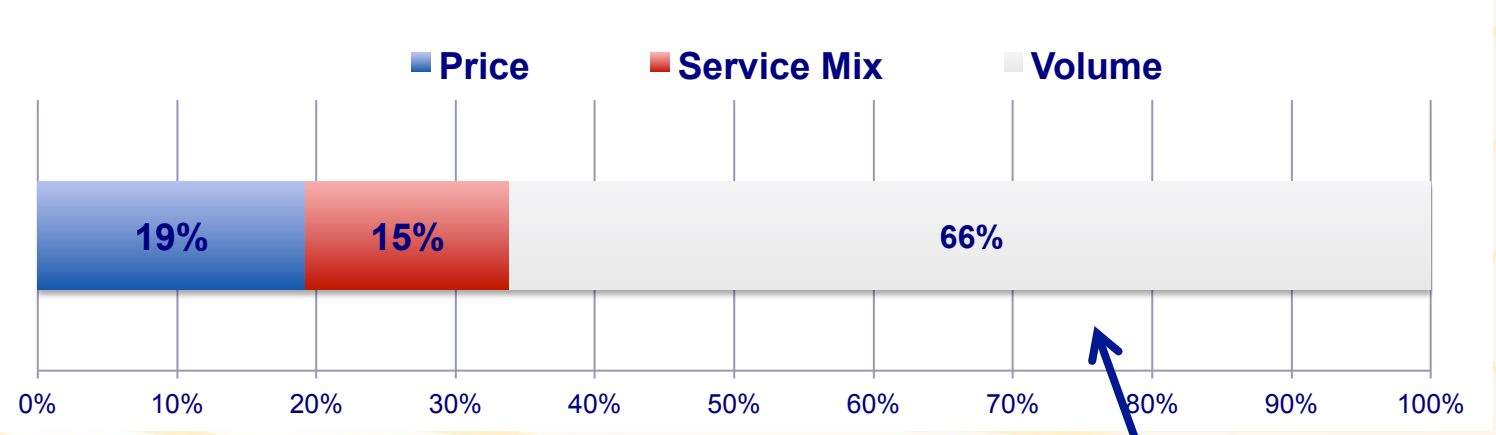
Service Type	% of Tot Cost Diff	Weighted Contribution		
		Price	Service Mix	Volume
IP	86%	66%	0%	19%
OP	1%	0%	0%	1%
PB	12%	4%	-1%	9%
RX	1%	2%	0%	-1%

For IP stays, semi-private 2 bed rooms accounted for 97% of all IP related costs

Among highest cost episodes:
- **70%** higher avg price/day
- 16% more hospital days

Condition Episodes: Asthma

Total Episode Variability



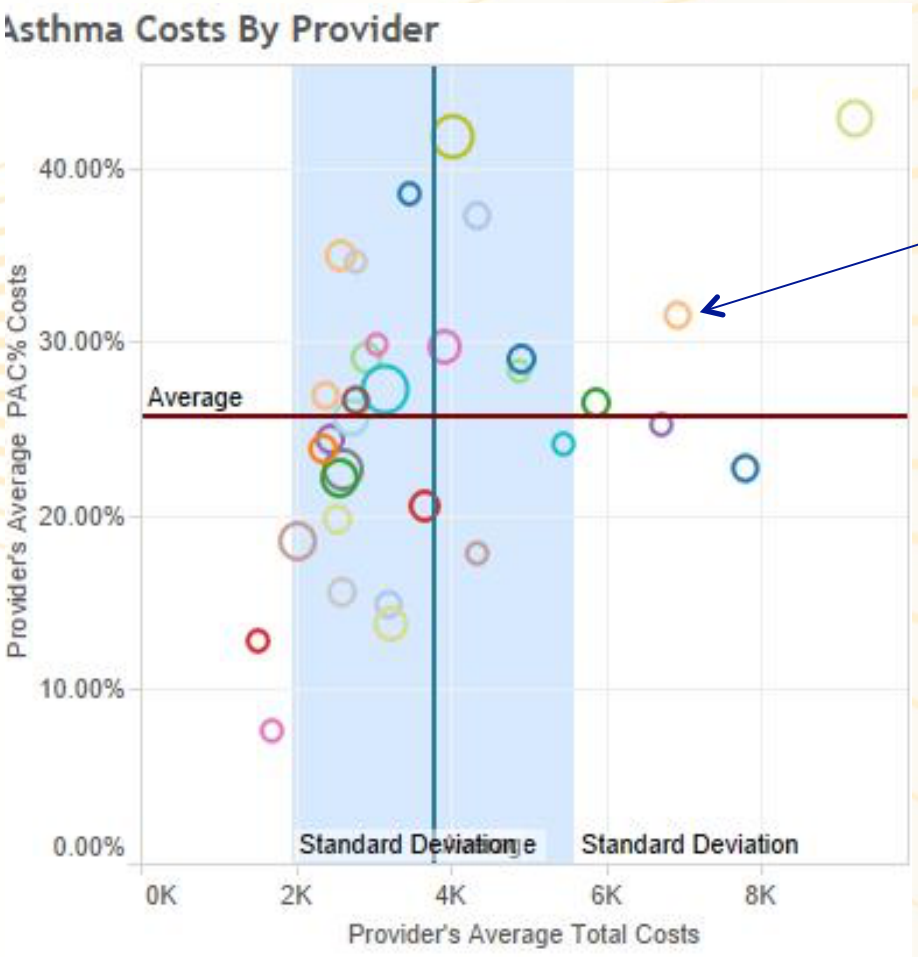
Service Type	% of Tot Cost Diff	Weighted Contribution		
		Price	Service Mix	Volume
IP	24%	8%	3%	13%
OP	5%	1%	-2%	5%
PB	21%	3%	0%	18%
RX	50%	7%	13%	30%

Volume of Rx and professional services appear to be driving variability

Small Number Typical Services Driving Asthma Volume

- Professional Services
  - 3 services accounted for 97% of PB cost differences
    - # of E&Ms for Levels 3 & 4 established office visits was 83% higher in high cost episodes
    - Oxygen equipment (DME) claims were 132% higher
- Pharmacy
  - Broncholdilator claims ~1/3 of Rx cost differences
  - 600% more claims in high cost episodes
- Why the large differences?
  - Poor management? Overuse?

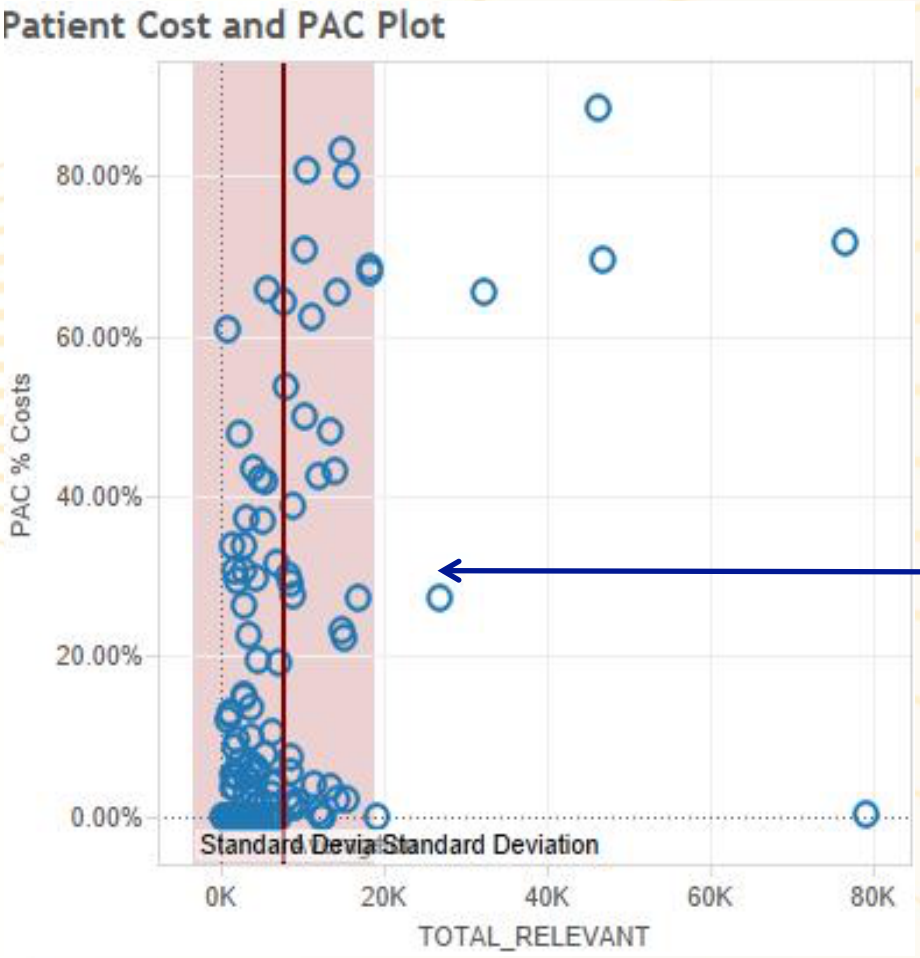
Asthma Costs Vary Substantially by Provider



Provider may be an outlier on PACs or Costs or both

Drill down to patients to find patient level drivers

Many Asthma Patients Have High PACs and Total Costs



The average PAC rate was 26%.

Several patients have substantially higher PAC rates for this provider

What are major drivers of PACs in chronic care?

Potentially Avoidable Complications in Chronic Care

- PACs are largely comprised of services related to treatment of disease exacerbation
  - ED visits
  - IP admits
- Analysis of ED and IP use can isolate intervention opportunities for "Super-Utilizers" of these and other conditions
- Definition of "Super-Utilizers"
  - 6+ ED visits over a two-year period
  - 3+ inpatient stays over a two-year period
  - Both

Distribution of Super-Utilizers
(% of all members)

# ED Visits	# Admissions: 0 – 1	2	3+
0 – 3	86.6%	5.3%	5.5%
4 – 5	0.6%	0.3%	0.8%
6+	0.3%	0.1%	**0.5%**

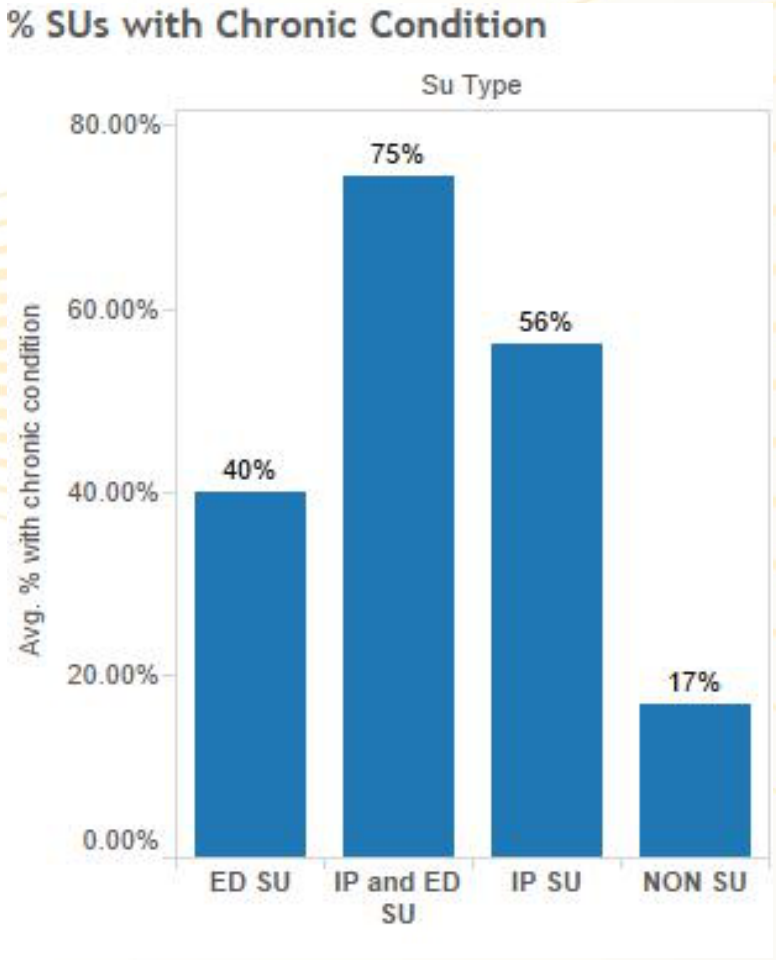
22% of total health spending

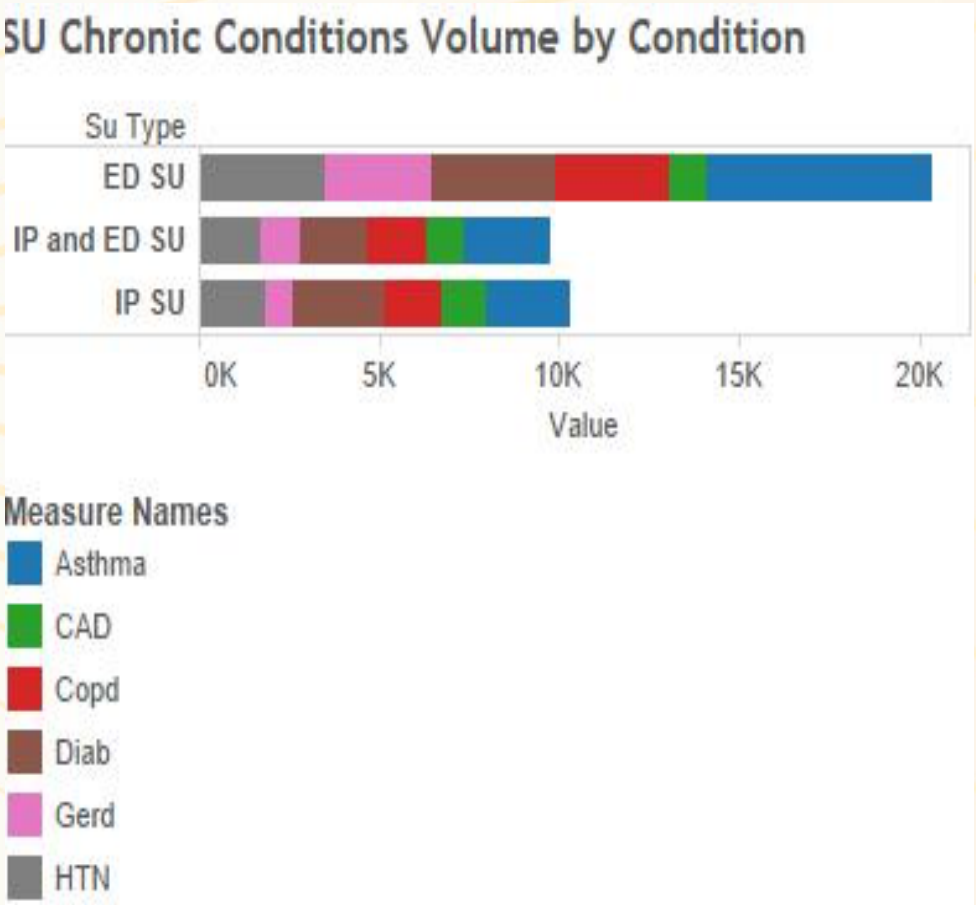
6% of total health spending

Opportunity to address ~1/3 of total spend simply by reducing unnecessary IP stays and ED visits among ~7% of all members!

Based on a Sample of Medicare patients

Strong Relationship Between Chronic Disease and ED/IP Use





What Metrics Inform Health Plan Policy Decisions?

- Compare episode costs and potentially avoidable complication (PAC) rates
  - Identify the drivers of variation
- Evaluate the potential savings from reducing variation
  - Know potential yield

➔Analyze additional drivers of cost variation—Is it price, volume or service mix?

  - Target your efforts

Translate Results into Actionable Strategies for Health Plans

- Potential solutions may involve:

- *Where price is the driver,* solutions may include:
  - reference pricing
  - pricing transparency
  - formulary management
  - tiered networks to guide patients to efficient providers
- *Where service mix and/or volume is driver,* solutions may include:
  - bundled payments
  - gain sharing
  - P4P
  - Reducing co-pays for high valued services

Takeaways

- IEVA can help shed light on important underlying drivers of cost variation between episodes
- Drivers unique to episode
  - Knee Replacement and other procedures
    - IP prices matter
  - Asthma and chronic conditions
    - Variation in volume of typical services
    - Variation in PACs
- Provides a starting point for deeper investigation and/or development of targeted interventions
  - Price: Reference pricing, network tiering
  - Volume: Bundled Payments, gainsharing, etc.

Putting Variability To Work For Providers

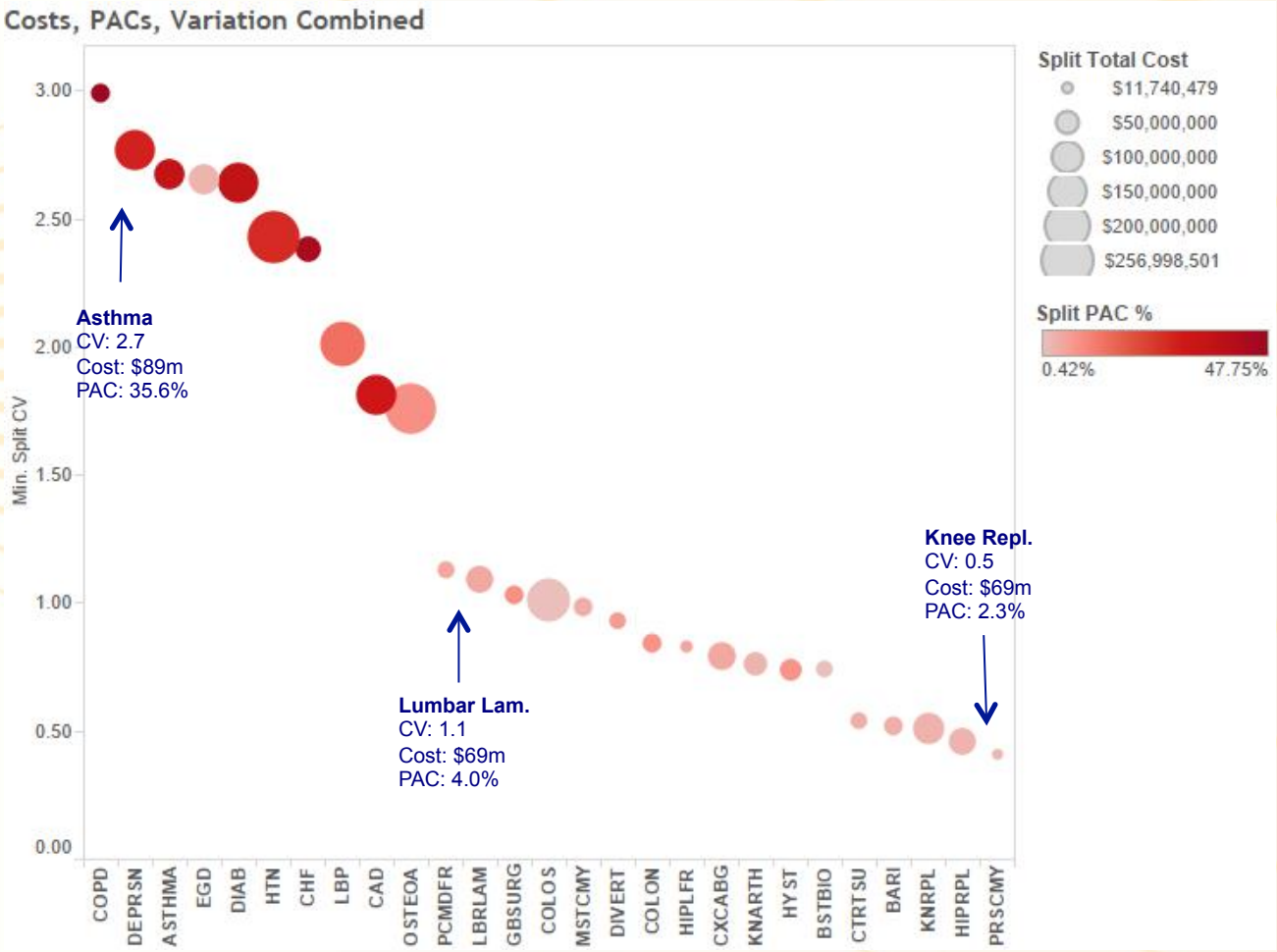
Amita Rastogi, MD, MHA
Medical Director, Cost of Care Programs

Andrew Wilson, PhD (Candidate), MPH, MA
Research Leader

Agenda

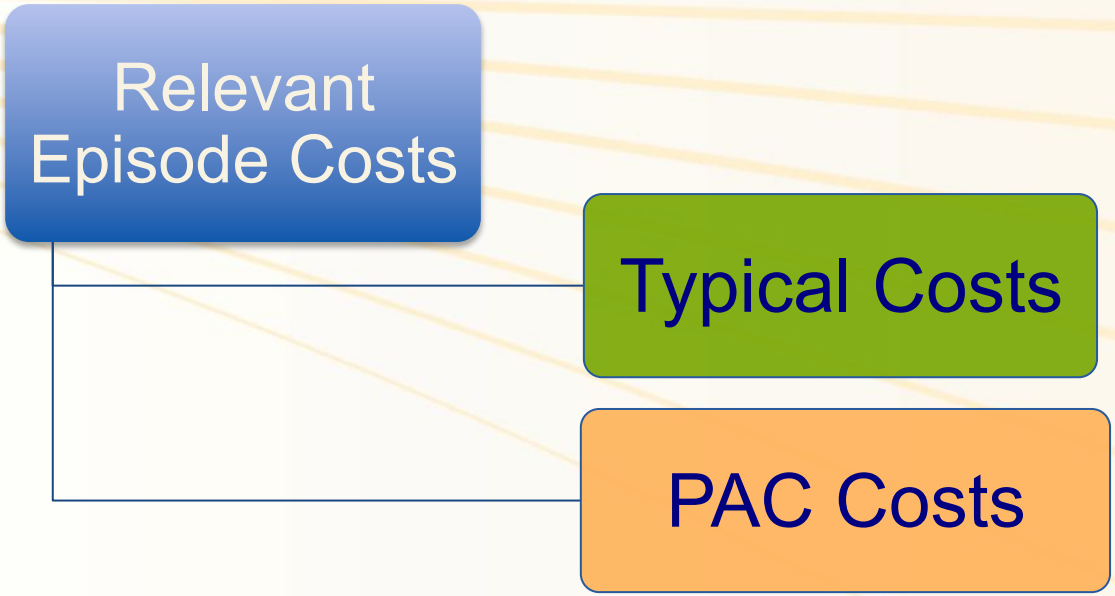
- Episode-based Analytics:
  - To make data actionable
  - To target process re-engineering efforts
- Closing the gap:
  - In misuse: using potentially avoidable complications (PACs) costs to provide margins
  - In overuse:
    - Avoiding inappropriate services to create savings
    - Avoiding inappropriate episodes at the population level
  - In underuse: proactive services to achieve high quality, patient-centered coordinated care
    - Preventive care services
    - Following evidence-informed guidelines

Combining Costs, Variation and PACs to Target Opportunity



Components of ECRs

- Episodes split between two types of costs
  1. Typical and routine services
  2. Potentially avoidable complications (PACs)



What are PACs?

- Misuse: Failures to implement clinical care plans and procedures properly (IOM)
- Negatively effect patients and (potentially) avoidable
  - Errors, readmissions, etc.
- ECR Analytics distinguish between two types of PACS:
  1. Type 1: Related to index condition
  2. Type 2: Patient safety failures
- Identified on inpatient, outpatient, and professional claims

The Value Equation

- PACs represent (potential) waste in the system

- Under value-based payment models (bundled payment, global budgets), PACs represent for many providers the "low-hanging fruit" to capture savings.

Hypothetical Case

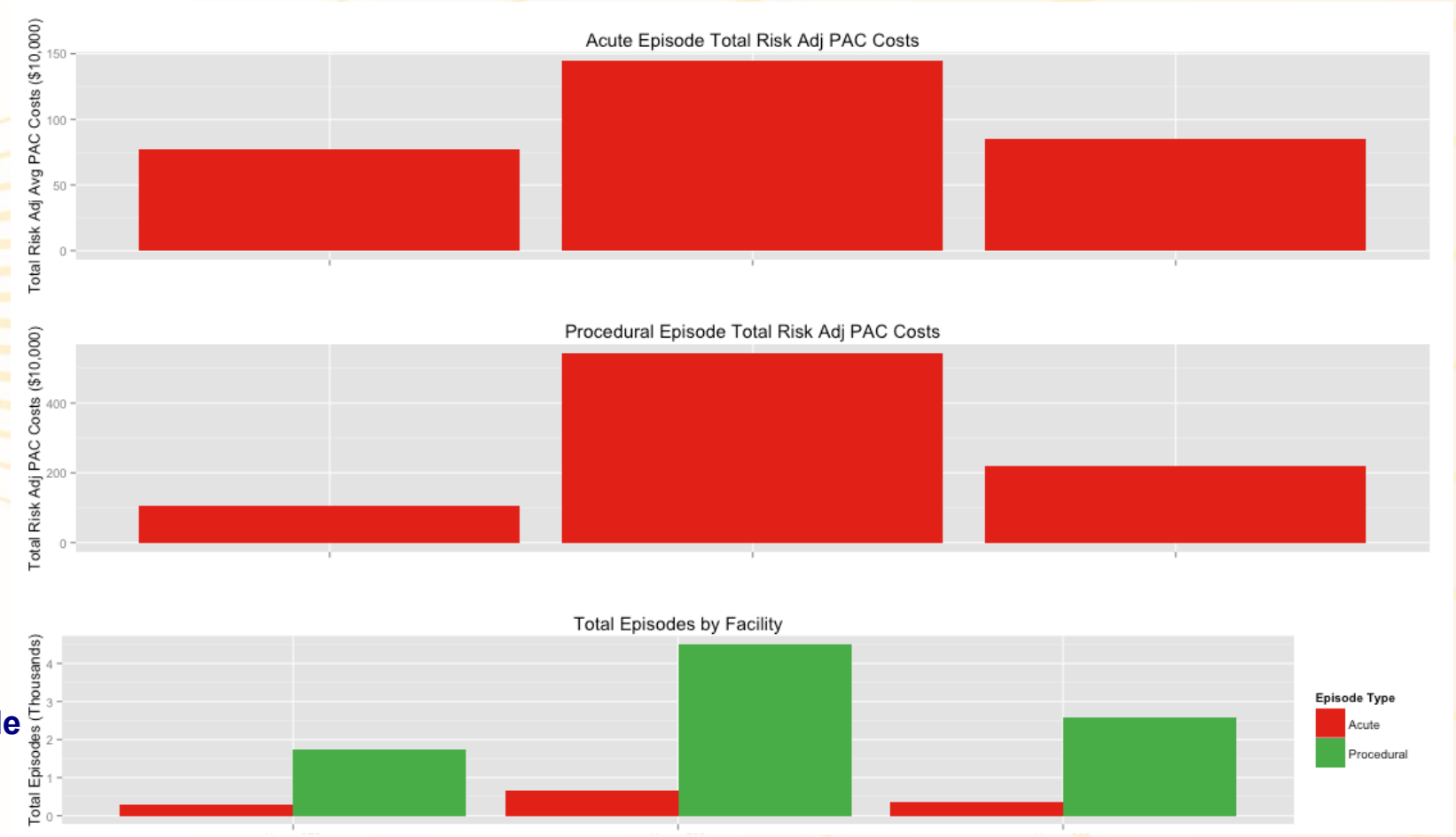
- Single hospital system
  - 3 acute facilities of varying sizes and case-mix
- Apply analytics to understand the extent and nature of PACs and ID targets for PAC reduction
  - Focus on procedures and acute events
  - Understand the different signals created by the total costs associated to PACs and the frequency of PACs
    - Two different metrics that can be combined

Comparison of PAC Costs by Facility

Total Acute PAC Costs

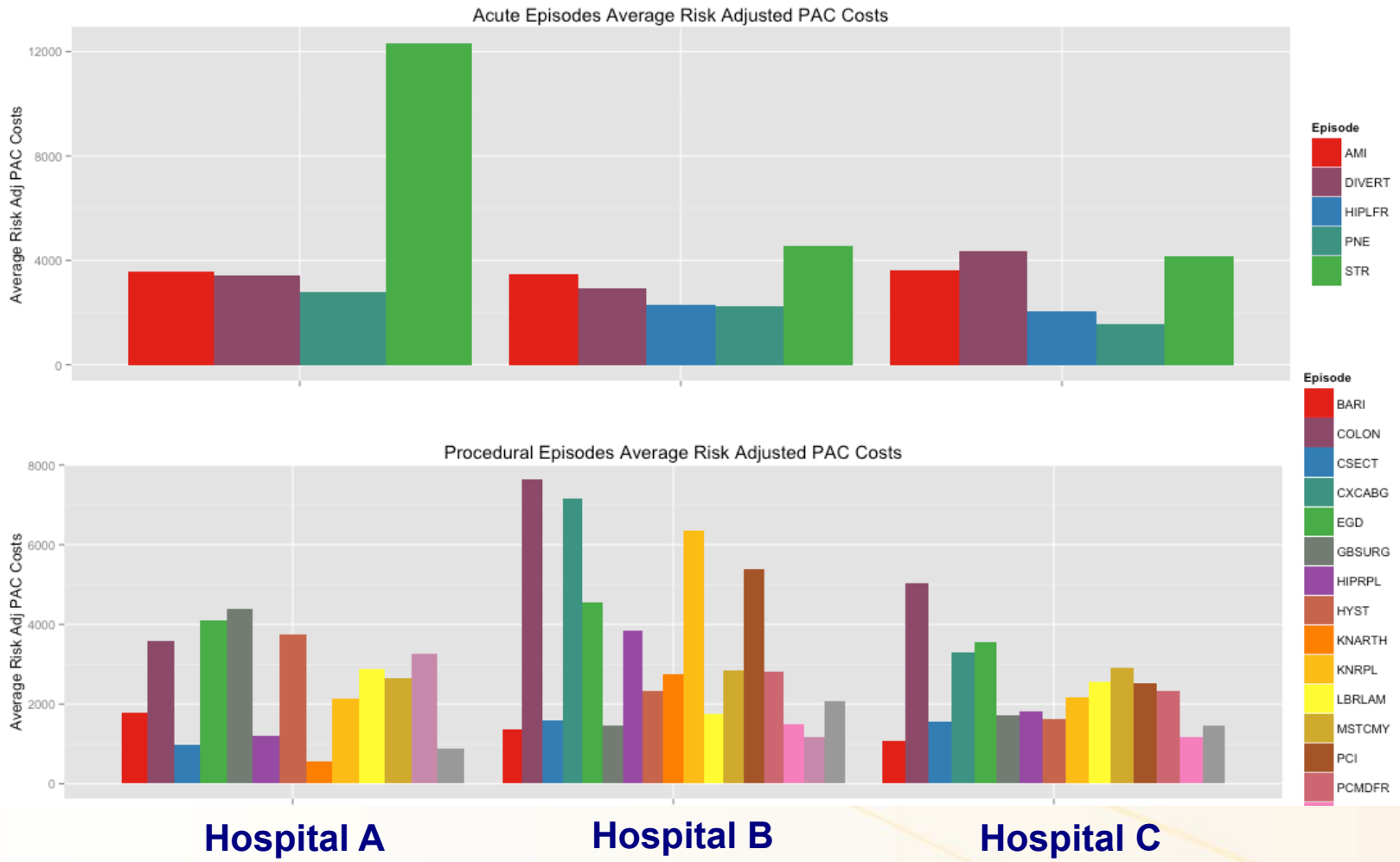
Total Procedure PAC Costs

Total Episode Volume



The View Looking At Costs

Risk Adjusted PAC Costs by Facility



Acute Episodes

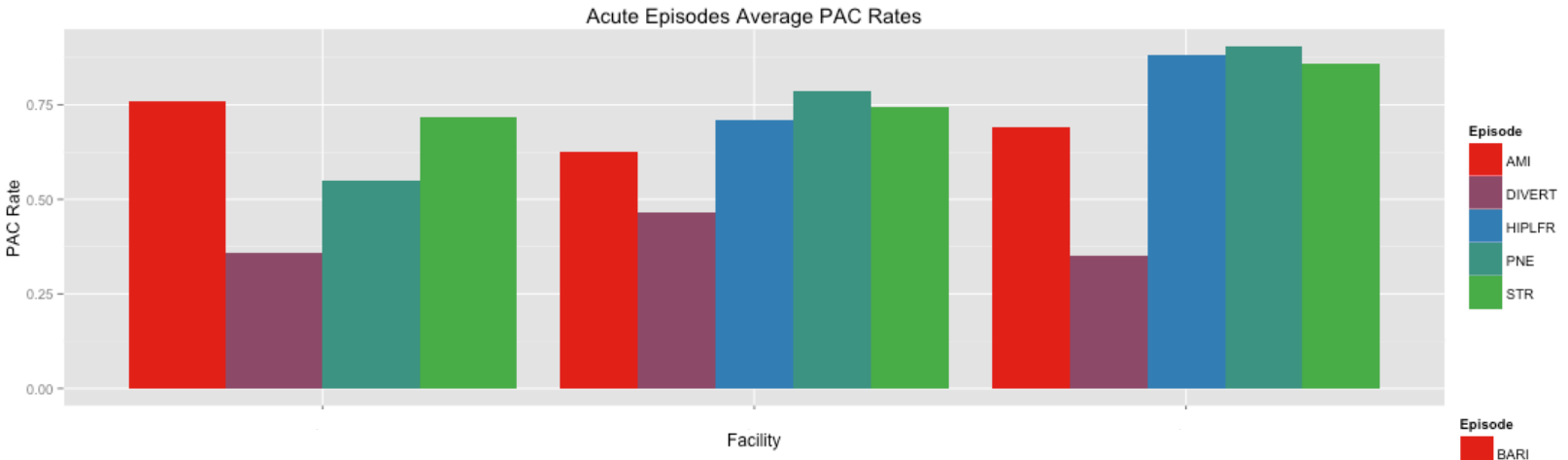
Procedural Episodes

Hospital A **Hospital B** **Hospital C**

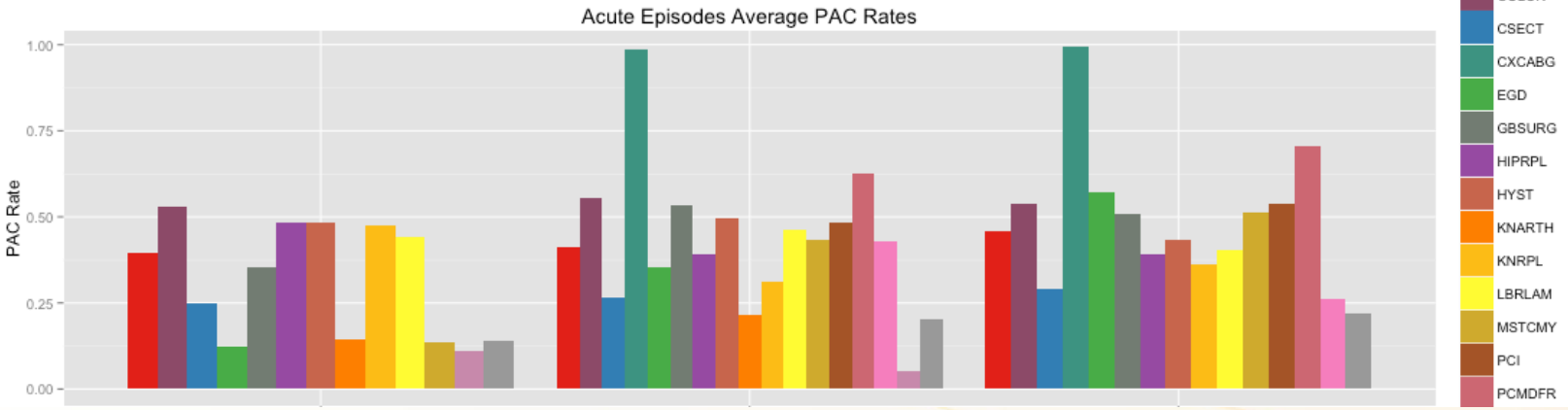
The View Looking At Frequency

Risk Adjusted PAC Rates by Facility

Acute Episodes

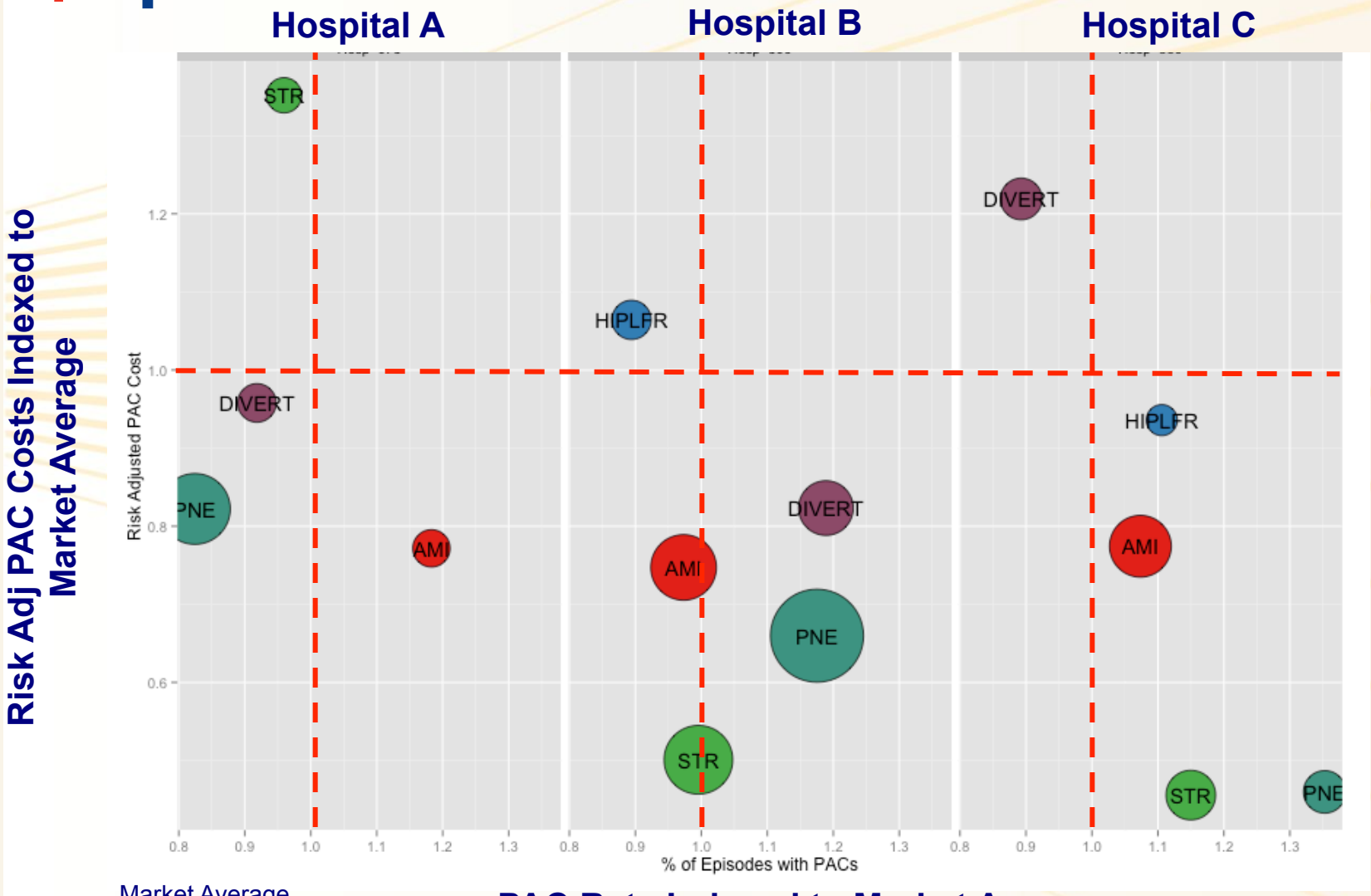


Procedural Episodes

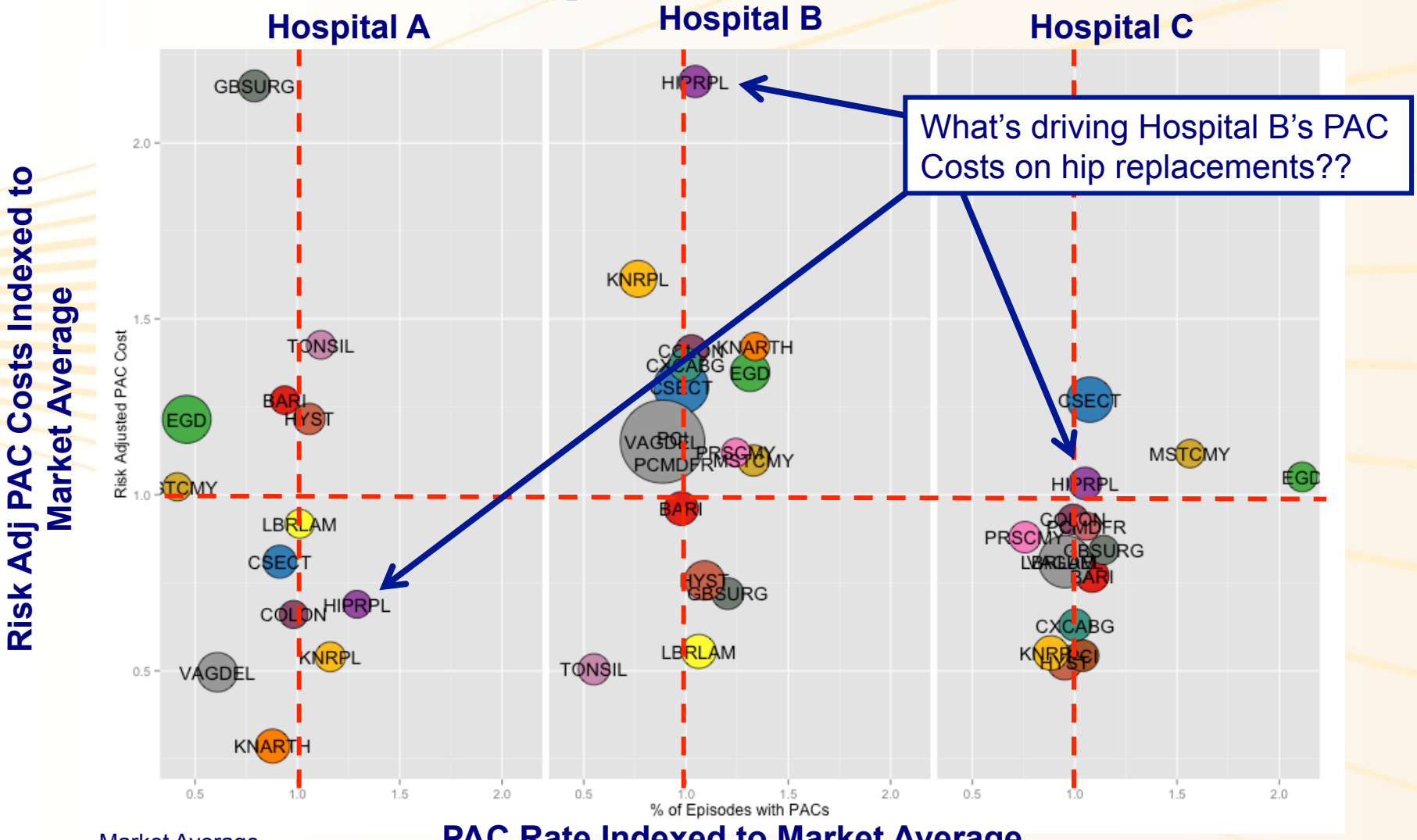


Hospital A **Hospital B** **Hospital C**

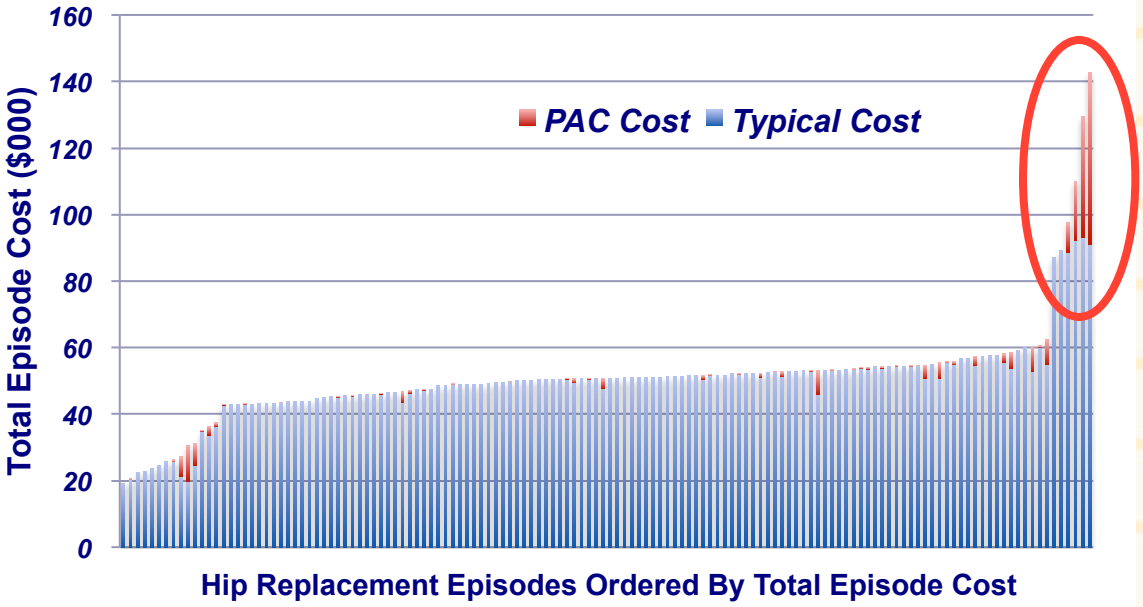
The Combined View – Acute Episodes



The Combined View – Procedural Episodes



Root Cause: Readmissions

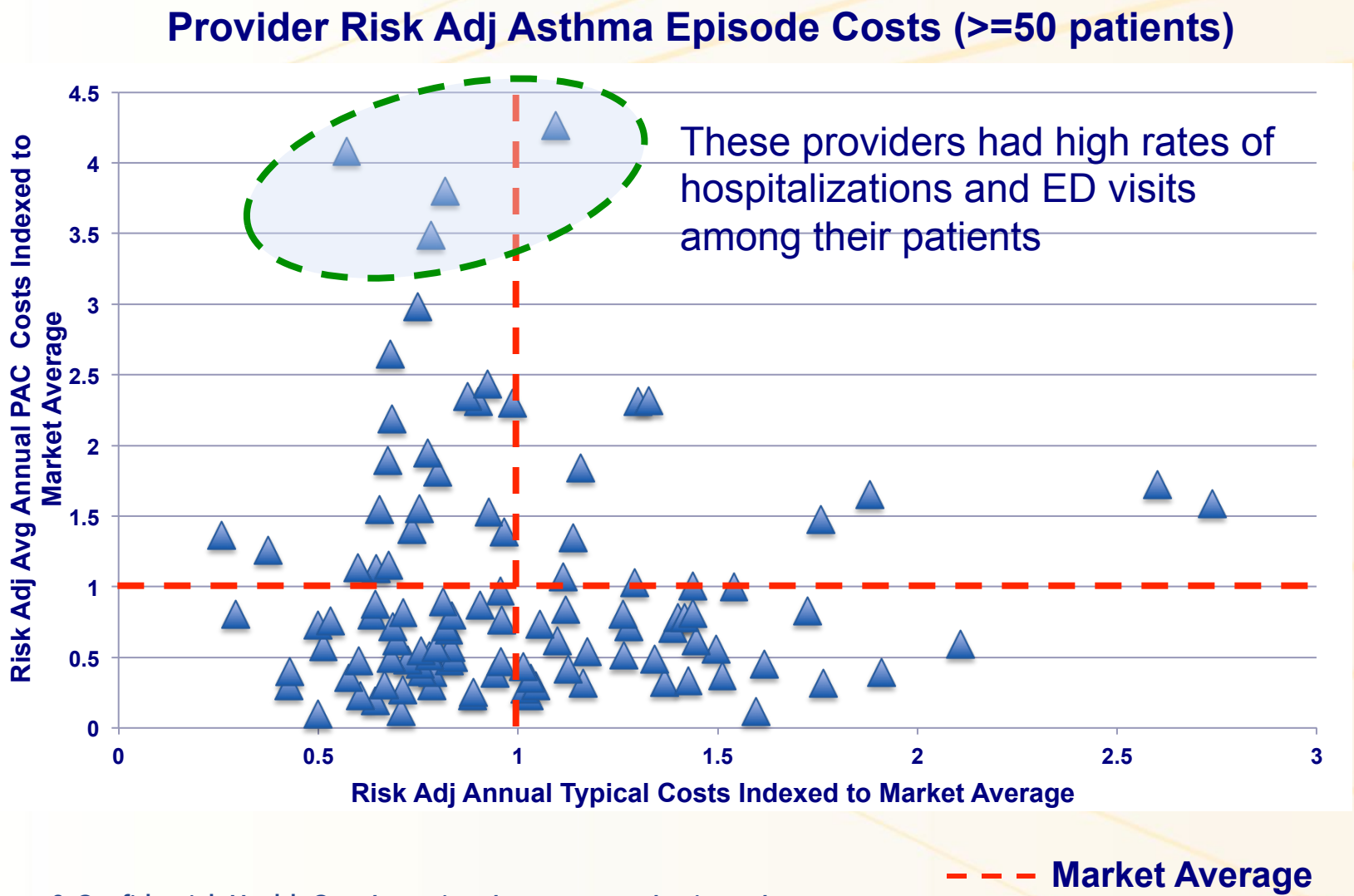


Hospital B – Hip Replacements

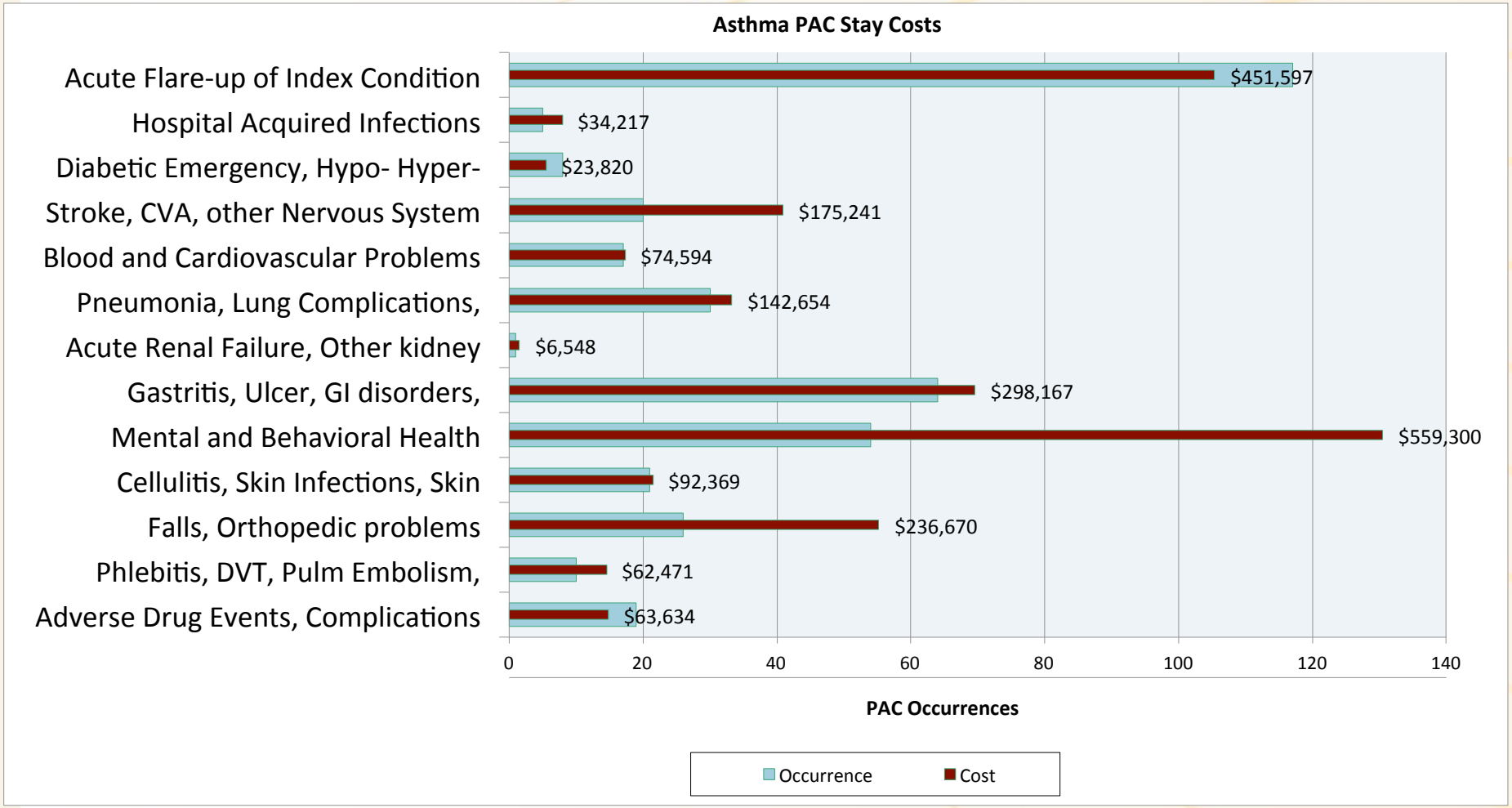
3 patients accounted for just 9% of Hospital B's total episode costs, but 53% of total PAC costs…

…Each had a readmission with costs ranging from $18,000-$52,000

Asthma PACs Caused By ED Visits and Hospitalizations

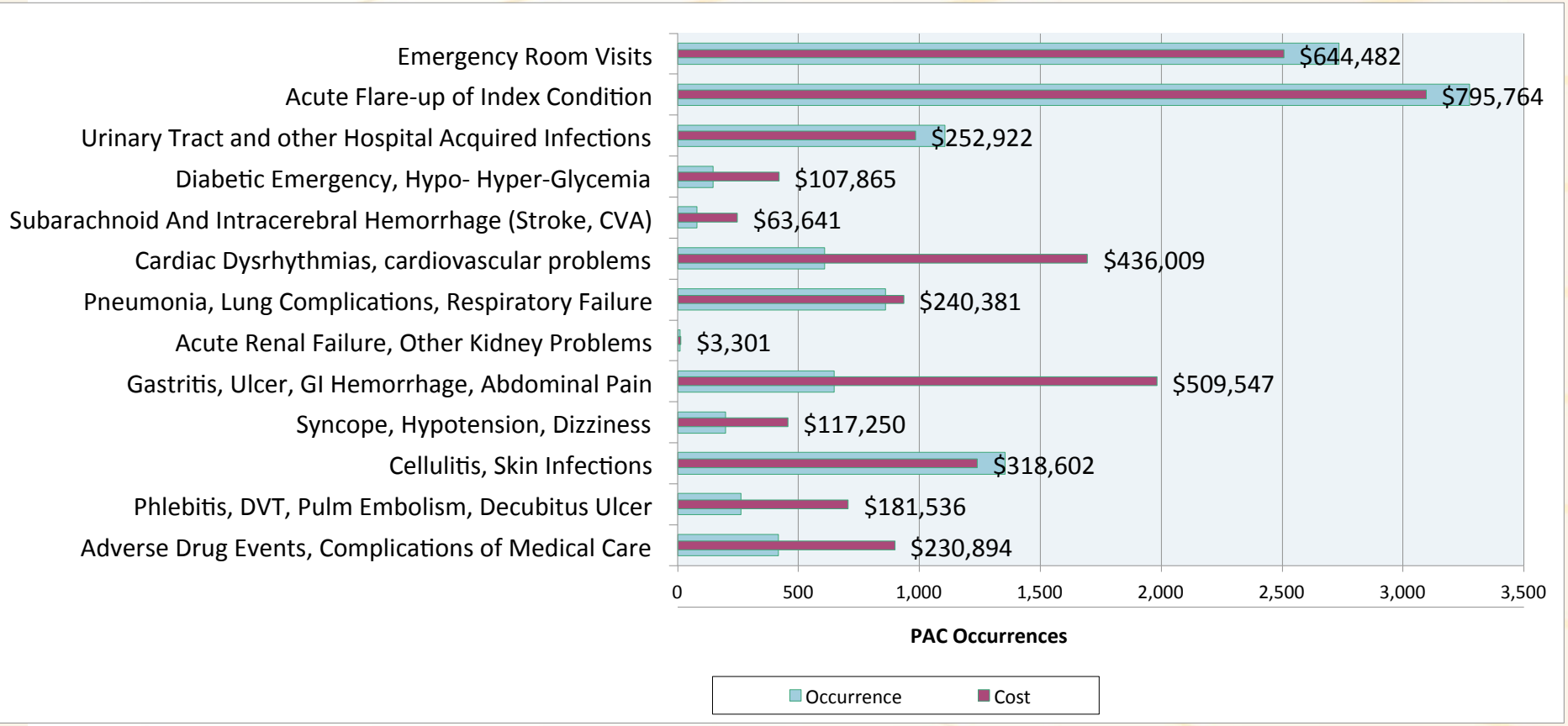


Reasons for Hospitalization



PACs on Professional Claims

Asthma Professional PACs



Breaking Down Typical Care

- The IEVA helps identify the variability in all services
  - Adjusted for severity, the patients with high variability in services can be investigated for root cause analysis
- HCI^3's ECRs further classify services as:
  - Core – to determine the potential for underuse of recommended services
  - Overuse – leveraging the ABIM Foundation's Choosing Wisely campaign, and identifying other overtreatment

Opportunities To Reduce Variability in Typical Care

- Potentially avoidable services identified as overused services by the Choosing Wisely campaign are flagged within specific ECRs.
- Core services for certain conditions based on evidence-informed guidelines or expert opinion
  - help identify gaps in care or underuse in the management of an episode.
- Episodes are associated to one another based on their clinical relevance
  - Allows inferences about appropriateness of procedural episodes in managing conditions

Underuse: Defining Core Services

CORE SERVICES	No. of Optimal Services per year			
Category	**CAD**	**CHF**	**HTN**	**Arrhythmias / Heart Block**
Physician Services	4	6	1	1
Preventive Medicine, Counseling, Coordination	2	2	1	1
Chest X-Ray		1	1	
Heart Echo / Ultrasound	1	2		0.2
Electrocardiogram - EKG monitoring	1	1	1	1
Cardiovascular Stress Testing	0.5	0.5		0.1
Coumadin (anti-coagulant) Management		1		1
CBCs		1		1
Metabolic panel	1	1	1	1
Lipid Level Monitoring	1	1	1	1
Urine Protein			1	
Thyroid Function Test				0.5
Pacemaker Check				0.3

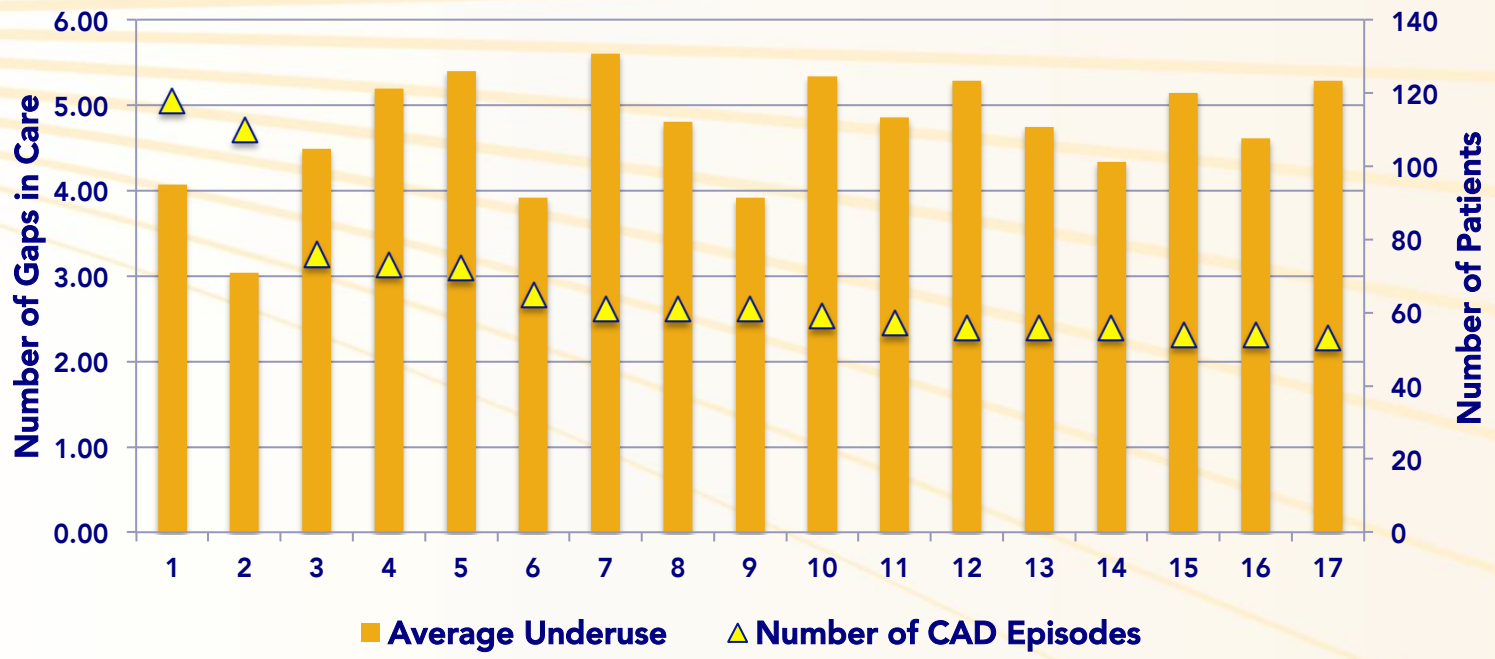
Underuse by Provider

- Due to multi-assignment of claims into concurrent episodes, we avoid the potential to undercount relevant services within episodes.
- On average, high volume providers seem to be providing needed core services for CAD patients.

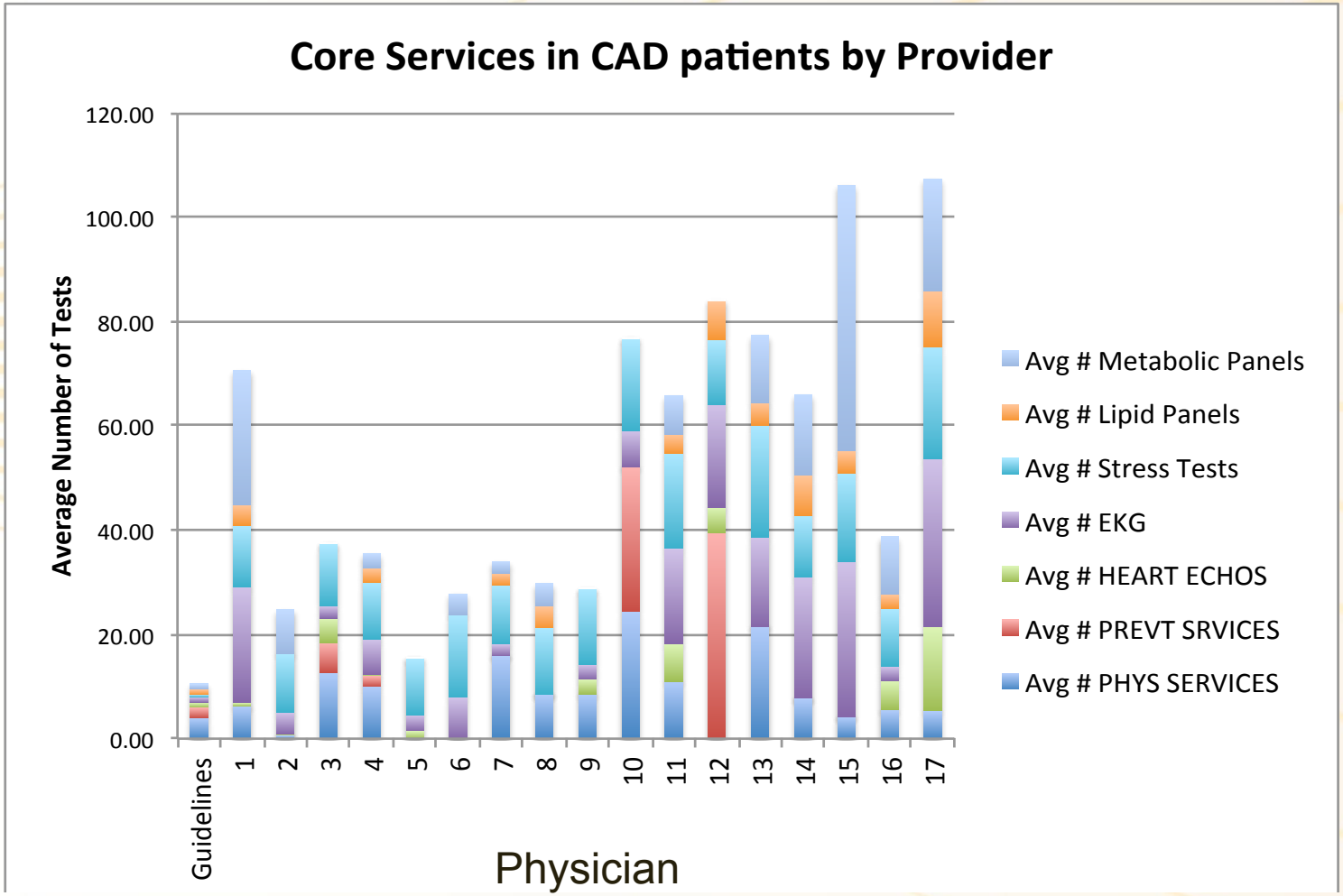
Physician ID	Number of Episodes	Avg # PHYS SERVICES	Avg # PREVT SRVICES	Avg # HEART ECHO	Avg # EKG	Avg # Stress Tests	Avg # Lipid Panels	Avg # Metabolic Panels
Guidelines		4.00	2.00	1.00	1.00	0.50	1.00	1.00
Phys # 1	118	4.59	0.52	0.88	1.38	1.57	1.39	2.16
Phys # 2	110	6.18	38.35	0.98	5.72	1.99	1.43	2.22
Phys # 3	76	4.04	1.97	0.34	2.65	0.97	1.28	2.45
Phys # 4	73	3.57	1.62	0.16	1.03	1.21	1.00	1.27
Phys # 5	72	3.08	0.94	0.28	1.25	1.37	0.77	1.25
Phys # 6	65	4.73	2.86	0.52	2.99	1.83	0.90	2.12
Phys # 7	61	3.39	0.48	0.15	1.02	0.90	0.80	1.03
Phys # 8	61	3.37	0.90	0.37	2.49	1.03	1.39	1.23
Phys # 9	61	4.87	0.14	0.84	3.86	1.35	0.84	1.01
Overall	14,865	3.77	1.81	0.44	2.72	0.97	1.29	1.92

Gaps in Care in Some CAD patients

- But analysis of individual patients demonstrated significant gaps in care across the seven categories of services.
- Physicians could use this type of analysis to identify which patients to target to provide more optimal care



Too Many Services For Other CAD Patients

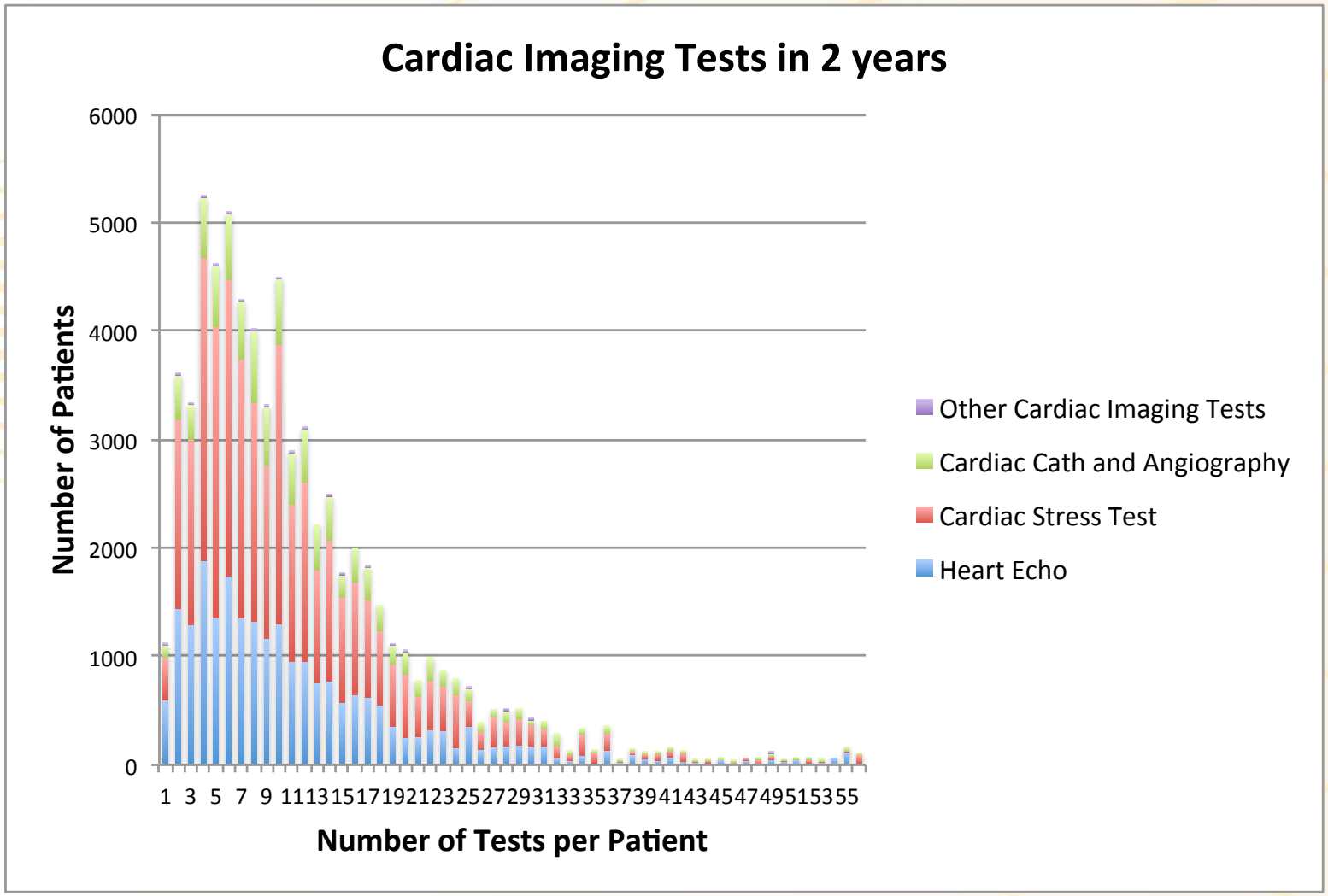


Overuse of Services in CAD

- 15,347 Patients had CAD
- Of these – 1,749 (11.40%) had one or more PCI (Angioplasties)
- And 897 (5.84%) had CABG (coronary artery bypass) procedure
- 69 (0.46%) patients had both (CABG and Angioplasty)

Patients with CAD = 15,347	Number of tests	Average Number per patient	# CAD Patients who had a test	% CAD Patients who had a test
Heart Echo	23,464	1.53	6,986	45.5%
Cardiac Stress Test	35,225	2.30	7,611	49.6%
Cardiac Cath and Angiography	9,927	0.65	3,621	23.6%
Other Cardiac Imaging	100	0.01	57	0.4%
Any Cardiac Imaging Test	68,716	4.48	10,774	70.2%

Overuse of Imaging tests in CAD



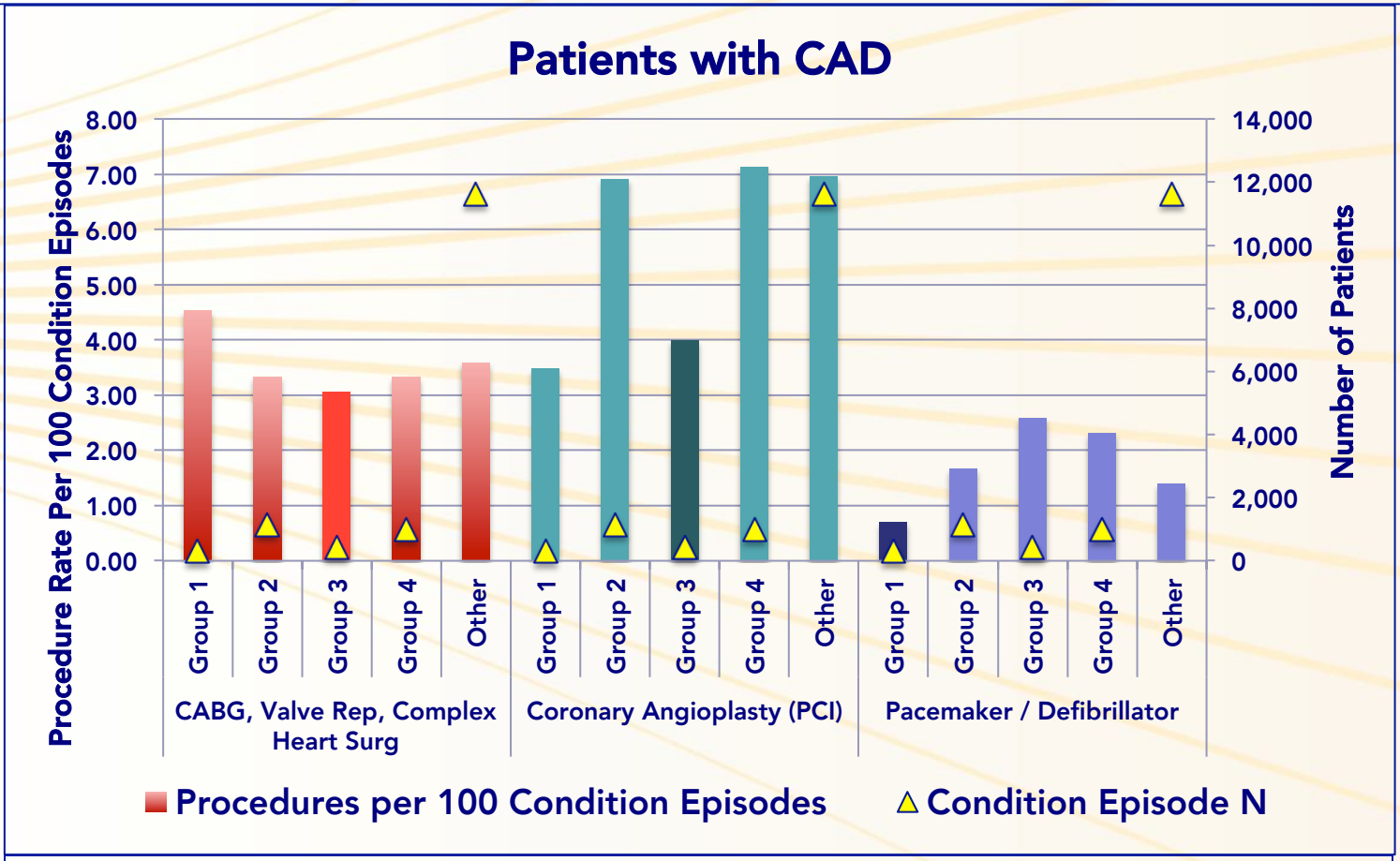
Super-utilizers of CAD Services

Member ID	# of Heart Echos	# of Cardiac Stress Tests	# of Cardiac Cath & Angiography	Total Cardiac tests	Had PCI
Mbr # 21	32	8	37	77	0
Mbr # 22	37	0	37	74	0
Mbr # 23	16	36	0	52	0
Mbr # 24	12	20	18	50	1
Mbr # 25	32	0	10	42	1
Mbr # 26	21	4	14	39	1
Mbr # 27	6	27	4	37	1
Mbr # 28	26	0	6	32	0
Mbr # 29	1	25	6	32	1
Mbr # 30	28	0	4	32	0
Mbr # 31	0	25	5	30	0
Mbr # 32	7	21	2	30	0
Mbr # 33	6	21	0	27	0
Mbr # 34	21	0	5	26	0
Mbr # 35	20	0	4	24	0
Mbr # 36	0	24	0	24	0
Mbr # 37	1	21	1	23	1
Mbr # 38	3	20	0	23	0
Mbr # 39	2	21	0	23	0
Mbr # 40	0	2	20	22	1

In 2 years, these patients had ridiculously high volume of cardiac tests – WHY ???

Appropriateness of Procedures

Variability in Rates of Procedures in CAD patients Across Provider Groups



Incidence of CABG in US population = 1.57% and of PCI is 7.34%

Low Back Pain and Lumbar Laminectomy Sub-Analysis

- 775,866 population – 57,812 had Low Back Pain (7.45%)
- 2,275 had Lumbar Laminectomies (3.94% of LBP patients)
- Of all patients w LBP: 41.0% had X-Ray Spine and
- 31.6% had either an MRI or CT Spine
- 16% had one MRI Spine & 13.73% had 2 or more MRI Spine

# LBRLAM	Patients w LBRLAM	Average # X_RAY SPINE	Average # MRI SPINE	Average # CT SPINE
0	55,537	0.66	0.43	0.04
1	2,121	4.69	1.90	0.53
2	138	7.25	4.09	0.86
3	14	8.79	5.71	2.14
4	1	7.00	8.00	1.00
5	1	17.00	10.00	3.00
Total	**57,812**	**0.82**	**0.49**	**0.06**

Example Drill Down Report

Some Patients received as many as 16 MRI spine in 2 years

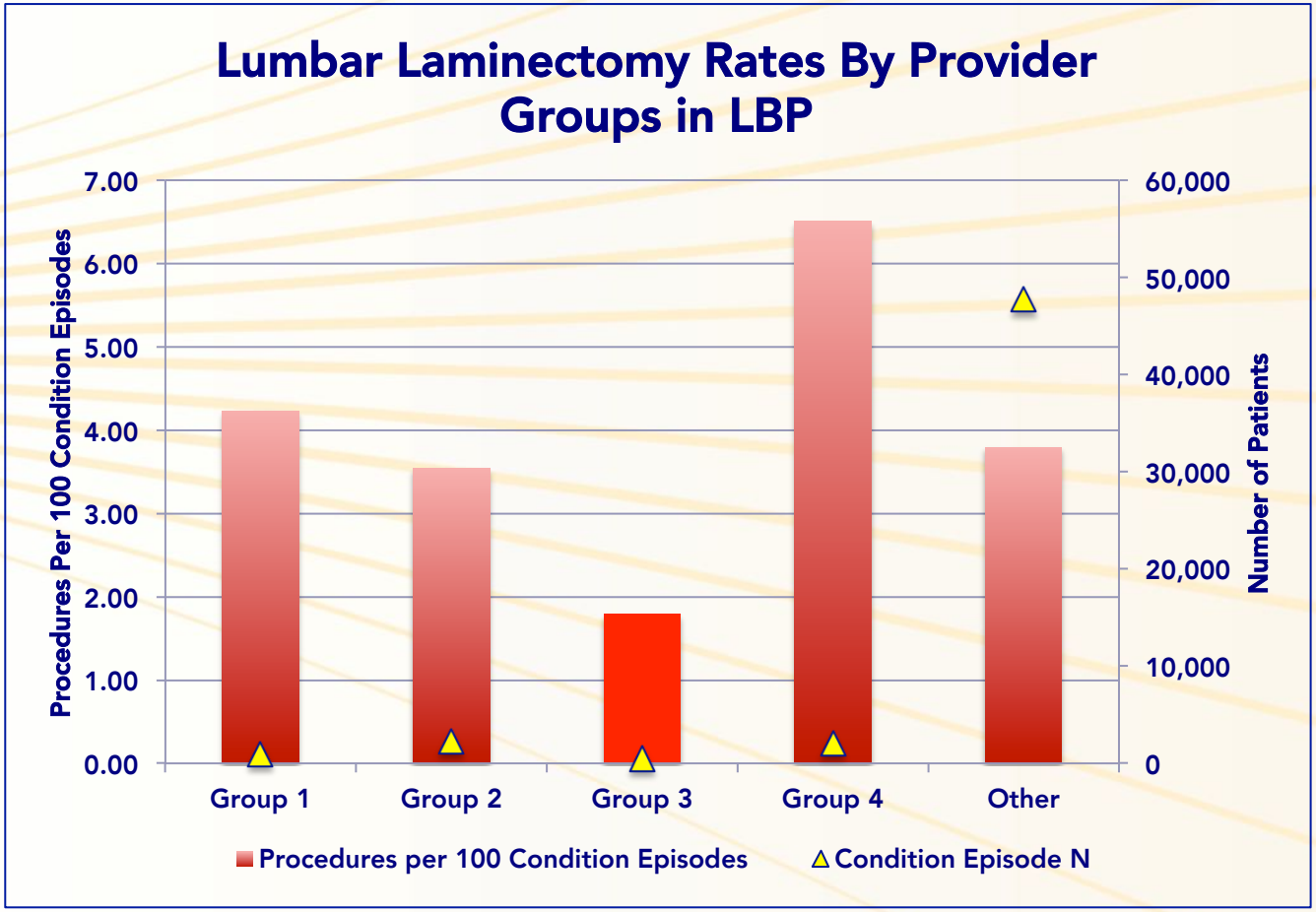
Member_ID	MRI_SPINE_CNT	CT_SPINE_CNT	X_RAY_SPINE_CNT	Total Imaging	Had LBRLAM
Mbr # 1	16	4	3	23	0
Mbr # 2	16	0	1	17	0
Mbr # 3	14	2	7	23	0
Mbr # 4	14	0	6	20	0
Mbr # 5	3	12	0	15	0
Mbr # 6	0	19	2	21	0
Mbr # 7	0	12	8	20	0
Mbr # 8	3	10	32	45	1
Mbr # 9	4	5	30	39	1
Mbr # 10	14	6	13	33	3
Mbr # 11	7	7	17	31	1
Mbr # 12	4	7	20	31	1
Mbr # 13	2	6	23	31	1

Super Utilizers in LBP

- 283 patients w LBP (0.5%) were considered as Super-Utilizers of services, with at least 10 count of imaging services of the spine over the 2 year period
- Interestingly some of the super-utilizers of services received up to 5 lumbar laminectomy procedures over 2 years

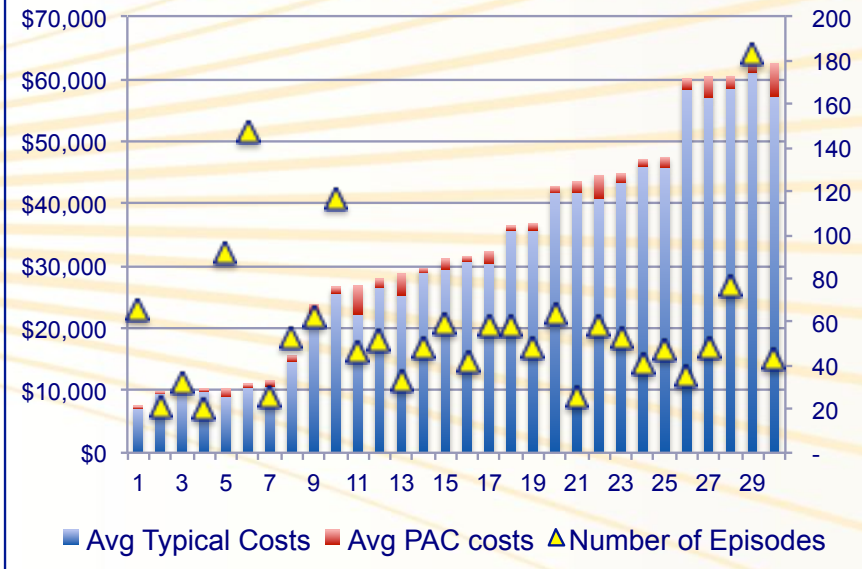
# LMBLAM	Patients w LBRLAM	Average # X_RAY SPINE	Average # MRI_SPINE	Average # CT_SPINE	Average # Total Imaging
0	58	9.74	3.38	1.66	14.78
1	174	12.31	2.52	1.52	16.35
2	44	11.93	4.66	1.11	17.70
3	6	11.83	6.33	4.17	22.33
5	1	17.00	10.00	3.00	30.00
Total	283	11.73	3.14	1.54	16.41

Appropriateness of Procedures



Risk Adjustment

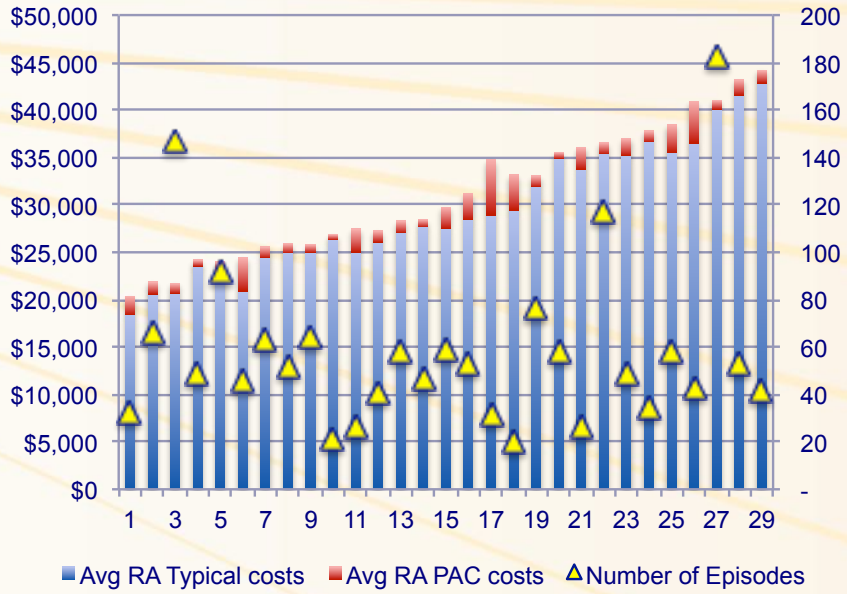
Lumbar Laminectomy Actual Costs by Facility (N>=20)



Observed Costs vary due to complexity of procedures performed within a lumbar laminectomy episode

Risk-adjustment eliminates differences due to complexity of procedures and patient comorbidities, and reveals true differences across facilities

Lumbar Laminectomy RA Costs by Facility (N>=20)



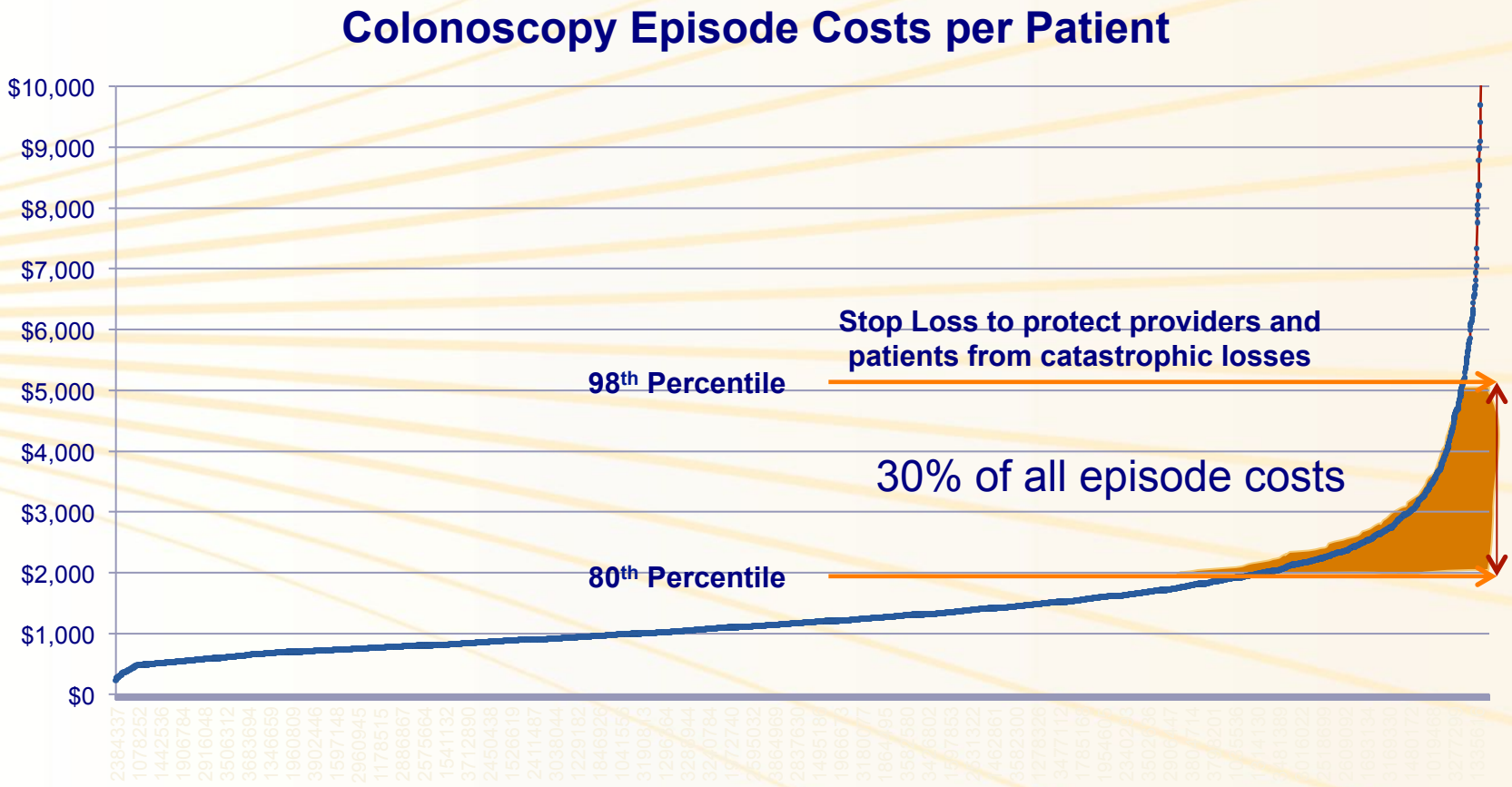
In Summary

- Understanding the causes of variability creates opportunities for providers
  - Reducing PACs improves patient care
  - Reducing underuse reduces the potential for avoidable complications
  - Reducing overuse generates significant Savings
- Current ECR definitions embed tags that can help create powerful feedback reports for providers and help them manage patients better

Using Variability To Activate Consumers

Doug Emery

What is the Goal?



Holding providers and patients responsible for costs between the 80th and 98th percentile of episode costs would save 30%

Consumer Activation: State of the Art is Very Problematic

- Quality tools are scattered, indistinct and methods difficult to interpret (example: US News and World Report Hospital Rankings)
- Transparency tools are incomplete and ambiguous (example: crude FFS methods for estimating OOP costs, either by episode or within deductible)
- Current FFS benefits plans make activation almost impossible
- Result: low uptake by employees and consumers

What is Needed?

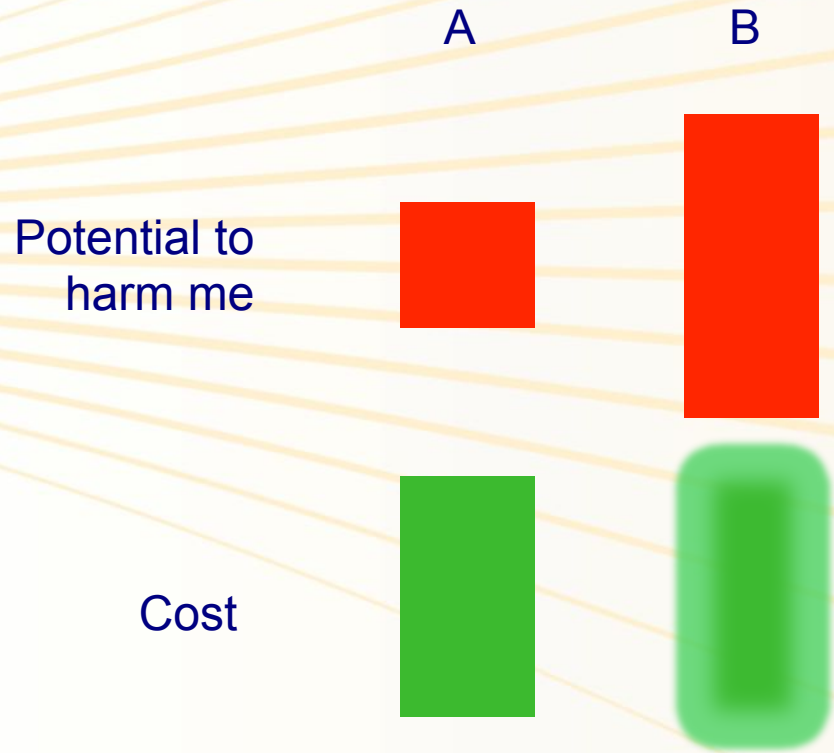
The CTQs – Critical to Quality consumer parameters

- **Simple – a child could understand it**
- **Unambiguous – cost, for example, is not fuzzy, it is fixed and known *upfront***
- **Searchable – the ability to drill down into increasingly complex pieces of information, *if consumers so choose***

Where Do We Start?

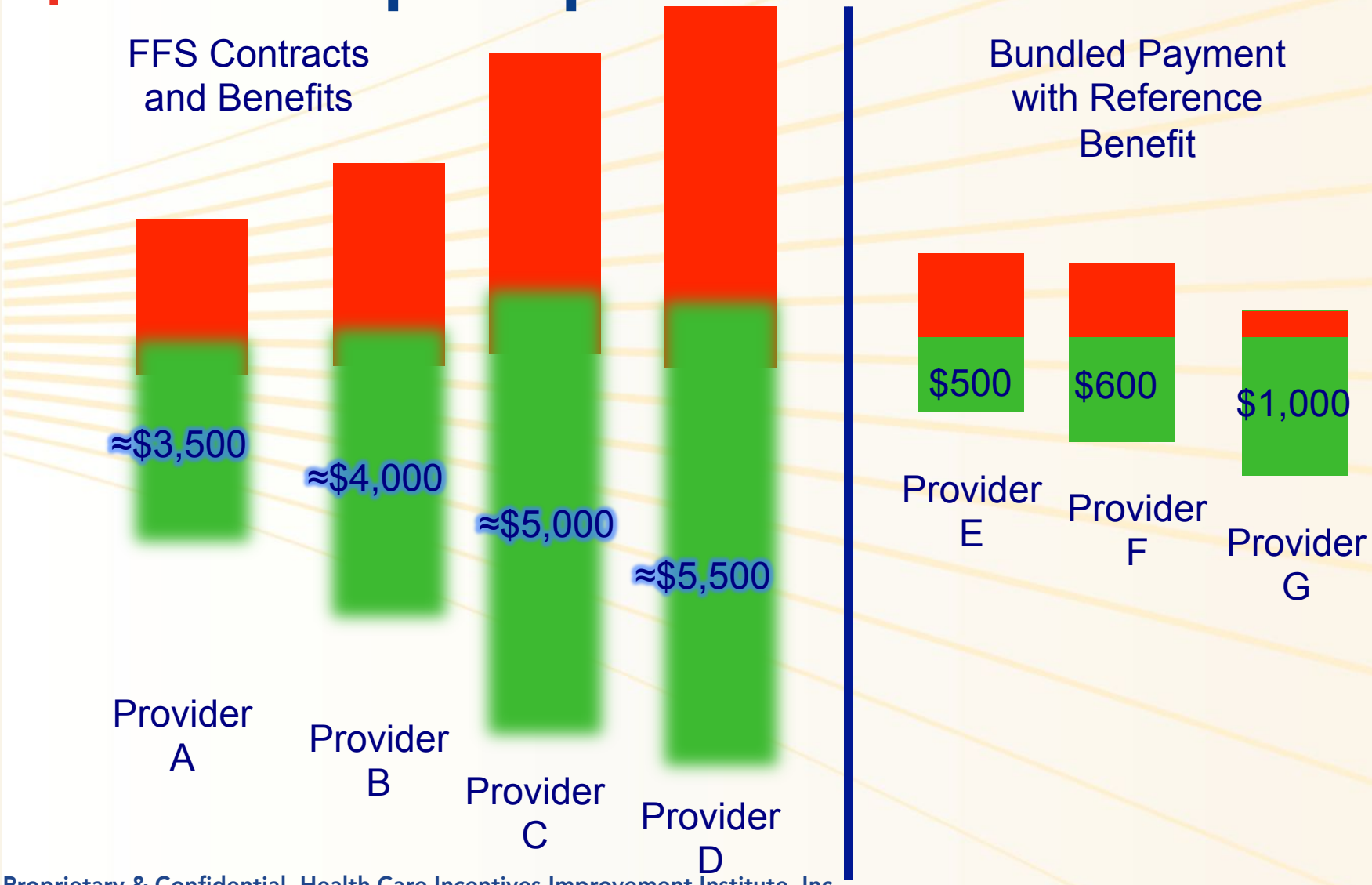
- **Evolutionary Psychology** – there are least 200 hard-wired intuitive cognitive biases in the human brain – take advantage of it!
- **Prospect Theory** – losses loom larger than gains (Daniel Kahneman and Amos Tversky)
- **Experimental Field Data** – Judith H. Hibbard et al, "An Experiment Shows That A Well Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care" (Health Affairs 31, No.3 (2012): 560-568.

A Simple, Intuitive Method: Red Bar / Green Bar Gateway



Example – Joint Replacement Procedure

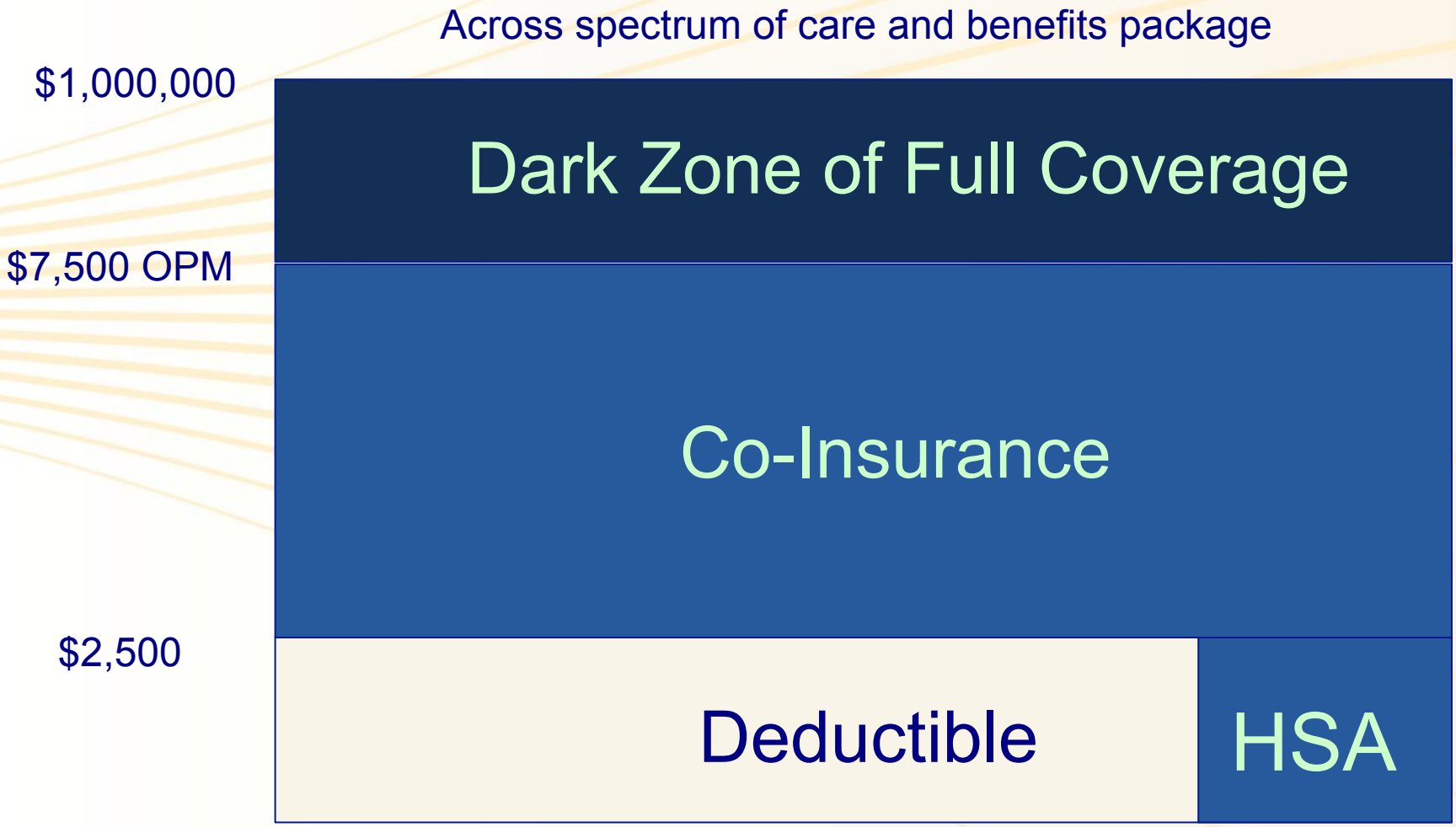
John's In-Network Providers for Total Hip Replacement



The Problem: Indiscriminant FFS Sick Plans (unilateral deductible)

Annual Deductible: *In-network* $500 Individual / $1,500 Family *Out-of-Network* $5,000 Individual / $15,000 Family
Annual Out-of-Pocket Maximum: *In-network* $1,500 Individual / $3,000 Family *Out-of-network* $7,500 Individual / $15,000 Family
Co-Insurance/Co-Pay: *In-network* 80% *Out-of-network* 60%
Primary Care Physician Services: *In-network* $25 Primary Care $80 Specialist *Out-of-network* Deductible, 60%
Other Physician Services: *In-network* Deductible, 80% *Out-of-network* Deductible, 60%
Preventive Care (In-network coverage only)
Mammograms, Pap Smear, Prostate Screening, Well Child to Age 6, Physicals $25 Copay, then 100% 0%
Hospital / Skilled Nursing Facility Charges: *In-network* $100 Copay, 80% *Out-of-network* $500 Copay, 60%
Outpatient Facility Charges: *In-network* Deductible, 80% *Out-of-network* Deductible, 60%
Emergency Room: *In-network* Deductible, *Out-of-network* 80% Deductible, 60%
Ambulance: Deductible, 80%
Other Services (Outpatient Facility, Home Health, Physical Therapy, Mental Health): *In-network* Deductible, 80% *Out-of-network* Deductible, 60%
Prescriptions $10 (Generic) / $25 (Preferred) / $60 (Non-Preferred)
Lifetime Maximum $1,000,000

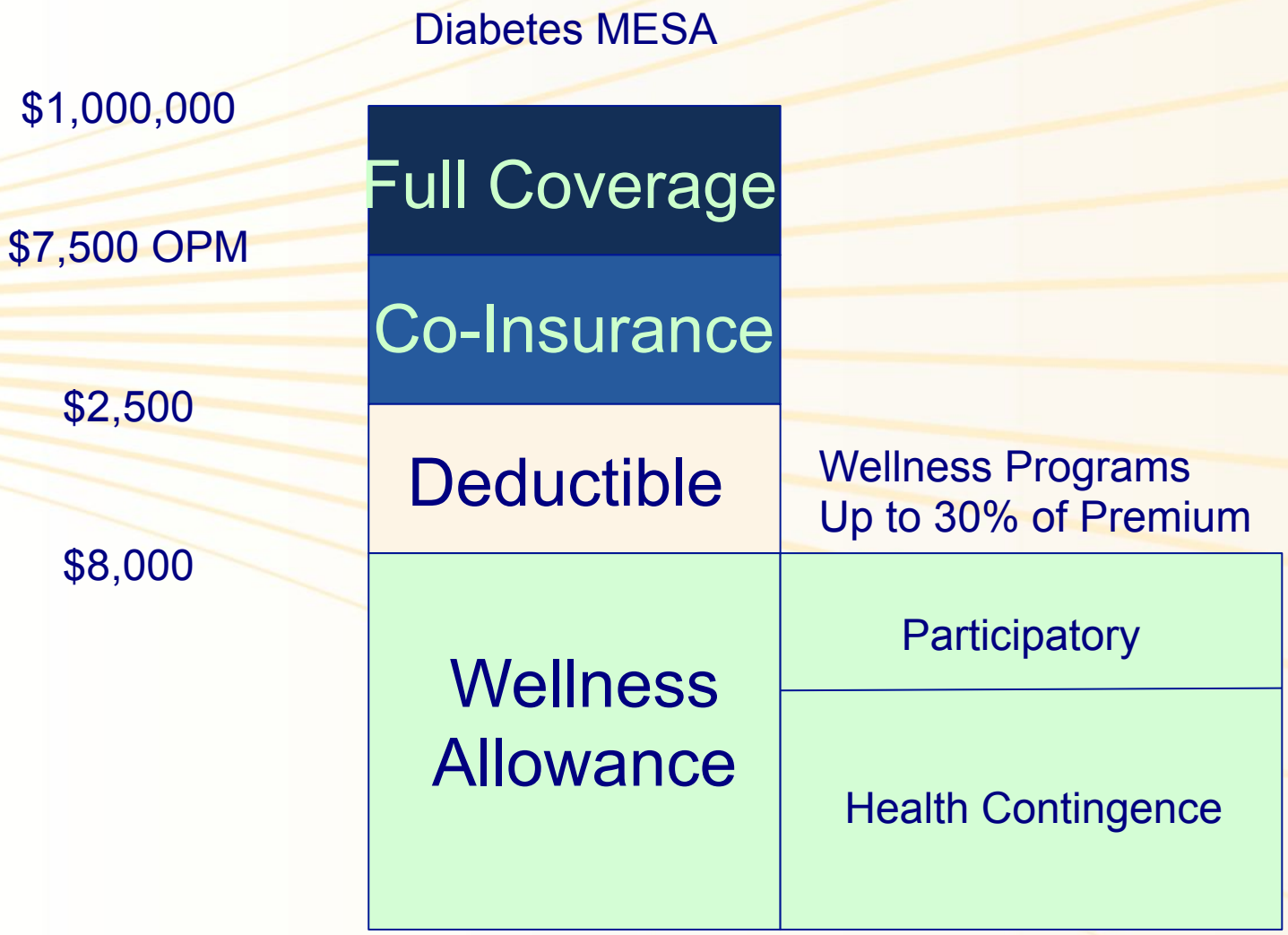
Blind "Coverage"



The Solution P4P = B4P: Medical Episode Savings Accounts/MESA

- A multilateral deductible system that distinguishes clinical nuance – that is, cost exposure is tuned to condition and patient response
- Rather than just generating a bill at the end of a care episode, a MESA gives the patient an allowance at the beginning.
- A MESA gives the patient a list of high-performing providers who can provide the needed care, each provider's negotiated bundled price, and the quality recognitions they have earned.
- Armed with clear cost and quality information, the patient can then choose any provider on the list.
- A MESA can be linked to wellness programs so that patient consumption performance can be rewarded (B4P)

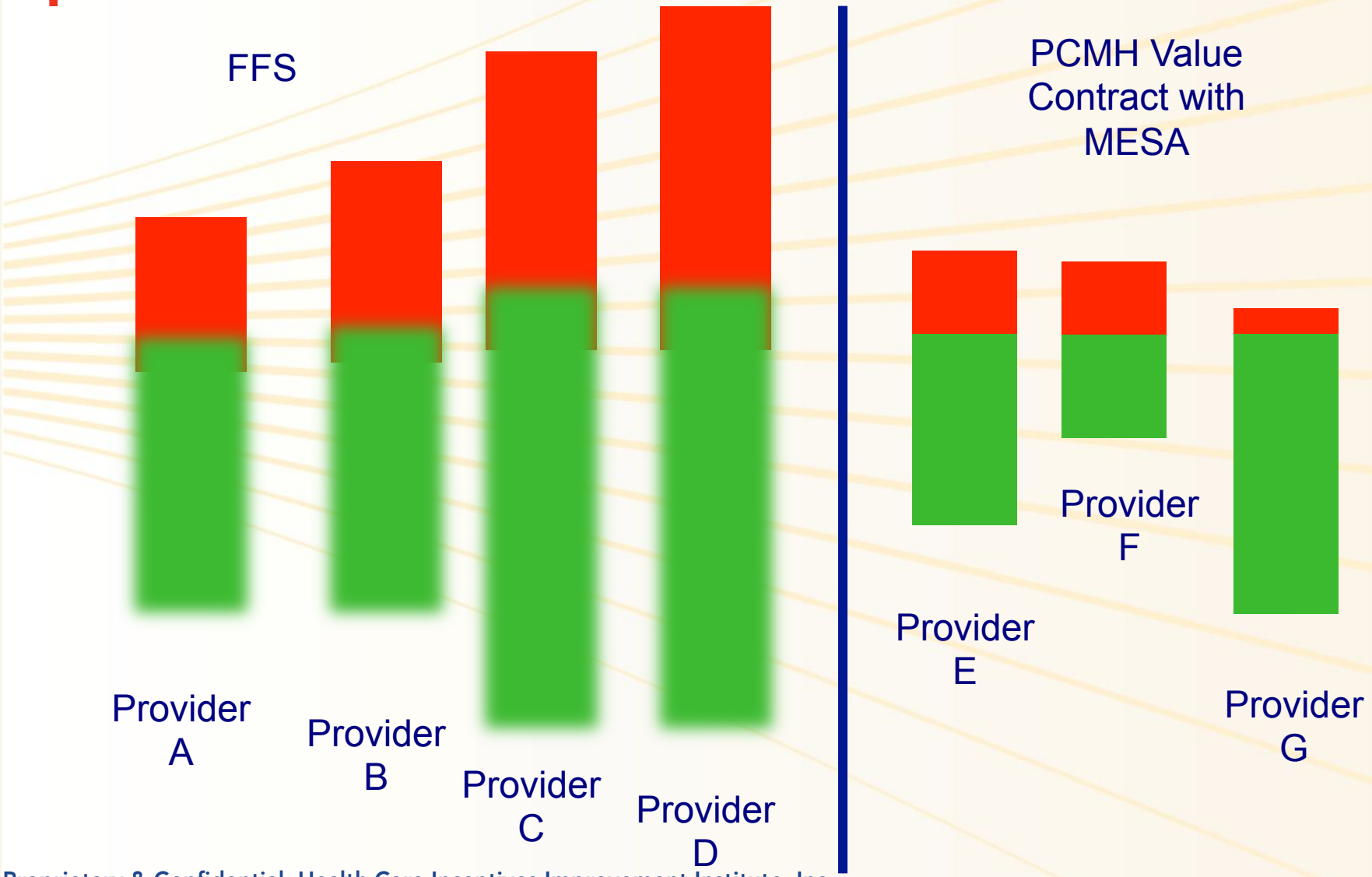
MESAs: Parsing Clinical Nuance



Example – Diabetes

- **Mary Walsh**
- Age 45
- Nashua, NH
- Spending Allowance for Annual Diabetes Care: **$8,000**

Mary's In-Network Providers for Diabetes



Mary – An Employee With Diabetes

- At the beginning of the year, she receives one allowance that covers preventive care and another allowance that covers diabetes care (and related conditions) for the year.
- She is given a list of doctors who can provide care, some with bundled fees.
- Once she chooses a doctor, she is given a schedule of recommended services for the year.
- If she does not get recommended services, or gets non-recommended services, she is assessed a penalty and her allowance amounts are reduced.
- "Use it or lose it" – any funds not used by year-end are forfeited.

Matching MESA with wellness and accountable care

The Scenario

- Mary selects Dr. James Younger practicing with Medical Partners
- Mary's MESA for diabetes is $8,000 for 2015
- Medical Partners has a contract with her plan to manage her 2015 diabetes care for $7,000

Mary's Wellness Ledger

Mary's MESA Budget: $8,000 HP Contract: $7,000 Mary's Plan Cost: $17,000

PWP $1,000 **HCWP 30% = $5,100 50% = $8,500**

PWP	HCWP	
Recognized Provider	**HbA1c**	**< 7.0**
Recommended OV	Lipid	< 100mg / dl
Diabetes Education	Blood Pressure	< 130 / 80
Nutritional Program	BMI	< 20
Med Compliance	Smoking	Quitter
Vaccinations		
Gym Membership		

The Takeaway…

Health *is* Wealth

The solution is to merge health benefits to one's *sense of estate*

For Mary, over the course of her career, that's $186,862 (@5%) added to her family's savings!

In Summary

- Consumers have already transformed the low end of the market, but now we need to move the activation "up-market"
- A combination of value-based payments and value-based benefits can transform the market IF:
  - Consumers have simple to understand interfaces on provider price and quality (Red Bar / Green Bar Gateway)
- Wellness programs that rewards *results* can move patients to high value providers who have less variability (take out the 30% excess)
  - We need Congress to allow new wellness rewards to accrue to tax-deferred instruments (remember Mary!)

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