

CIVHC Delivery System Redesign/Payment Reform Strategy Session

January 6, 2011

Consumer Engagement, Incentives and Disincentives: Recommendations from Strategy Session

Medical homes. Patients would be required to designate a primary care provider (or appropriate specialist) as their medical home. Services provided thorough a medical home would have low/no cost sharing. Patients would have low or zero co-payments for medications and other treatments (e.g., cardiac rehabilitation) their medical home prescribes to help them manage their conditions. They should receive financial incentives (e.g., reduced insurance premiums or cash awards) for improving their health and adhering to treatment plans developed with their medical home.

Patients who switch primary care providers multiple times a year without appropriate justification (e.g., a change in the consumer's residence or the provider's location, poor quality ratings of the provider, etc.) would be required to pay a fee. Patients who do not select a medical home or use a consistent care provider would have higher cost-sharing. Inappropriate ER use for non-urgent care that could be received from a patient's medical home would have higher cost-sharing.

Inpatient care. Patients requiring inpatient care would receive information on hospitals' relative value (quality and cost) for equivalent services. Inpatient care providers would be grouped into cost/quality tiers. Patients would have to pay a portion of the difference in cost for using a provider in a high-cost tier.

Inappropriate utilization. Evidence-based guidelines would indicate when major acute care (e.g., surgery) is appropriate. Patients would pay a portion of the difference in cost between major acute care and alternative treatments/services when the need for major acute care is uncertain, and pay the full difference in cost when major acute care is not recommended.

Prevention and wellness. Patient premiums and cost-sharing would be reduced for preventive care received from a high-quality, reasonably-priced, convenient provider (e.g., urgent care providers, pharmacies, etc.) and for participation [and improvement]¹ in health promotion activities.

Patient education. Patients would be educated about the importance of preventive care, health improvement activities and the value of selecting and consistently using a primary care provider as a medical home for preventive care.

Shared decision-making. Patients would have financial incentives to participate in sharing decision-making processes.

Data and information. Transparent, easily accessible, understandable data would be available to consumers. Any impact of the availability of this data upon consumers' choices of providers would be

¹ One group recommended this language.

evaluated before including financial incentives/disincentives. Primary care practices and specialists would be grouped into tiers based on quality, cost and patient experience measures. Patients would be informed about the tiers in which providers and practices are ranked. Although financial incentives and disincentives could be attached to these tiers to influence consumers' choice of providers, they would not necessarily be used. *[Note: This does not align with recommendations above concerning incentives and disincentives.]*

What is the evidence base?

- **Medical homes:** Some studies show significant medical home savings; others have found minimal or no overall savings but report other benefits (e.g., improved care quality, reduced medical errors, higher patient satisfaction, enhanced health care access and fewer health disparities).² Most studies that support medical homes' potential to reduce overall spending have not assessed a complete version of the approach. Instead, they have looked at selected components, such as ensuring all patients have a primary care doctor or establishing care coordination programs for patients with diabetes or heart disease.
- **Wellness promotion:** Studies of worksite wellness programs demonstrate that well-designed programs can reduce employer and employee health expenditures on absenteeism, at least for large employers.³
- **Patient education:**
 - Evidence base from 14 systematic reviews of health literacy programs: utilization and cost – some positive effects; health knowledge – improved; patients' experience – improvements in satisfaction and self-efficacy; health status – unknown.
 - Evidence base from 49 systematic reviews of patient self-care: utilization and cost – some positive short-term effects health knowledge – improved; patients' experience – positive short-term effects; health status – limited short-term effects.⁴
- **Shared decision-making:** Evidence base from 17 systematic reviews: utilization and cost – mainly positive effects; health knowledge – improved; patients' experience – improved; health status – no effect.⁵
- **Cost-sharing incentives and disincentives:**

[FILL IN]

² For more information see, National Conference of State Legislatures, *Medical Homes*, Health Cost Containment and Efficiency Series (Denver: NCSL, forthcoming Spring 2011).

³ For more information see, National Conference of State Legislatures, *Employer-Sponsored Health Promotion Programs*, Health Cost Containment and Efficiency Series (Denver: NCSL, forthcoming spring 2011).

⁴ "Patient Empowerment, The Key to Quality Improvement," PowerPoint presentation; www.esgh.net/www/about/presentations/files/folder_1207649000/Athens_December_2005.ppt.

⁵ IBID.

