Value-Based Benefits Project Quickly Identifies Where to Focus Benefit Changes

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Memphis Business Group on Health
Value Based Benefit Project Quickly Identifies Where to Focus Benefit Changes

May, 2009 – In 2008 Memphis Business Group on Health (MBGH) conducted a year-long Value-Based Benefits Project with the support of sanofi-aventis. The purpose of the project was to educate Memphis-area employers on the principles of value-based benefits and to provide them with the opportunity to evaluate their health benefits for opportunities to apply those principles. The project supported the Healthy Memphis Common Table's Aligning Forces for Quality project consumer engagement strategies to motivate consumers to use high-value services to take better care of themselves and physician performance measurement and public reporting strategies designed to increase the provision of evidence-based treatment for patients with chronic disease.

In Phase1, an educational session presented by Dr. Mark Fendrick, Professor of Internal Medicine & Health Management & Policy at the University of Michigan introduced the concept of value-based benefits (VBB) and provided a basic understanding of value-based benefit principles. In Phase 2, a ¾ day workshop was conducted by the Center for Health Value Innovation to delve deeper into VBB concepts, helping employers become familiar with specific strategies deployed by other employers and to begin to think about what opportunities there might be in their own organizations. The purpose of Phase 3: Diabetes Value Based Benefits Project was to determine if diabetics were receiving high quality care and identify barriers and solutions to drive benefit decisions that change employee behaviors and reduce financial and health risks.

This report details Phase 3 of the project, including major program components, results, and lessons learned.

Major program components included:

- Six employers participated in the project representing approximately 315,000 covered lives.
- A data collection packet was provided to each employer to send to their health plan, TPA, disease management vendor, and/or PBM. The packet included:
    - A sample email explaining the purpose of the project, the timeline, and specific data needed.
    - Treatment flow charts, based on the American Diabetes Association-endorsed protocols and the NCQA Diabetes Physician Recognition Program.
    - Listing of diagnosis codes that defined the diabetic population and subpopulations (e.g. diabetics with high blood pressure) that were included in the project.
    - CPT, ICD 9 and medication codes that should be pulled for each service being measured.

- A project kick-off meeting was held with employers to review project objectives, data collection packet, project timetable, and next steps.
- A final meeting was held with employers where they shared results, identified opportunities and received feedback from a national expert on possible strategies to increase the number of diabetics receiving high quality care.
- The project took 6 weeks from the kick-off meeting to the final meeting.

Project Results

- Initially, only two of the six participating employers received usable data.
    - After the initial project, MBGH worked with two other employers and the Medical Director of their health plan to get usable data. One of these two employers did not have complete data because medication information was housed with another vendor.
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    - One employer was not willing to pay the additional $20,000 charge for an ad hoc report.
- Lab results and blood pressure measurements were not available in electronic format and therefore were not available for any of the employers.
- Diabetics received only some of the care they needed. (Note: information is only available for four employers at this time)
    - Most diabetics had at least one HbA1c test annually, although the range differed significantly among reporting employers (74%-91%)
    - Generally, only 60 to 79% of the diabetics were refilling their prescriptions appropriately, which is considered “suboptimal”.
    - Less than 4% received appropriate eye exams.
    - Less than 20% received appropriate foot exams.
    - Less than 35% received nephropathy assessments
- One employer initiated "value based" benefit design changes for the purpose of removing barriers to care for members with diabetes by waiving the co-pay requirements for supplies and prescription medications needed by the diabetic members if provided by an in-network provider. The employer’s participation in the Diabetes Value Based Benefits Project was a driver and supported the benefit design change.

Lessons Learned

Until employers look inside their own health plans and identify if their employees and dependents are receiving high-value services, value-based benefits is only a theory. Although the employers were familiar with the elements of high quality diabetes care and were aware that physician performance in taking care of diabetics in Memphis was not optimal, they had not personalized this to their own organizations and had not thought about the impact on the effectiveness of their own health plan. This project was a simple, quick way for them to gain this understanding and begin to identify what type of benefit or benefit design changes could motivate their employees to use more high-value services and improve their overall health.

The project was organized to require minimal effort from the employers. Pre-developed data packets, a short 6-week timeline, only two project meetings, and MBGH troubleshooting all contributed to minimizing project burden on employers. However, even with the low participation requirements, several employers were not timely in getting the data requests to their health plans and did not push plans for more timely data reports. The timing of the project, which was in the fall and overlapped with open enrollment, certainly contributed to the challenge for these employers.

It was interesting, although not surprising, that the health plans, TPAs, PBMs, and/or disease management vendors had never shared this type of information with their employer clients. Without the type of information reported through this project, it is not possible for employers to evaluate if their benefit plan and their vendors are effective in getting needed services to employees and dependents. MBGH plans to work with members on how to effectively manage vendors through performance expectations, evaluation/reports, and contracting to maximize their health benefit plan performance.

Finally, although participating employers took a look inside their plan and could see that for many aspects of the disease their diabetics are not receiving high quality care, it appears that few have actually implemented programs or changes in benefits or benefit design to address these gaps. There could be several reasons for this including competing priorities, lack of expertise in specific next steps, or absence of encouragement and/or support from key vendors. MBGH is currently exploring ways to work with participating employers to help identify why their employees and dependents are not receiving high quality diabetes care so targeted interventions can be implemented. For future projects, MBGH plans to build an intervention analysis and implementation phase into the project from the beginning in order to support employer momentum.

Based on the project results and lessons learned, MBGH is exploring the possibility of conducting a similar project for asthma in 2009.