SmarterHealthCare Coalition *in partnership with* V-BID CENTER FOR VALUE-BASED INSURANCE DESIGN UNIVERSITY OF MICHIGAN

Policy, Politics, and Progress: Improving the Patient Experience through Value-Based Insurance Design

January 29, 2020 | 9 AM – 12 PM | Kennedy Caucus Room

Join the Conversation:

@Smarter_HC
@UM_VBID
#SmarterHealthCare

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Welcome Remarks

Andrew MacPherson, *Co-Director,*
Smarter Health Care Coalition

Smarter Health Care Coalition

Our Mission.

- *To enhance the patient experience – encompassing access, affordability, and quality – by integrating benefit design innovations and consumer engagement within broader delivery system reform efforts in order to better align **coverage**, **quality**, and **value-based payment goals**.*

Our Progress.

Membership

- Growing membership – over 25 current members
- New members in 2019: JDRF, WellCare, Beyond Type 1, and Pacific Business Group on Health

Administration

- Department of Treasury issued guidance to expand pre-deductible coverage in HSA-HDHPs
- Coalition letter to Secretary Azar addressing harmful, low-value care

Legislation

- Bipartisan Budget Act of 2018 expanded CMMI MA V-BID demonstration to all 50 states
- Chronic Disease Management Act (S.3200) reintroduced in U.S. Senate

Agenda Overview.

- **Perspectives from the Trump Administration – The Future of Value-Based Insurance Design**
  Stephen Parente, *Senior Economist, Executive Office of the President, Council of Economic Advisers*

- **Using Data to Define High-Value Services**
  Dr. Ryan Bosch, *Founder and President, Socially Determined*

- **V-BID Model Incorporation of the Medicare Hospice Benefit into Medicare Advantage**
  John Richardson, *Chief Strategy Officer, National Partnership for Hospice Innovation*
  Tzvetomir Gradevski, *Strategic Initiatives and Policy Coordinator, National Partnership for Hospice Innovation*

- **Making Health Care Smarter by Decreasing Low-Value Care**
  Moderator: **Katy Spangler,** *Co-Director, Smarter Health Care Coalition*
  Panelist 1: **Beth Bortz,** *President and CEO, Virginia Center for Health Innovations*
  Panelist 2: **Amanda Deegan,** *Director, Global Public Policy, Walmart*
  Panelist 3: **Dr. John Keats,** *National Medical Director for Affordability and Specialty Partnerships, Cigna*

- **V-BID 2020: Expanding Coverage of Essential Clinical Care Without Increasing Premiums or Deductibles**
  Dr. Mark Fendrick, *Director, University of Michigan Center for Value-Based Insurance Design*

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Keynote Address Introduction

Katy Spangler, *Co-Director,*
Smarter Health Care Coalition

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Keynote Address:

Perspectives from the Trump Administration – The Future of Value-Based Insurance Design

Stephen Parente, PhD, MPH, MS, *Senior Economist, Executive Office of the President, Council of Economic Advisers*

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Expert Presentation:
Using Data to Define High-Value Services

Dr. Ryan Bosch, *Founder and President,*
Socially Determined

Using SDOH to Target Populations and Tailor Solutions

Ryan Bosch, MD
Founder & President, Socially Determined

January 29, 2020

SOCIALLYDETERMINED

Background, Perspective, and Qualifications

Socially Determined is an analytics company

created the first purpose-built SDOH platform

managing the ingestion, normalization, storage, integration, and analysis of clinical, financial, geographic, and social data

generating SDOH risk analytic insights, target cohorting, related geospatial products, and data feeds.

Approach: First, Ask the Right Questions

What's happening in your community?

How are SDOH risks concentrated and distributed across the communities we serve?

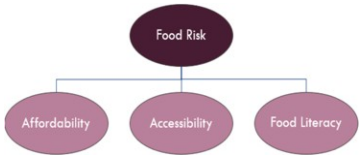
Who is at risk?

Which of the subpopulations that we serve are most impacted by SDOH risks?

How are SDOH risks driving variation in utilization, cost, and outcomes?

How should we prioritize opportunities to address SDOH? How do we measure impact and maximize ROI?

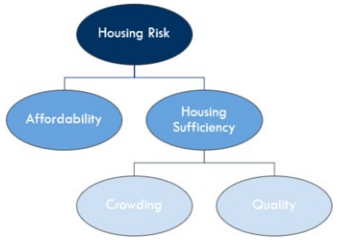
Specific SDOH Risk Categories



Food Insecurity

FII = $f(availability, cost, quality)$

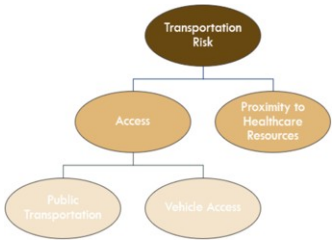
A measure of the accessibility and nature (i.e., healthy versus unhealthy) of food sources in the environment



Housing Insecurity

HII = $f(cost, quality, features)$

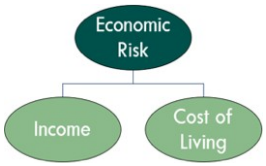
A measure of the stability and nature of the home environment



Transportation Barriers

TBI = $f(vehicle\ ownership, access\ to\ public\ transit)$

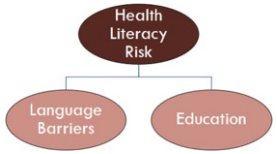
A measure of transportation options, access, and affordability



Economic Wellbeing

EWI = $f(income, employment, financial\ assets)$

A measure of financial security, strength, and resiliency



Healthy Literacy

HLI = $f(education\ level, language, intellectual\ disability)$

A measure of literacy and language barriers that may impact communication with service providers

Crime & Violence

CVI = $f(violent\ crime, property\ crime, interpersonal\ violence)$

A measure of the frequency and nature of exposure to crime and violence

Case Report: Food Insecurity among Pediatric Diabetics

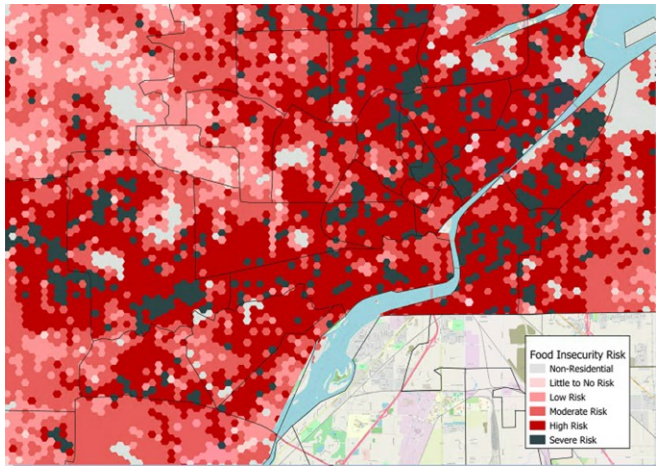
Identified at-risk individuals, with a focus on socially susceptible conditions, such as pediatric diabetics at-risk of food insecurity

Quantified the financial opportunity of addressing the social risk to prioritize intervention strategy and inform ROI model

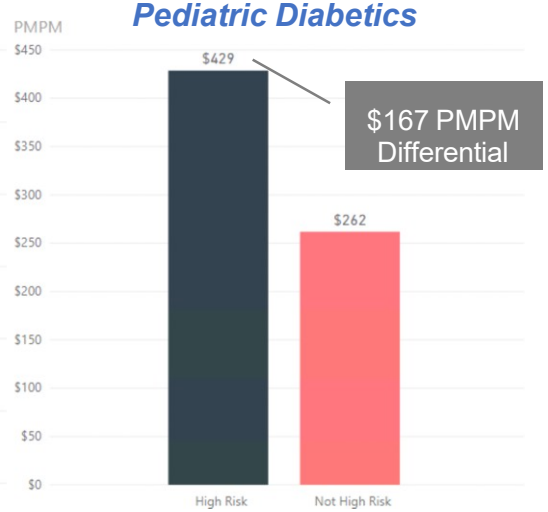
Precision deployment of existing interventions:

- *Food Pharmacy*
- *Cooking Classes*
- *Non-Profit Grocery Store*
- *Mobile Grocery Van*

Geospatial Rendering of Risk
Food Insecurity

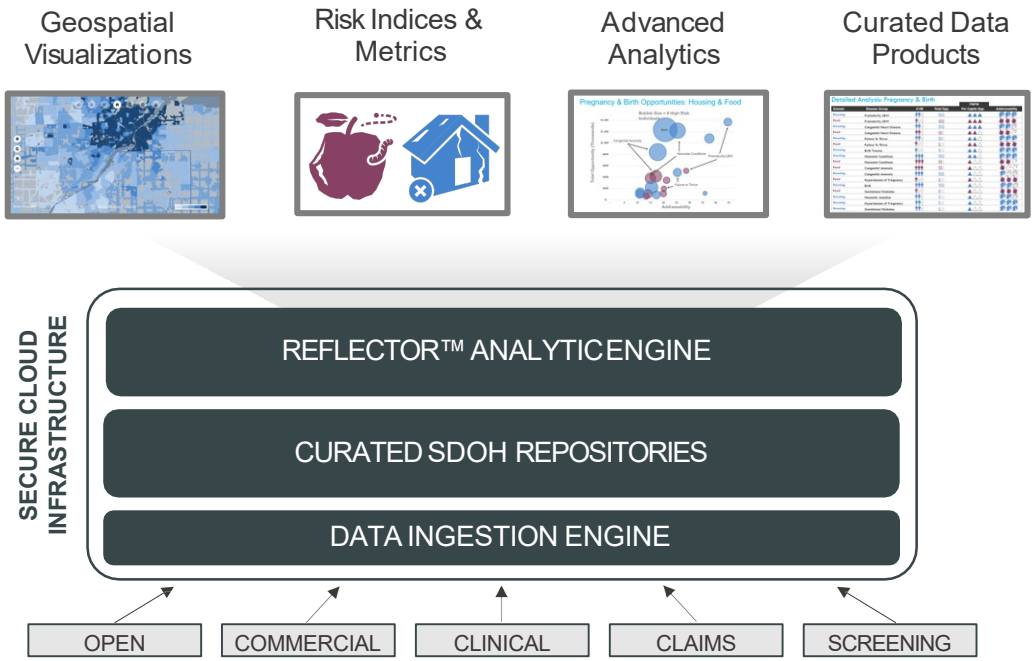


PMPM Comparison: High Risk vs. Not
Pediatric Diabetics



Intervention Strategy
Existing Food Programs

A Solution: the dedicated Analytic Platform: *SocialScape™*



Distilled SDOH Intelligence

- A science-based approach to SDOH – the first risk metrics in the industry
- A nationwide repository of social risk data culled from more than 130 open and commercial datasets
- Automated processing of client clinical, claims, and/or programmatic data
- Fully secure, cloud-based processing of PHI and PII
- Packaged products, ready for operational integration

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Expert Presentation:

V-BID Model Incorporation of the Medicare Hospice Benefit into Medicare Advantage

John Richardson, *Chief Strategy Officer, National Partnership for Hospice Innovation*

Tzvetomir Gradevski, *Strategic Initiatives and Policy Coordinator, National Partnership for Hospice Innovation*

Value-based Insurance Design (V-BID) Model

Incorporation of the Medicare Hospice Benefit into Medicare Advantage

Policy Politics and Progress: Improving the Patient Experience through Value-Based Insurance Design

January 29, 2020

John Richardson

Chief Strategy Officer

Tzvetomir Gradevski

Strategic Initiatives & Policy Coordinator

National Partnership for Hospice Innovation

The not-for-profit voice for advanced illness, hospice, and palliative care

A partnership of community-based non-profit, hospice, palliative, and advanced illness care providers.

Presentation Overview

- **NPHI Overview**
- **Background**
  - Medicare Hospice Benefit
  - Brief history of the "carve-out"
  - V-BID Model (general)
- **Hospice Carve-in Model**
- **Future Considerations**

About NPHI

- The National Partnership for Hospice Innovation (NPHI) is the national voice for community-based, non-profit hospice, palliative care, and advanced illness providers across the country focused on the highest quality, person and family-centered, end-of-life care.

- Our membership includes over 70 members across 30 states serving approximately 32,000 hospice patients on a daily basis.

Background: Medicare Hospice Benefit (MHB)

- Patients are eligible for the benefit if they are certified as having a terminal prognosis with a life expectancy of 6 months or less
- 50% of all Medicare decedents (1.5 million) used hospice in 2017 with an average length of stay of 89 days and median length of stay of 18 days
- Hospices are paid a per-patient daily rate based on the level of care they provide
- Four different levels of care offered through an interdisciplinary team (IDT) distinguished by intensity and location of services:
  - Routine home care (RHC) (98% of all hospice days)
  - Continuous home care (CHC)
  - Inpatient respite care (IRC)
  - General inpatient care (GIP)

Background: Hospice Benefit Carve-Out

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) first established the hospice benefit and the Omnibus Budget Reconciliation Act of 1985 made it a permanent part of Medicare.

TEFRA of 1982 also established managed care plans in Medicare but initially excluded hospice because utilization was low and there was little cost data.

The Balanced Budget Act of 1997 established in statute that hospice is carved out of Medicare managed care.

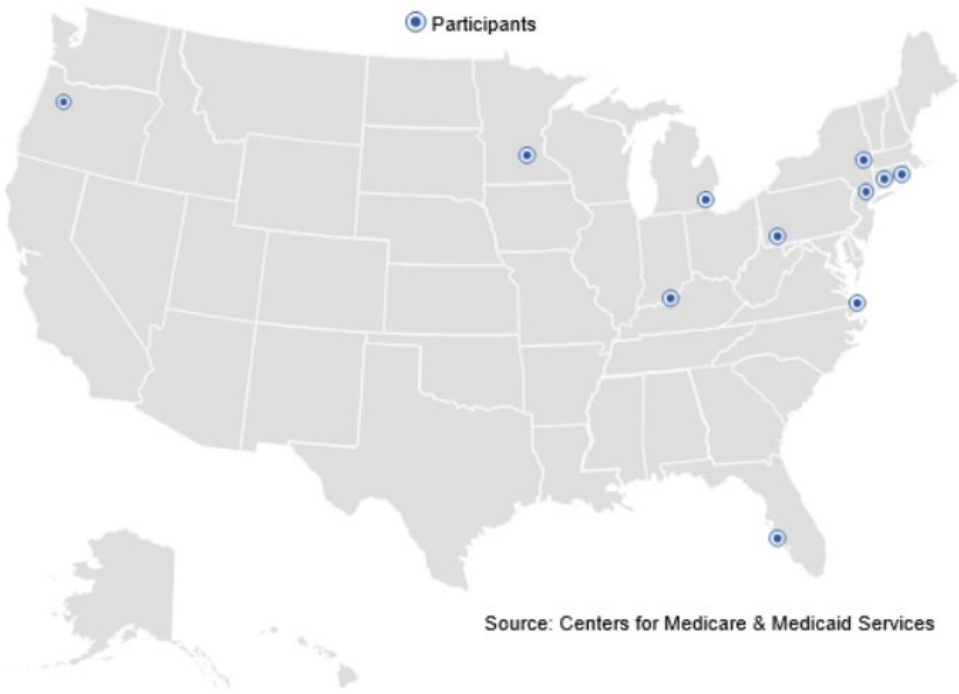
Past Congressional consideration on the carve-in:

- Considered but not adopted under MACRA
- Considered but not adopted under the CHRONIC Care Act

In 2019, CMMI announced it will begin testing a MA carve-in of the MHB under the MA VBID model starting in 2021 through 2024.

Background: V-BID Model (general)

- Model offered since 2017 through Center for Medicare and Medicaid Innovation (CMMI) to test improving outcomes through plan benefit design
- Open to participation across all 50 states through flexibility offered by Congress
- 14 Medicare Advantage plans participating in 2020 offering benefits to over 280,000 beneficiaries



MA VBID Hospice Carve-in

Preserving the Hospice Benefit & Quality Measures

CMS explicitly requires MA plans to provide the MHB as currently defined under statute and regulation, unless it waives certain provisions in future iterations of the Model	• 6-month prognosis • Four levels of care • Use of an interdisciplinary care team
CMS will measure plan performance in the following quality domains:	• Palliative Care and Goals of Care Experience • Enrollee Experience and Care Coordination at End of Life • Hospice Care Quality and Utilization
Beginning in 2023, it may adjust payments to plans based on the following measures:	• Proportion of Enrollees Admitted to Hospice for Less than 7 Days • Rate of Lengths of Stay beyond 180 Days • Transitions from Hospice Care, Followed by Death or Acute Care

Requirements to Offer Palliative and Transitional Concurrent Care

Palliative Care

- Unlike hospice, palliative care does not require an enrollee to have a life expectancy of six months or less, and palliative care may be provided together with curative treatment at any stage in a serious illness
- Plans must propose their approach for providing access to timely and appropriate palliative care services for their enrollees

Transitional Concurrent Care

- Plans must work with their network of hospice and non-hospice providers to define and provide a set of *concurrent care* services related to a hospice enrollee's terminal condition and related conditions that are appropriate to provide on a transitional basis, aligned with an enrollee's wishes

Network Adequacy & Payment

Network Adequacy

- **Year 1:** Enrollees can see in-network and out-of-network providers; plans are required to pay out-of-network providers at 100% of FFS
- **Year 2:** Enrollees can still see out-of-network providers but may be required to go through a "consultation program"; out-of-network providers are still paid at 100% of FFS
- **Year 3:** CMS will allow plans to use a "traditional" network adequacy approach; plans must have at least one hospice provider in each county

Payment

- **First month of hospice stay:** Standard A/B payment + hospice-specific capitation payment
- **All subsequent months:** Only hospice-specific capitation payment

Thank you!

Contact Information

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Tzvetomir Gradevski
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National Partnership for Hospice Innovation

ADVOCATING EXCELLENCE IN ADVANCED ILLNESS, HOSPICE, AND PALLIATIVE CARE

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Panel Discussion: Making Health Care Smarter by Decreasing Low-Value Care

Moderator:
Katy Spangler, *Co-Director, Smarter Health Care Coalition*

Panelists:
Beth Bortz, *President and CEO, Virginia Center for Health Innovations*
Amanda Deegan, *Director, Global Public Policy, Walmart*
Dr. John Keats, *National Medical Director for Affordability and Specialty Partnerships, Cigna*

Collaborating to Improve Health Care Value

Beth A. Bortz, President and CEO

VIRGINIA CENTER FOR HEALTH INNOVATION

The Virginia Center for Health Innovation

- Founded in 2012 as a 501C3
- Public-private partnership with annual funding from the Commonwealth of VA
- Mission: To accelerate the adoption of value-driven models of wellness and healthcare
- Governed by a diverse, multi-stakeholder board of directors
- Secured more than $23M in grants for Virginia

VCHI Board and Leadership Council

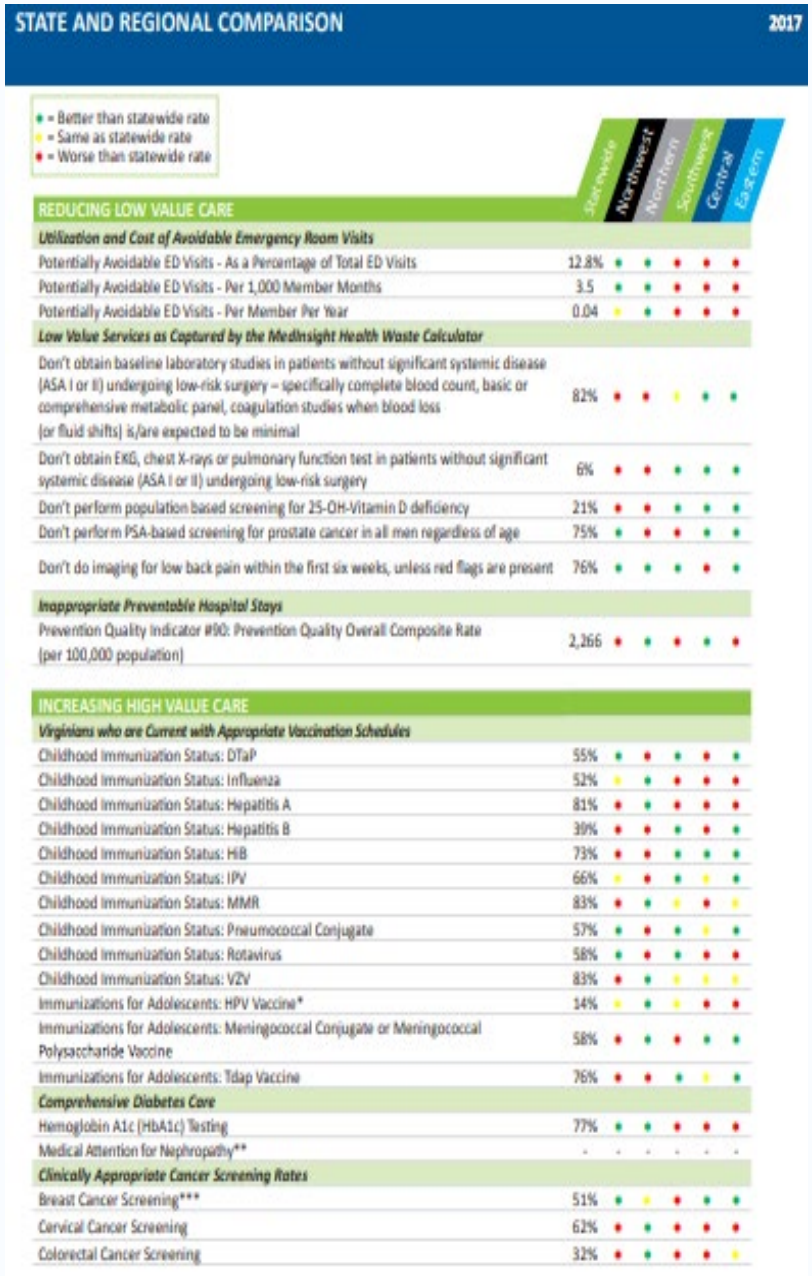
- AARP Virginia
- Advocate Health
- Aetna
- Anthem
- APC
- Augusta Health
- Aviant Health
- Ballad Health
- Biogen
- Boehringer-Ingelheim
- Bon Secours Virginia
- Carilion
- Centra Health
- Cigna
- Cogit Analytics
- Commonwealth of Virginia
- Dominion Energy
- GIST Healthcare
- GlaxoSmithKline
- HCA Virginia
- Inova Health System
- Johnson & Johnson
- LabCorp
- Maxim Healthcare Services
- MSV Foundation
- Merck
- Novo Nordisk
- Optima
- PATH Foundation
- Patient First
- Pfizer
- PhRMA
- Privia Health
- Riverside Health System
- Sanofi
- Sentara
- UnitedHealthcare
- UVA Health Care System
- Va Academy of Family Physicians
- Va Association of Health Plans
- VCU Health
- Virginia Health Care Foundation
- Va Hospital and Healthcare Association
- Va Oral Health Coalition
- Va Community Healthcare Association
- Va Council of Nurse Practitioners
- Virginia Nurses Association
- Virginia Premier
- Walgreens
- Westrock
- Workpath

Establishing a Virginia Health Value Dashboard

- The purpose of the Health Value Dashboard is to prompt action for improving the value of health care services.

- Our measurement approach is to identify and report on the delivery of both low value and high value clinical services across Virginia and its regions.

- Our action aims are to engage key stakeholders in systematically reducing low value services, increasing high value services, and improving the infrastructure for value-based care. We invite all organizations that provide, purchase, or fund health care to engage in this effort.



STATE AND REGIONAL COMPARISON 2017

● = Better than statewide rate
● = Same as statewide rate
● = Worse than statewide rate

REDUCING LOW VALUE CARE	Statewide	Northwest	Northern	Southwest	Central	Eastern
Utilization and Cost of Avoidable Emergency Room Visits						
Potentially Avoidable ED Visits - As a Percentage of Total ED Visits	12.8%	●	●	●	●	●
Potentially Avoidable ED Visits - Per 1,000 Member Months	3.5	●	●	●	●	●
Potentially Avoidable ED Visits - Per Member Per Year	0.04	●	●	●	●	●
Low Value Services as Captured by the MedInsight Health Waste Calculator						
Don't obtain baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery – specifically complete blood count, basic or comprehensive metabolic panel, coagulation studies when blood loss (or fluid shifts) is/are expected to be minimal	82%	●	●	●	●	●
Don't obtain EKG, chest X-rays or pulmonary function test in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery	6%	●	●	●	●	●
Don't perform population based screening for 25-OH-Vitamin D deficiency	21%	●	●	●	●	●
Don't perform PSA-based screening for prostate cancer in all men regardless of age	75%	●	●	●	●	●
Don't do imaging for low back pain within the first six weeks, unless red flags are present	76%	●	●	●	●	●
Inappropriate Preventable Hospital Stays						
Prevention Quality Indicator #90: Prevention Quality Overall Composite Rate (per 100,000 population)	2,266	●	●	●	●	●

INCREASING HIGH VALUE CARE						
Virginians who are Current with Appropriate Vaccination Schedules						
Childhood Immunization Status: DTaP	55%	●	●	●	●	●
Childhood Immunization Status: Influenza	52%	●	●	●	●	●
Childhood Immunization Status: Hepatitis A	81%	●	●	●	●	●
Childhood Immunization Status: Hepatitis B	39%	●	●	●	●	●
Childhood Immunization Status: HiB	73%	●	●	●	●	●
Childhood Immunization Status: IPV	66%	●	●	●	●	●
Childhood Immunization Status: MMR	83%	●	●	●	●	●
Childhood Immunization Status: Pneumococcal Conjugate	57%	●	●	●	●	●
Childhood Immunization Status: Rotavirus	58%	●	●	●	●	●
Childhood Immunization Status: VZV	83%	●	●	●	●	●
Immunizations for Adolescents: HPV Vaccine*	14%	●	●	●	●	●
Immunizations for Adolescents: Meningococcal Conjugate or Meningococcal Polysaccharide Vaccine	58%	●	●	●	●	●
Immunizations for Adolescents: Tdap Vaccine	76%	●	●	●	●	●
Comprehensive Diabetes Care						
Hemoglobin A1c (HbA1c) Testing	77%	●	●	●	●	●
Medical Attention for Nephropathy**	-	-	-	-	-	-
Clinically Appropriate Cancer Screening Rates						
Breast Cancer Screening***	51%	●	●	●	●	●
Cervical Cancer Screening	62%	●	●	●	●	●
Colorectal Cancer Screening	32%	●	●	●	●	●

Dashboard Results

- Released 2019
- 2017 Data

A Deeper Dive Into the Low Value Care Measures

	January 2020, HWC Version 7.1
Reporting Period	2018
Number of Measures	48
CMS Data Included?	Yes
Dollars Spent on Unnecessary Services	$539 million per year
Unnecessary Services Identified	1.72 million per year

Virginia Overall Results – 2018 Summary

36% of members exposed to 1+ low service

31% of services measured were low value

$8.11 PMPM in claims were unnecessary

Top 4 Measures by Percent of Low Value Dollars for Virginia - 2018

MEASURE	RISK OF HARM	% of Low Value Dollars	Average Proxy Cost Per Service	Low Value Index
Don't obtain baseline laboratory studies in patients without significant systemic disease undergoing low-risk surgery.	L	23%	439	82%
Don't place peripherally inserted central catheters (PICC) in stage III-V CKD patients without consulting nephrology	H	15%	13,992	86%
Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.	M	13%	280	15%
Don't routinely order imaging tests for patients without symptoms or signs of significant eye disease	L	13%	622	17%

Taking Action to Advance the Dashboard

AIM 1:

Reducing Low Value Care

Smarter Care
VIRGINIA

Advancing Aim 1: Reducing Low Value Care

Important Definitions

Choosing Wisely® – designed by the American Board of Internal Medicine and the National Physicians Alliance to help physicians, patients and other health care stakeholders think and talk about overuse of health care resources. Each medical specialty was asked to identify 5 medical tests and/or procedures that they know to be unnecessary and/or harmful.

Low Value - Services that research has proven to add no value in particular clinical circumstances and in fact can lead to subsequent unnecessary patient harm and higher total cost of care.

All Payer Claims Database –includes paid claims from commercial health insurance companies and the Department of Medical Assistance Services. This voluntary program facilitates data-driven, evidence-based improvements in the access, quality, and cost of healthcare. For the purposes of this work, VHI and VCHI were also able to secure Medicare fee for service data to add to the Medicaid and commercial data.

MedInsight Health Waste Calculator – an analytical software tool that provides actionable insight on the degree of necessity of healthcare services and determines optimal efficiency benchmarks.

Statewide Data Starts to Create a National Stir

COSTS & SPENDING

By John N. Mafi, Kyle Russell, Beth A. Bortz, Marcos Dachary, William A. Hazel Jr., and A. Mark Fendrick

DOI: 10.1377/hlthaff.2017.0385
HEALTH AFFAIRS 36,
NO. 10 (2017): 1701–1704

DATAWATCH

Low-Cost, High-Volume Health Services Contribute The Most To Unnecessary Health Spending

An analysis of data for 2014 about forty-four low-value health services in the Virginia All Payer Claims Database revealed more than $586 million in unnecessary costs. Among these low-value services, those that were low and very low cost ($538 or less per service) were delivered far more frequently than services that were high and very high cost ($539 or more). The combined costs of the former group were nearly twice those of the latter (65 percent versus 35 percent).

Health Affairs article, ***"Low-Cost, High Volume Services Contribute The Most To Unnecessary Health Spending"***, was the 3rd most read *Health Affairs* Article in 2017.

Smarter Care
VIRGINIA

Advancing the VCHI Health Value Dashboard

Exciting New Partnership

- VCHI was awarded a **$2.2 M grant** from Arnold Ventures to launch a statewide pilot to reduce the provision of low-value health services.
- The initiative will span **3 years**, with an additional 6 months for evaluation.
- It will employ a two-part strategy to reduce 7 sources of provider-driven low value services and prioritize a next set of consumer-driven measures for phase two.

Core Components

CLINICAL LEARNING COMMUNITY

Health system and physician practice partners working together to reduce seven provider-driven measures.

EMPLOYER TASK FORCE

15-25 Virginia employers working together to increase their knowledge of low-value care and identify consumer-driven measures to drive change through benefit design and employee education.

PLAN TO IMPROVE HEALTH VALUE

Developed at a joint conference of the clinical learning community and employer task force members.

Funded by a 3 year, $2.2. M grant from Arnold Ventures

Project Aims

- In three years, we will produce **a 25% relative reduction in seven low-value care measures** that are provider-driven while prioritizing up to six consumer-driven measures for our next phase of work.
- Additionally, we will:
  - increase clinician competence in reviewing performance reports and implementing targeted interventions to improve outcomes;
  - improve understanding of which interventions are effective in reducing seven provider-driven low value care tests and procedures and provide health systems and practice leaders throughout the country with tested best practices they can implement;
  - reduce the physical, emotional, and financial harm patients experience from unnecessary tests and procedures;
  - educate Virginia employers (including state government) on the actions they can take to drive complementary payment reform that better incentivizes value in health care.

Clinical Learning Community

BalladHealth™

CarilionClinic

INOVA™

HCA
Hospital Corporation of America℠

SENTARA®
HEALTHCARE

VCUHealth™

Sentara Quality Care
NETWORK

SIGNATURE
PARTNERS

VIRGINIACARE
PARTNERS | An HCA affiliate
Physician-led Evolution in Patient Care

Clinical Learning Community

- 1000+ practice sites, nearly 7,000 clinicians, serving all 5 Virginia health planning regions.
- The systems/CINs have been randomized into 3 cohorts.
  - Cohort 1 (Inova/SP and Sentara) launched in August 2019.
  - Cohort 2 (Ballad and Carilion) launched in November 2019.
  - Cohort 3 (VCU and HCA/VCP) launches in March 2020.
- Each health system is establishing a clinical leadership team (CLT). Strong recognition that a system approach to the challenge is essential.
- Active intervention period for each cohort is 18 months.

Resources Provided

- Provider Performance Data Reports (Provided Quarterly)
- CME-approved webinars (4)
- Faculty office hours
- Monthly calls with Project Leadership Team and other Cohort CLT members
- Online Platform (Virginia Health Innovation Network)

Provider Driven Measures

"Drop the Pre-Op"

- Don't obtain baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low risk surgery - specifically complete blood count, basic or comprehensive metabolic panel, coagulation studies when blood loss or fluid shifts is/are expected to be minimal

- Don't obtain baseline diagnostic cardiac testing (trans-thoracic /esophageal echocardiography) or cardiac stress testing in asymptomatic stable patients with known cardiac disease (ie. CAD, valvular disease) undergoing low or moderate risk non-cardiac surgery

- Don't obtain EKG, chest x-rays or pulmonary function test in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery

Provider Driven Measures

Treatment & Screening

- Don't order annual electrocardiograms or any other cardiac screening for low-risk patients without symptoms

- Don't perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present

- Don't routinely order imaging tests for patients without symptoms or signs of significant eye disease

- Don't place peripherally inserted central catheters (PICC) in stage III-V CKD patients without consulting nephrology

The Employer Task Force includes 17 employers, selected in partnership with the Governor's office and the Virginia Business Council.

Goals:

- Increase employer knowledge concerning the challenge of low-value health services,
- Expose Virginia employers to employers that are mobilizing for change
- Engage employers in specific actions they can take in employee communications, benefit design, and contracting to drive improvement.

Employer Task Force:

Timeline & Deliverables

The task force will:

- Meet 6 times over 22 months;
- Prioritize up to 6 consumer-driven low value care measures for improvement;
- Develop an action plan to reduce consumer and provider-driven low-value services; and
- Conclude with a combined conference with the health system CLTs. At this conference, *A Virginia Plan to Improve Health Value* will be developed.

Developing a Virginia Plan to Improve Health Value

- Final product to be developed at a joint conference of the health system CLTs and the Employer Task Force (September 2021)
- Should reflect learning and future priorities of both groups
- Will be shared with Governor Northam and the Virginia General Assembly's Joint Commission on Health Care

Walmart

Making Smarter Care by Decreasing Low Value Care

REAL LIFE.

REAL SOLUTIONS.

Dr. John Keats
January 29, 2020

Cigna.

926486 09/19

TOP 5 LOW-VALUE CARE SERVICES

The Task Force on Low-Value Care identified a “top five” list of services for purchaser action:

1. Diagnostic testing and imaging for low-risk patients prior to low-risk surgery
2. Population-based vitamin D screening
3. Prostate-specific antigen (PSA) screening in adults ages 75+
4. Imaging for acute low-back pain for the first 6 weeks after onset, unless clinical warning signs are present (red flags)
5. Use of more expensive branded drug when generics with identical active ingredients are available

DIAGNOSTIC TESTING AND IMAGING BEFORE LOW-RISK SURGERY

Cigna is tackling this issue in a comprehensive way with a Beta version of our Health Care Value Check-up Tool. We are working internally and with Altarum to identify Choosing Wisely services and determine the best way to create appropriate recognition of the overuse of low value services.

- Our Cigna Care Designation (CCD) program evaluates 21 specialties, including most common surgical specialties. Achieving the designation requires delivering increased quality at reduced overall cost relative to their peers. This discourages ordering of unnecessary pre-operative testing

-We are piloting episode-of-care programs where surgeons can garner up-side risk payments for reducing overall cost of discrete surgical procedures. Avoiding pre-op testing that is not needed improves the chance of earning rewards.

VITAMIN D SCREENING TESTS

- Vitamin D testing (CPT 82306 and 82652) is considered medically necessary in a non-pregnant individual age 18-64 for any of the following:
  - Condition or medical diagnosis associated with Vitamin D deficiency
  - Previously documented Vitamin D deficiency
  - Known or suspected excessive Vitamin D blood levels (i.e., toxicity)
- Vitamin D testing for any other indication including screening in the general population is considered not medically necessary.
- Vitamin D testing (CPT82306) more frequently than twice in 12 rolling months is considered not medically necessary for any diagnosis other than chronic kidney disease or intestinal malabsorption.
- Vitamin D testing utilizing both CPT 82306 and CPT 82652 in combination is considered not medically necessary.

Driving Utilization and Cost Improvements

Utilization decreased ~32% from 2017 to 2019

Estimated cost savings of $24 million across book of business

PROSTATE-SPECIFIC ANTIGEN TESTING FOR ADULTS 75+

Cigna covers annual PSA testing for prostate cancer screening for EITHER of the following:

- For asymptomatic adults beginning at age 40 who are at high risk of prostate cancer because of **ANY** of the following:
  - family history (i.e., multiple first-degree relatives diagnosed at an early age)
  - African-American race
  - previous borderline PSA levels
- For asymptomatic adults who are age 50 and over with a life expectancy of at least 10 years
- Coverage is consistent with Endocrine Society Clinical Practice Guidelines

IMAGING FOR LOW BACK PAIN WITHIN 6 WEEKS OF ONSET

All of the following are required prior to advanced imaging:

Initial clinical evaluation performed

A face-to-face evaluation within the last 60 days

The initial evaluation is not required within the last 60 days if another face-to-face evaluation was performed in that time frame

- This may be satisfied by the initial evaluation, re-evaluation or another visit

Failure of recent (within 3 months) 6-week trial of physician-directed treatment and/or observation.

Cigna has developed an evidence based back pain care program for our CAC PCP partners.

This program is being rolled out in multiple markets

The program reinforces through measurement that imaging studies in the first 6-8 weeks for back pain in the absence of defined “red flags "should not be obtained.

Spotlight: Comprehensive Pain Management Program

Based on the intervention data for 3 CACs, there was a 29% - 55% decline in the use of advanced imaging services between the baseline period and most recent intervention period.

Community Medical Associates - 55% Reduction in Claims; 44% Reduction in Costs

AZ Connected Care - 29% Reduction in Claims; 18% Reduction in Costs

Cigna Medical Group - 40% Reduction in Claims; 38% Reduction in Costs

GENERIC PRESCRIBING: CONTINUED ACTIVE MANAGEMENT OF CIGNA FORMULARIES

Reducing drug spend leveraging generic equivalents and low cost therapeutic alternatives

CIGNA'S DRUG LIST STRATEGY

- **Offer lowest cost,** clinically effective options
- **Focus on drug value:** not chasing rebates
- **Remove egregiously** priced low value drugs
- **Preferred brand specialty drugs** under both medical and Rx benefit

Multisource Drugs

Generally brand drugs with equivalent generics

Depression	Sleep Disorder	Cardiovascular
Abilify	Ambien	Cardizem CD
$1028 per mo	$518 per mo	$1496 per mo
↓	↓	↓
$550 per mo aripiprazole	$5 per mo zolpiden	$31 per mo diltiazem

Therapeutic Alternatives

Generally drugs with similar clinical value for the treatment of a disease or condition:

Example classes impacted:

- Diabetes
- Asthma
- COPD
- Nasal steroids

With **Cigna's Mandatory Generic program**, customers who insist on the brand named drug – when there is a lower cost covered alternative available – will pay an additional cost. The employer's plan will pay no more than the cost of the generic.

GENERIC PRESCRIBING: CIGNA CAC

Generic dispensing rate is 1 of 17 quality metrics Cigna uses to measure its CAC relationships. Our CACs have aligned incentives to improve generic drug utilization.

We supply generic dispensing reports to CAC's that permit drill down at the provider and drug level

Pharmacy savings messages identify opportunities at the customer level to convert from a brand to generic

- Information mailed directly to customers and also displayed within iCollaborate for the CAC embedded care coordinator to view as actionable drug-related opportunities

For CACs with an aligned pharmacist:

- Our pharmacists will review the customer's drug regimen to look for brand to generic conversions particularly if adherence is negatively impacted by cost of therapy.

Spotlight: Baton Rouge Clinic

BRC began an internal recognition program at the department and physician level that will require a minimum number of points related to quality measures and process improvement measurements.

BRC has also launched an initiative to better manage marginally hypertensive and diabetic patients through lifestyle and rx as appropriate programs.

The generic prescription dispensing rate increased 4.3%, 1.1% better than market.

Smarter Health Care Coalition *in partnership with* V-BID CENTER FOR VALUE-BASED INSURANCE DESIGN UNIVERSITY OF MICHIGAN

Panel Discussion: Making Health Care Smarter by Decreasing Low-Value Care

Audience and Moderator Questions

Moderator:
Katy Spangler, *Co-Director, Smarter Health Care Coalition*

Panelists:
Beth Bortz, *President and CEO, Virginia Center for Health Innovations*
Amanda Deegan, *Director, Global Public Policy, Walmart*
Dr. John Keats, *National Medical Director for Affordability and Specialty Partnerships, Cigna*

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Closing Keynote Address:

V-BID 2020: Expanding Coverage of Essential Clinical Care Without Increasing Premiums or Deductibles

Dr. Mark Fendrick, *Director, University of Michigan Center for Value-Based Insurance Design*

SCHOOL OF PUBLIC HEALTH
CENTER FOR VALUE-BASED INSURANCE DESIGN
UNIVERSITY OF MICHIGAN

V-BID 2020: Expanding Coverage of Essential Clinical Care Without Increasing Premiums or Deductibles

A. Mark Fendrick, MD

University of Michigan Center for Value-Based Insurance Design

www.vbidcenter.org

@um_vbid

Please click here to view Dr. Fendrick's full presentation.

V-BID

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Thank-you and Closing Remarks

Ray Quintero, *Co-Director, Smarter Health Care Coalition*

Our Mission.

- *To enhance the patient experience – encompassing access, affordability, and quality – by integrating benefit design innovations and consumer engagement within broader delivery system reform efforts in order to better align **coverage**, **quality**, and **value-based payment goals**.*

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Thank-you!

Policy, Politics, and Progress:
Improving the Patient Experience through Value-Based Insurance Design

January 29, 2020 | 9 AM – 12 PM | Kennedy Caucus Room

Find materials from today's summit on www.smarterhc.org.

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