

# Bringing the Consumer Perspective to Health Care Transformation

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CT SIM Consumer Meeting  
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# Yes, THAT *Consumer Reports*



**Consumers Union**  
POLICY & ACTION FROM CONSUMER REPORTS

Reliability History - Toyota Prius

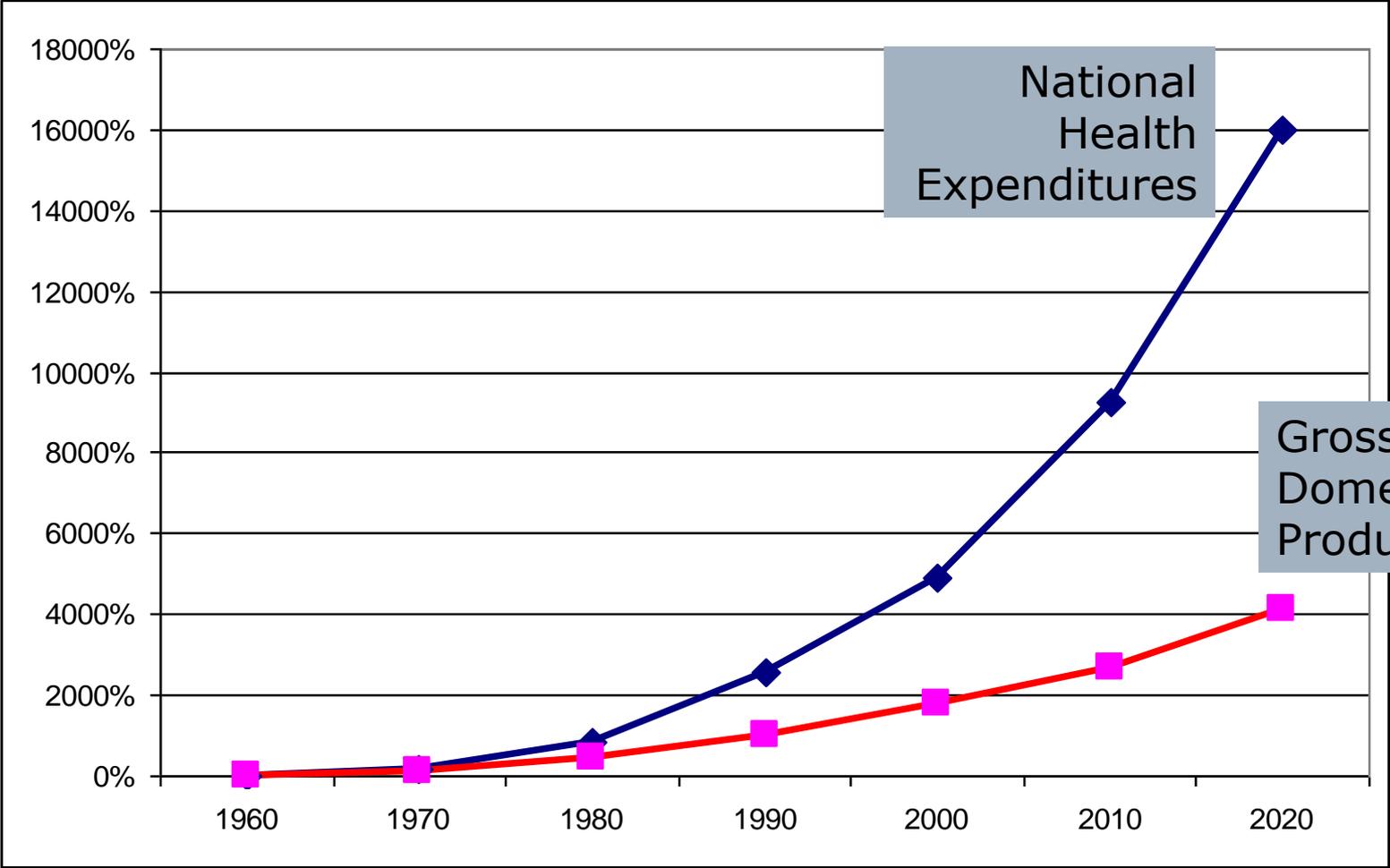
BETTER <<<<<<<>>>>> WORSE  
Redesign year shows in RED.

	10	01	02	03	04	05	06	07	08
-	-	+	+	+	+	+	+	+	+
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-	-	+	+	+	+	+	+	+	+
-	-	+	+	+	+	+	+	+	+
Drive System	-	-	+	+	+	+	+	+	+
Fuel System	-	-	○	+	○	+	+	+	+
Engine Minor	-	-	+	+	+	+	+	+	+
Electrical System	-	-	●	+	○	+	+	+	+
Used Car Prediction	-	-	+	+	+	+	+	+	+

# Connecticut Has Four Urgent Problems

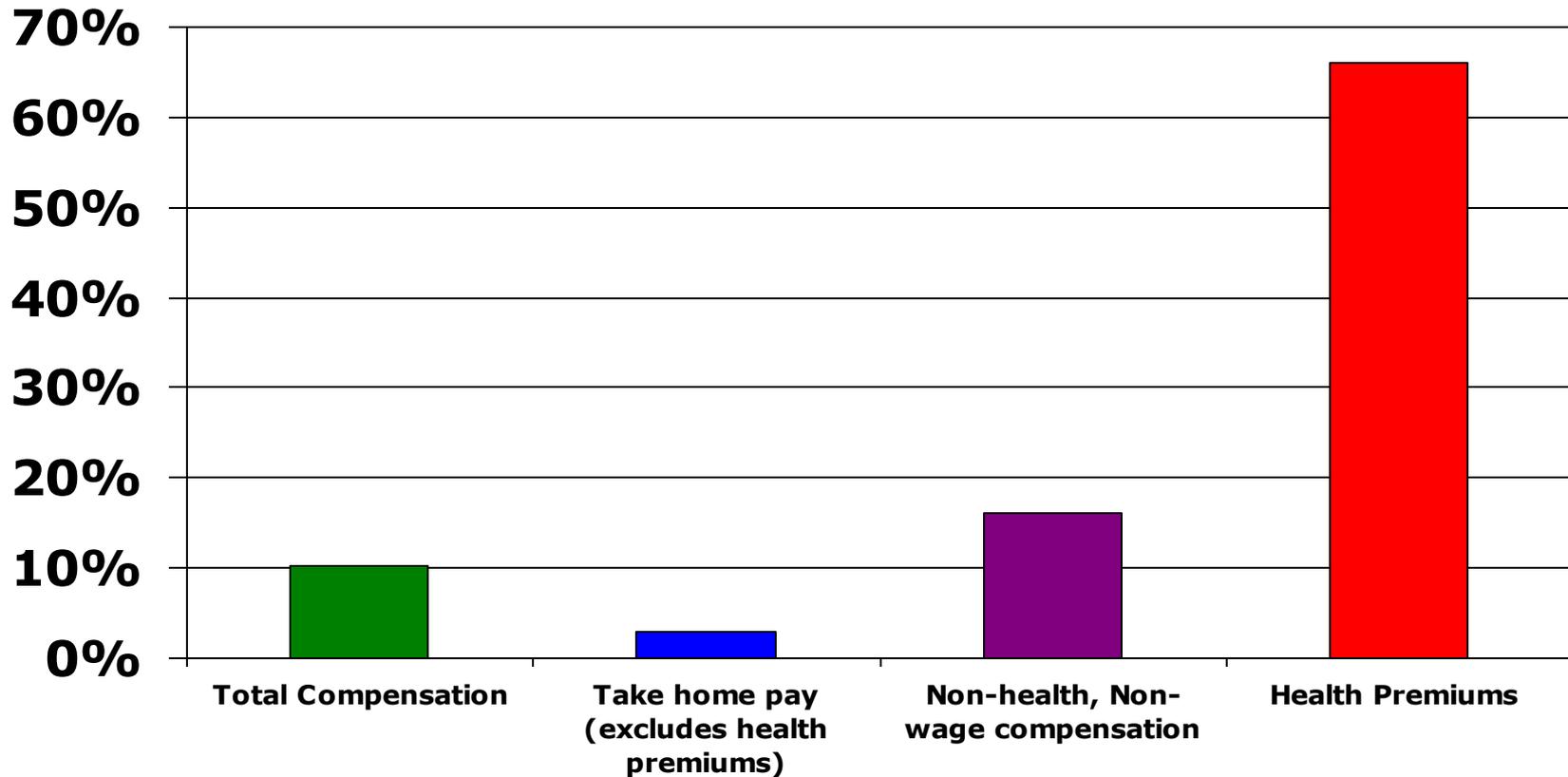
- ❑ Inadequate Health Outcomes
- ❑ Disparities in Health Outcomes
- ❑ Difficulty Affording Health Coverage and Health Care
- ❑ Unsustainable Growth in Health Care Spending

# Each Year, Health Spending Grows Faster Than the Economy Overall



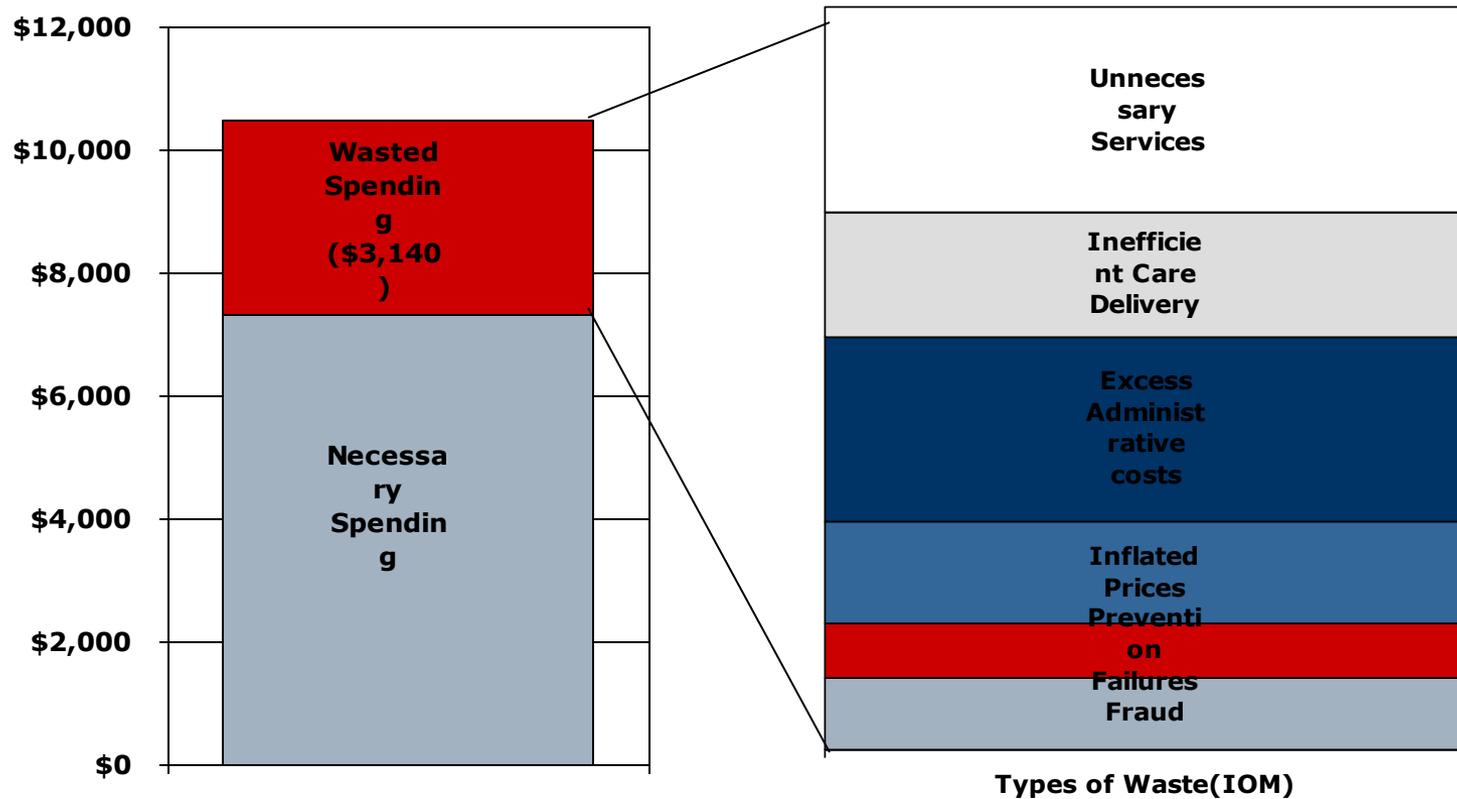
Source: CMS, National Health Expenditure Data

# High Health Spending Bottom line: less money for other things and less money in your paycheck



2000-2013 Growth In Compensation  
(US Average, adjusted for inflation)  
Source: CU analysis of BLS compensation survey data

# Experts Agree: Inadequate Value for Our Health Care Dollar



2012 Health Spending Per Person (CT)

Sources: CT Connecticut Health Care Innovation Plan, Institute of Medicine.

# Providing too few or too many services means poor outcomes or even patient harm

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## Too little:

- Public health
- Preventive measures

## Too much:

- Unnecessary services; duplicative tests
- Care provided to correct patient harm

*In the US, hospital acquired infections kill 7 times more people than drunk drivers. Source: MADD and CDC*

# But “waste” in the system isn’t our major cost driver

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- Year-over-year increases in charge per procedure accounts for a majority of spending growth.

# Good News: the CT State Innovation Plan is about Solutions

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But how to keep it all straight?

Advance Medical Home

Shared Savings Program (SSP)

*Consumer Empowerment*

Value-Based Insurance Design (VBID)

Pay for Performance (P4P)

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# Making Sense of the Alphabet Soup

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- Who is being targeted:
    - Consumer
    - Doctors, Hospital or other providers
    - Insurer
  - What is the approach:
    - Increased transparency
    - Financial incentive
    - Structural
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# For each “intervention,” ask

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- What is the goal?
    - Lower spending?
    - Increase quality?
    - Increase value?
    - Empower consumers?
  
  - How will we know if we’ve been successful?
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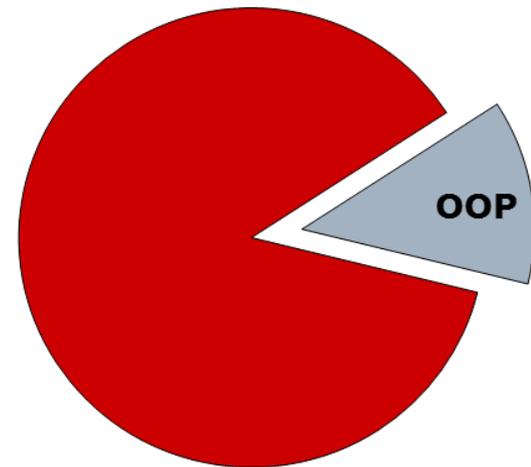
# The Role of the Consumer

- Consumers should have trusted, actionable information on the prices, quality and value of doctors, hospitals and treatments.
- Consumers deserve to shop with confidence.
- But we need to be realistic about consumers' ability to "move the market."

# Most Health Care Dollars Are Directed by Physicians

- ❑ Consumers' out-of-pocket spending = 13% of our nation's health care bill.
- ❑ And a portion of this is still directed by the doctor.
- ❑ Bottom line: Most health care is not "shoppable."

Total Health Care Spending



Source: CMS, National Health Expenditures

*The most expensive piece of medical equipment is a doctor's pen.*

# Fee for Service

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- Rewards physicians/hospitals for the volume of services and procedures, not care coordination activities or improved quality of services
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# Practice transformation...

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...requires structural changes in the delivery of services and management of providers, including efforts to improve patient-centered care and collaborations with external care settings and resources.

Financial incentives matter but a comprehensive approach is needed.

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# Many Ways to Get There

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- Care Coordination Fees
  - Pay for Performance
  - Value Based Payments
  - Shared Savings/Shared Losses
  - Patient Centered Medical Home
  - Accountable Care Organization
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# Care Coordination

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- the conscious effort by two or more health care professionals to facilitate and coordinate the appropriate delivery of health care services for a patient
- Examples:
  - Transitional care (typically from hospital to home).
  - Medication management

Check out this resource:

<http://www.cfmc.org/integratingcare/toolkit.htm>

# Care Coordination

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- ❑ Typically care coordination activities are not separately reimbursed.
  - ❑ By providing financial incentives for improved care quality and funding for integrated delivery systems, these reforms may encourage health care providers and institutions to participate in care coordination activities.
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# Pay for Performance

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- FFS + Bonus
  - A basket of quality measures is defined and incorporated into a scorecard. Clinicians can then earn a bonus, or an increase in future earnings, based on their performance on the scorecard.
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# Pay for Performance: Evidence

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- 12 years of experience in CA saw improvements in quality but also rising costs
  - New Approach: transition to “Value Based” Pay for Performance
    - A focus on *total cost of care* as well as quality thresholds
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# Shared Savings/Shared Losses

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- incentives across multiple specialty settings and hospitals to manage defined populations of patients.
  - two payment streams:
    - a traditional stream featuring FFS payments
    - a target budget for the managed population based on a “control group” or market baseline trend.
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# PCMH and ACO: Two closely related concepts

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- Patient-centered medical home (PCMH): a single provider is responsible for coordinating care for individual patients.
  - Accountable care organizations (ACOs): organizing care along a continuum from doctor to hospital.
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# Patient Centered Medical Home:

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- patient-centered,
  - comprehensive,
  - team-based,
  - coordinated,
  - accessible, and
  - focused on quality and safety.
- Goal: achieving primary care excellence so that care is received in the right place, at the right time, and in the manner that best suits a patient's needs
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# PCMH: Evidence

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- ❑ Despite agreement on the organizing principles, no consensus exists on an operational definition of the components of the PCMH or investments required
  - ❑ Mixed results thus far on both cost savings and quality
  - ❑ Possible reason: PCMHs have not been implemented on a large enough scale or for long enough to show real savings
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Often, the structure of the health plan,  
care delivery systems, and  
practice traits  
determine whether an intervention  
will be successful

# ACOs

- An ACO could be a real (incorporated) or virtual (contractually networked) organization, for example, a large physician organization that would contract with one or more hospitals and ancillary providers.
- The concept of financial risk: providers in the ACO would share in efficiency gains from improved care coordination and *could* be subjected to financial penalties for poor performance

# Consumer Considerations

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- Protect vulnerable consumers
    - access to and availability of care
  - Transparency
  - Consumer involvement
  - Evaluation and monitoring
    - Are goals being realized?
    - Can patients make informed decisions?
    - Fine tuning
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# ACO: Example

- Patients might be assigned to ACO based on their primary care physician; however, the patient is free to see providers outside of their ACO and even switch ACOs
  - Patient choice vs. possibly undermining effectiveness

# Thank you!

Please email  
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questions:  
  
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www.consumersunion.org

**ConsumersUnion®**  
POLICY & ACTION FROM CONSUMER REPORTS

HEALTH POLICY  
BRIEF  
JANUARY 2012

## What's Behind the Door: Consumers' Difficulties Selecting Health Plans

**SUMMARY**

Consumer testing by Consumers Union confirms the widely held perception that people struggle to understand their health insurance policies. This information gap has grave consequences for consumers and for the success of most health reform approaches. Indeed, improving consumers' ability to shop in the health insurance marketplace is an area of great untapped potential. But realizing this potential will require a multi-layered policy approach. It will require greater standardization of products in the marketplace, along with better tools for communicating health plan features to consumers. Both strategies will require an in-depth understanding of how consumers shop for coverage and the barriers they face. Rigorous consumer testing provides the nuanced information that can lead to measurable improvements in consumer understanding. This brief highlights the findings from three consumer testing studies. These consolidated results provide a strong foundation for regulatory and legislative efforts to enact policies and provide tools that improve consumers' understanding of health insurance, as well as health plans' own efforts to improve customer communications.

Consumer testing by Consumers Union confirms the widely held perception that people struggle to understand their health insurance policies. These difficulties are so profound that the vast majority of consumers are essentially being asked to buy a very expensive product—critical to their health—while blindfolded. As in the game show "Let's Make a Deal," they must make a selection without knowing what's behind the door.<sup>1</sup> This information gap has grave consequences for consumers and for the success of most health reform approaches.

### Why Engage In Consumer Testing?

If policymakers or regulators start with an incomplete or erroneous understanding of how consumers shop for health insurance, they will not design appropriate policies or regulations. However, these entities are hampered by a very limited amount of data on how consumers shop and the barriers they face. There is a general perception that shopping for and using health insurance is

1 – HEALTH POLICY BRIEF – JANUARY 2012 – WWW.CONSUMERSUNION.ORG