

DVHA Medicaid & Exchange Advisory Board

Overview of Clinical Benefit Design Process

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DVHA Chief Medical Officer

The US health care system is the most costly in the world, accounting for 17% of the gross domestic product with estimates that percentage will grow to nearly 20% by 2020.





***If you don't know where you're going you
might wind up someplace else.***

-Yogi Berra

3 Eras in Public Health



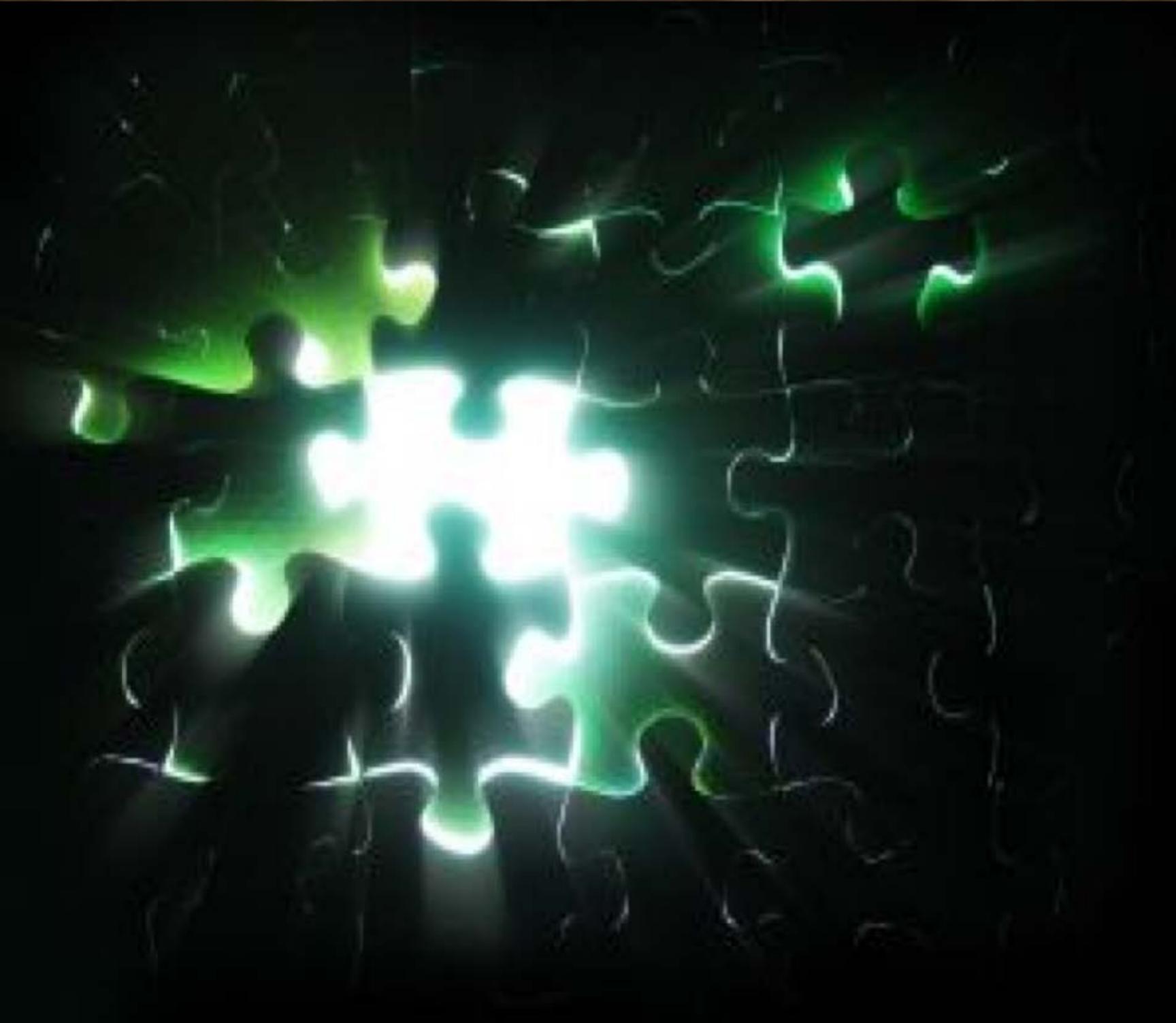
- ***Prior to 1850***
- ***Epidemics***
- ***Avoidance & Acceptance***

3 Eras in Public Health



- **1850-1949**
- ***“Sanitary Reform”***
through state &
local
infrastructure

3 Eras in Public Health



- ***1950-present***
- ***Gaps in healthcare delivery system***
- ***Effects some populations more than others***

Gaps in health insurance have created a new caste system in the United States

-HarvardMedicine, 2006

Triple Aim of Medicaid

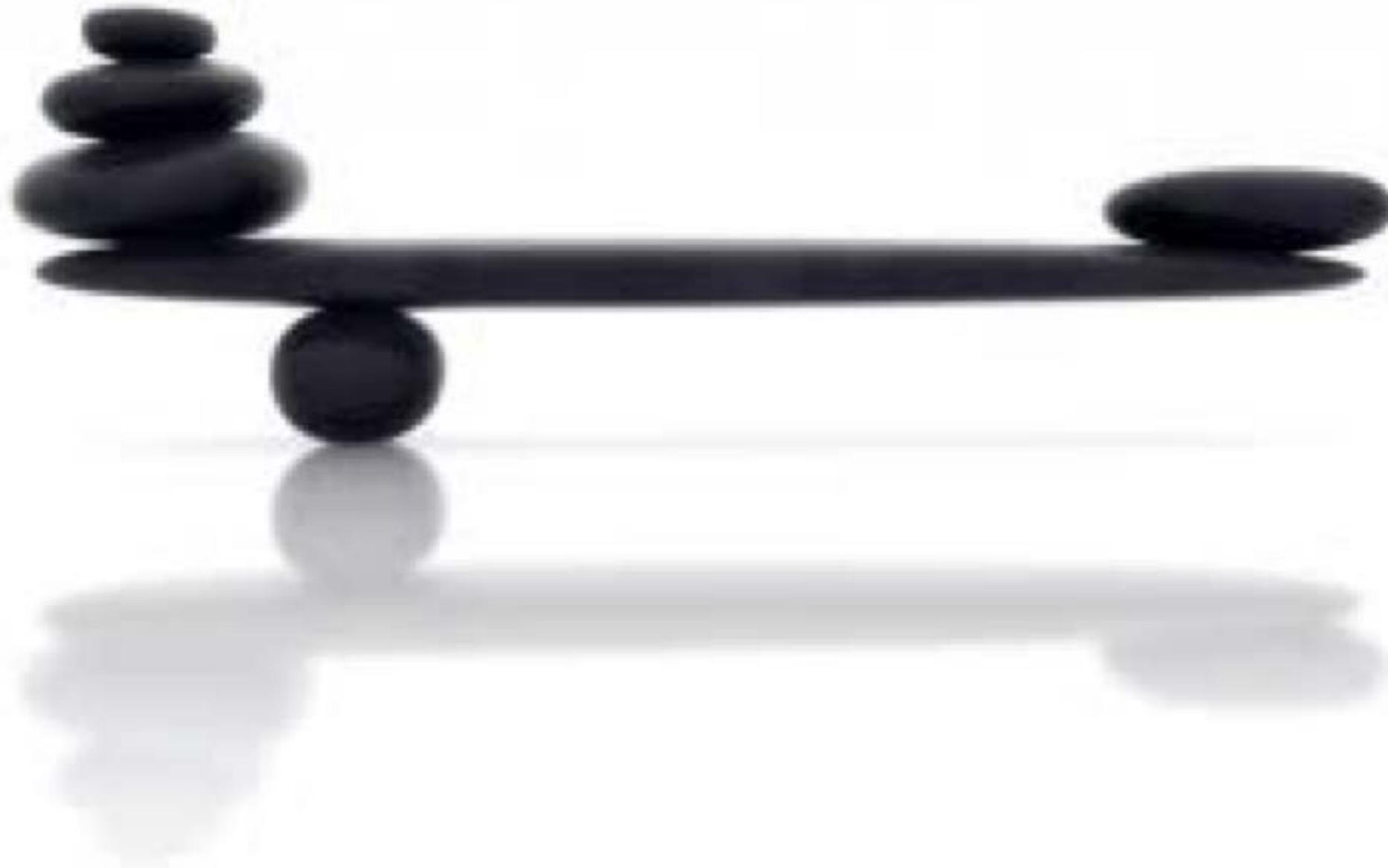
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- A. Improve care for individuals
- B. Improve care for populations
- C. Reduce per capita cost

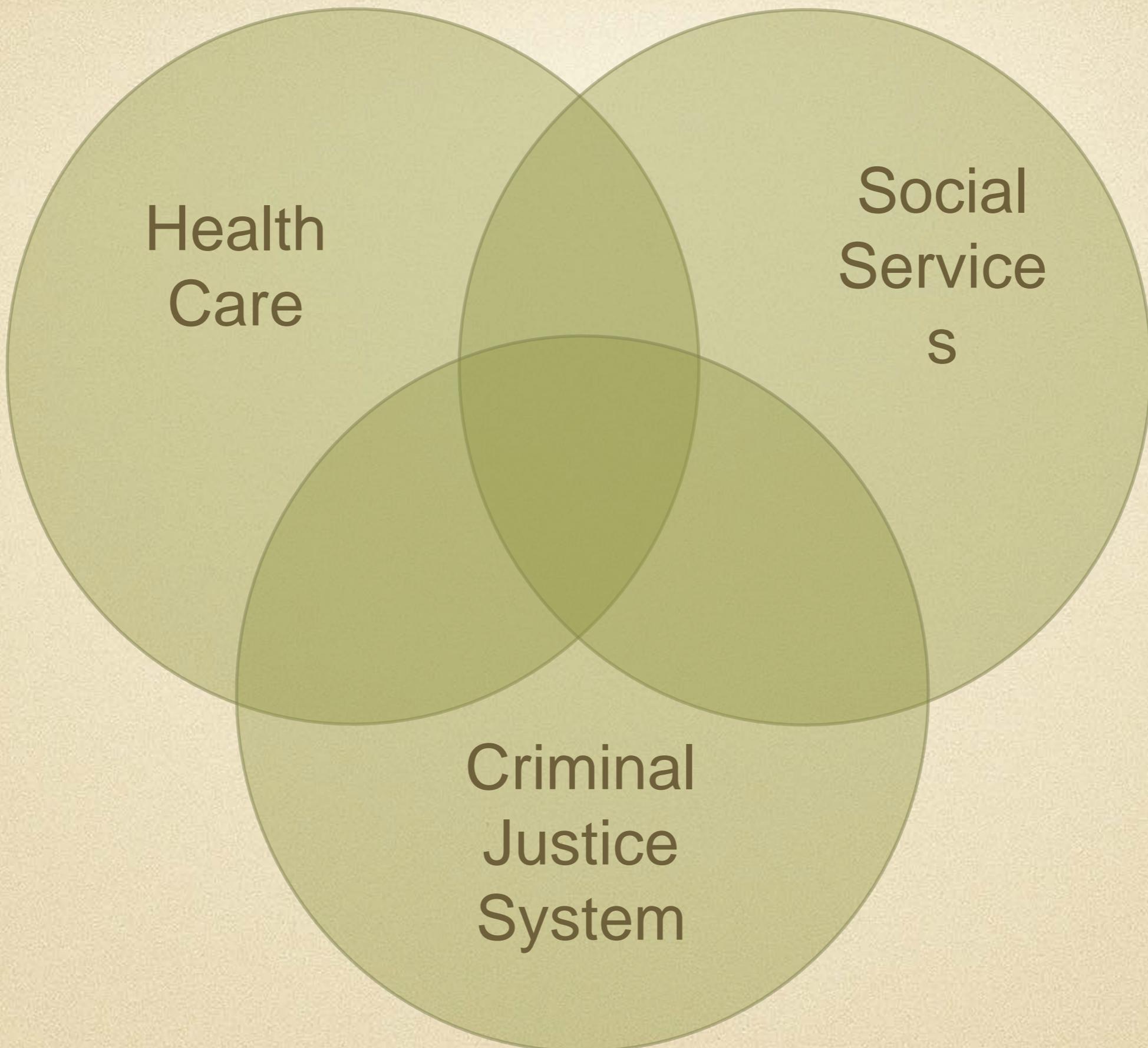
The 5 Components of the Triple Aim

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1. Focus on individuals and families
2. Redesign of primary care services and structures
3. Population health management
4. Cost control platform
5. System integration and execution



The 80/20 Rule



Health
Care

Social
Services

Criminal
Justice
System

New Public Health Tool: The Affordable Care Act: Better Coverage for Mental Health and Substance Use Disorders

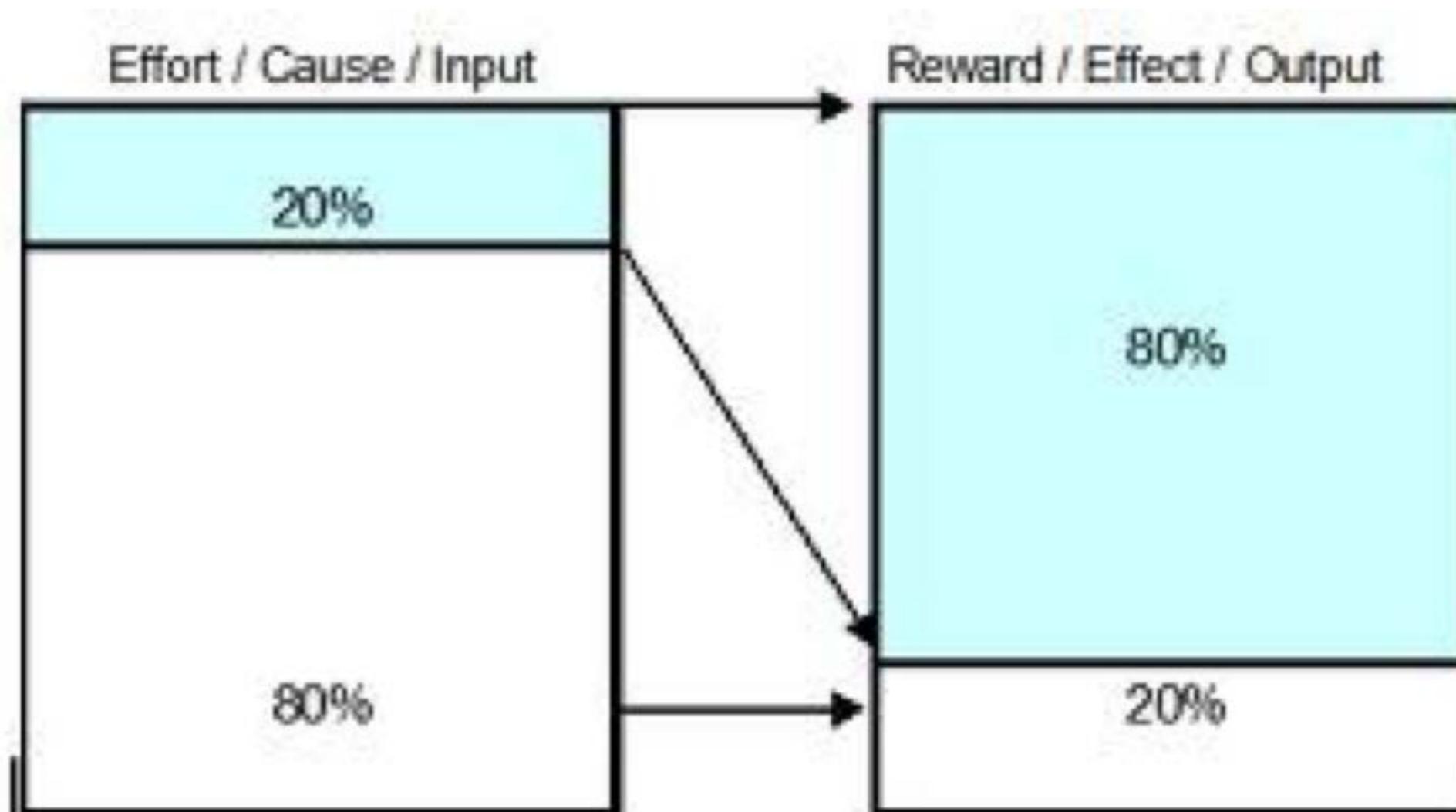
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- Treatment for mental health and substance use disorders is a benefit category covered as part of the package of Essential Health Benefits
- HHS finalized regulations that apply federal parity rules to mental health and substance use disorder benefits included in Essential Health Benefits.

New Public Health Tool: The Affordable Care Act: Better Coverage for Mental Health and Substance Use Disorders

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- In total, through the Affordable Care Act, 32.1 million Americans will gain access to coverage that includes mental health and/or substance use disorder benefits that comply with federal parity requirements
- An additional 30.4 million Americans who currently have some mental health and substance abuse benefits will benefit from the federal parity protections.
- By building on the structure of the Mental Health Parity and Addiction Equity Act, **the Affordable Care Act will extend federal parity protections to 62 million Americans.**

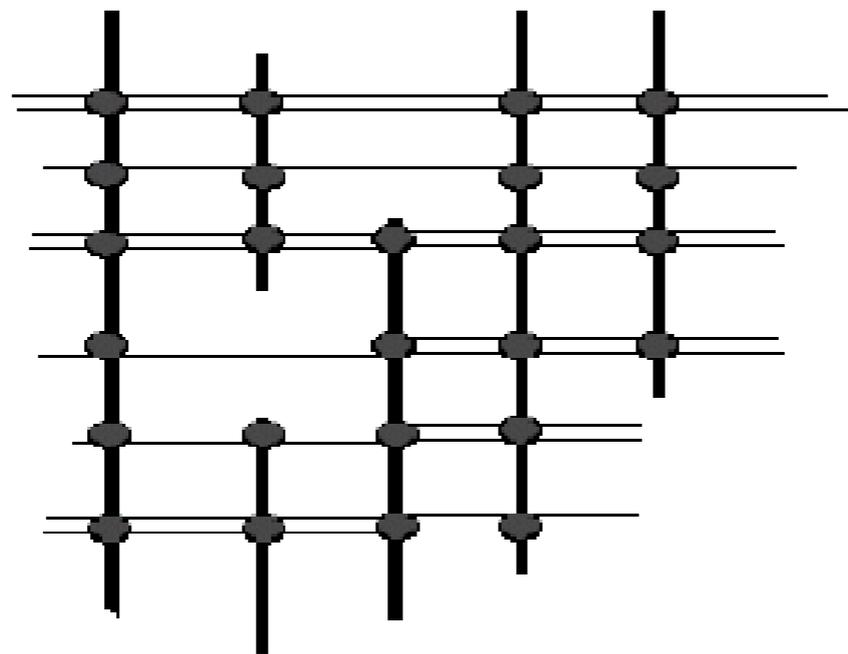


The 80/20 Rule

20% of the population causes 80% of the effect; overrepresented by those not accessing help

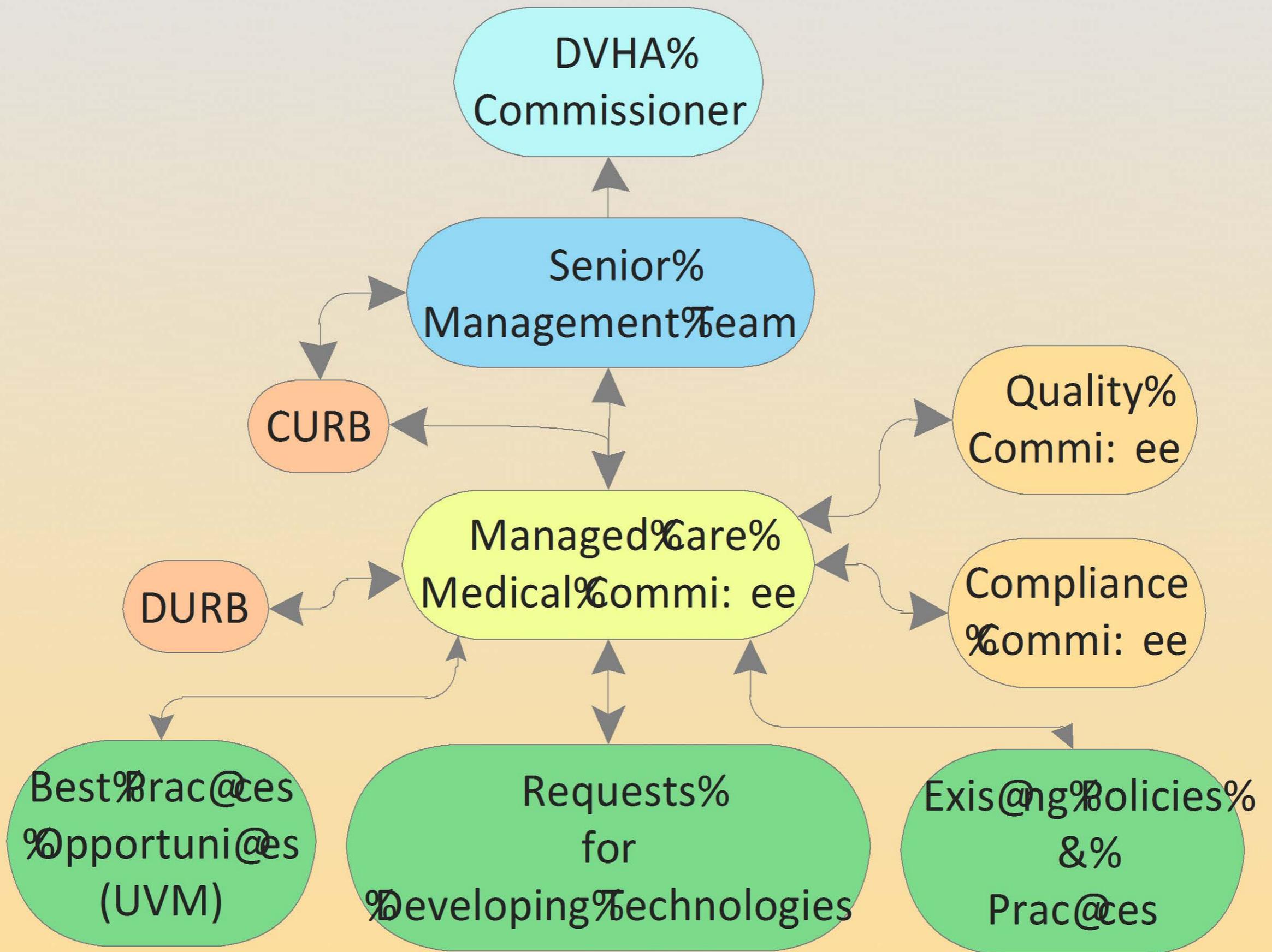
Horizontal & Vertical Integration with Social Service Programs

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% of GDP Spent on Health Care + Human Services

- U.S. is middle of the pack
 - U.S. spends ~75% on healthcare
 - others spend 30-50%

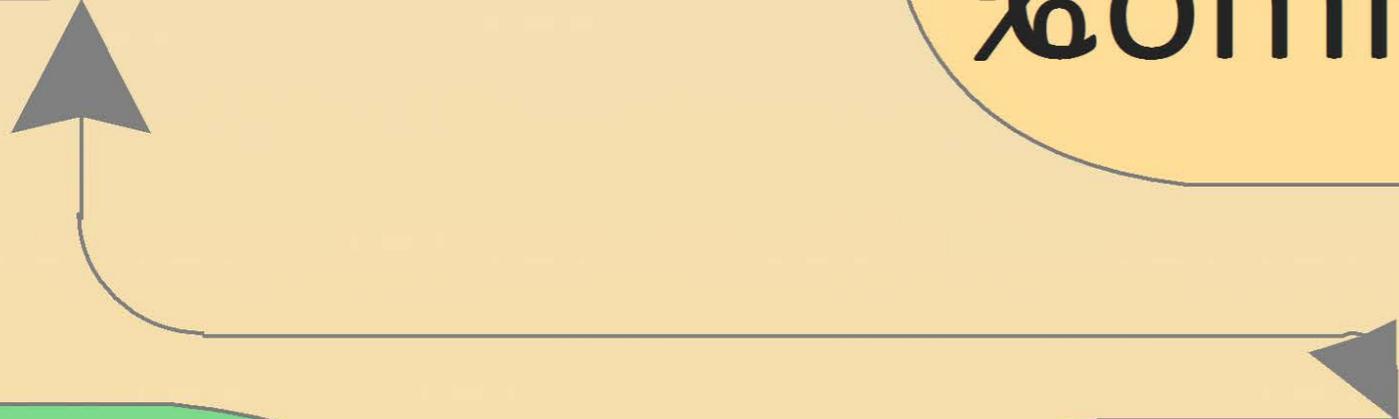


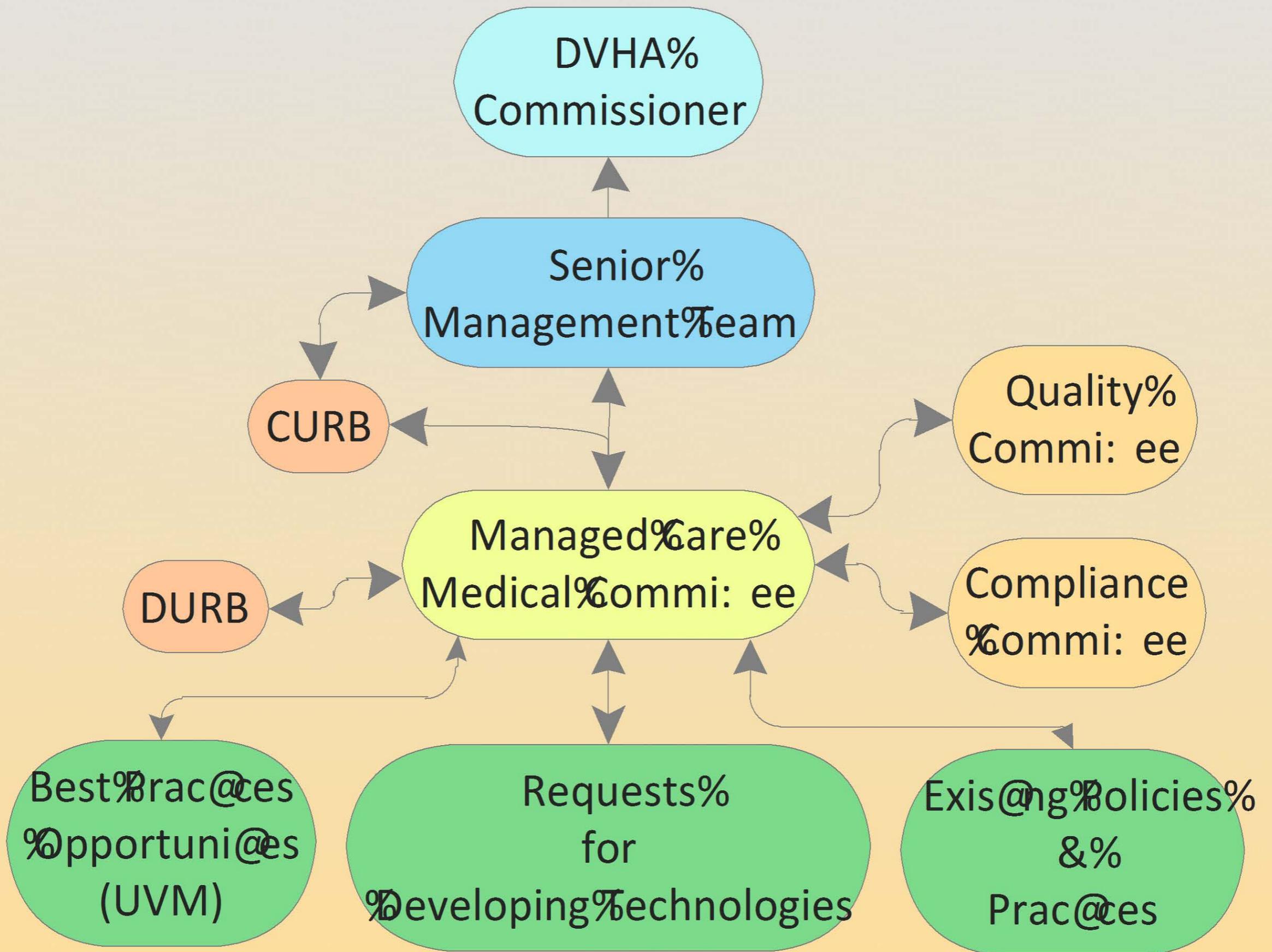
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Managed Care
Medical Community

Requests
for
Developing Technologies



Vetting New Technologies/Procedures for Medicaid Coverage

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- Clearly defined procedure/test with specs (target population, criteria, methodology)
- Current coverage status among CMS, commercial payers, other state MA plans
- Current literature (ranked according to level of evidence)
- Current recommendations of Specialty Societies/National Organizations/USPSTF
- Current Practice/Recommendations of local subject matter experts
- Analysis of potential impact specifically on VT MA Plan (triple aim: improved clinical outcomes, decreased avoidable cost, improved population outcomes/member satisfaction)

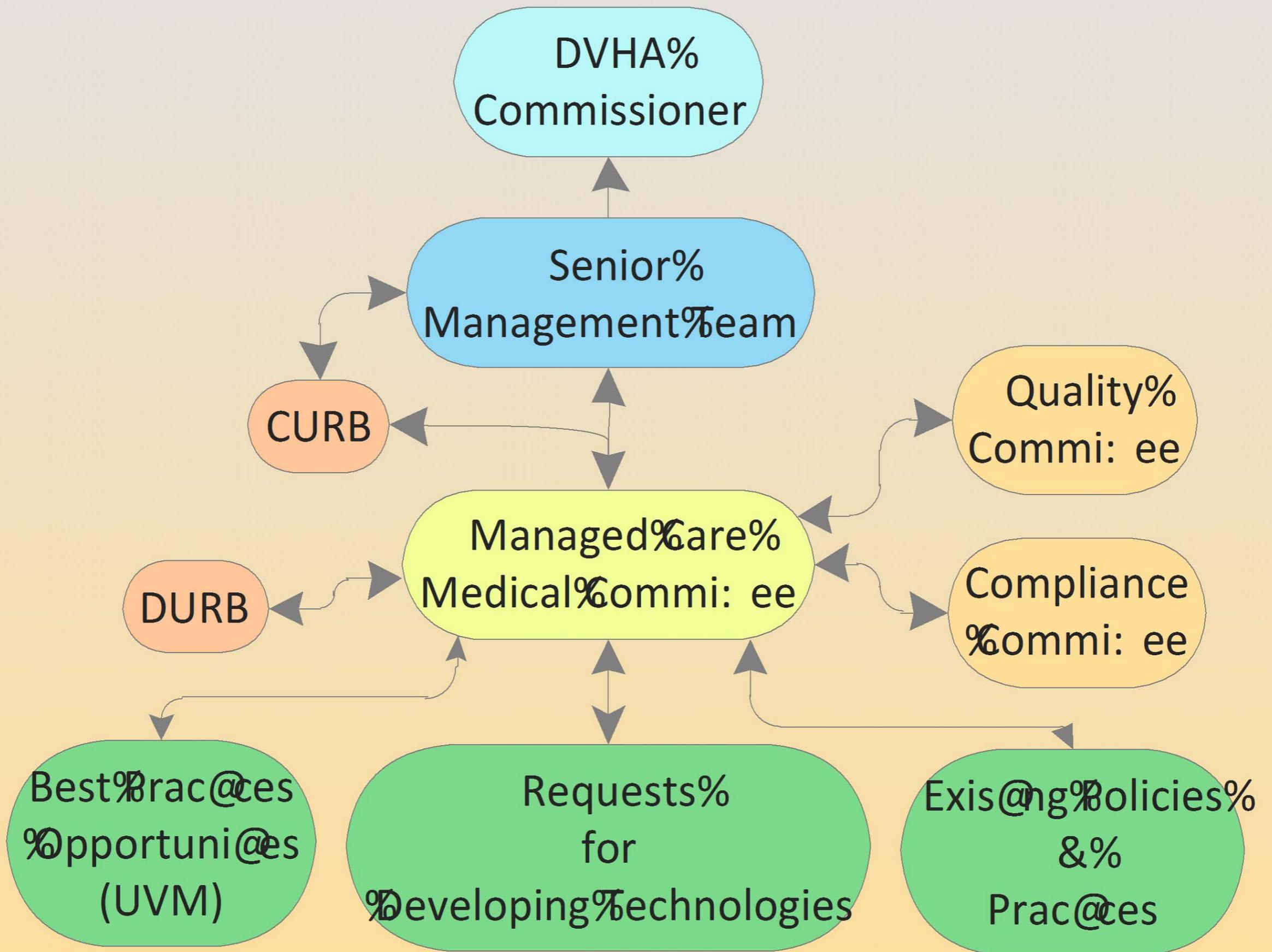
Vetting New Technologies/Procedures for Medicaid Coverage

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- Potential barriers to implementation (feasibility analysis)
- Input from Local and State stakeholders (VMS, VPQHC, Advisory Boards, State specialty societies, VDH)
- Decide if Prior Authorization required
- Presentation/discussion at CURB, provisional non-covered status x 3-6 months pending completion of steps 1-8 above.

Oxford Centre for Evidence-Based Medicine Levels of Evidence

Grade of Recommendation	Level of Evidence	Type of Study
A	1a	SR (with homogeneity) of RCTs and of prospective cohort studies
	1b	Individual RCT with narrow confidence interval, prospective cohort study with good follow-up
	1c	All or none studies, all or none case series
B	2a	SR (with homogeneity) of cohort studies
	2b	Individual cohort study
	2c	Outcomes research, ecological studies
	3a	SR of case control studies, SR of 3b and better studies
	3b	Individual case control study, nonconsecutive cohort study
C	4	Case series/case report, poor quality cohort studies
D	5	Expert opinion, bench research



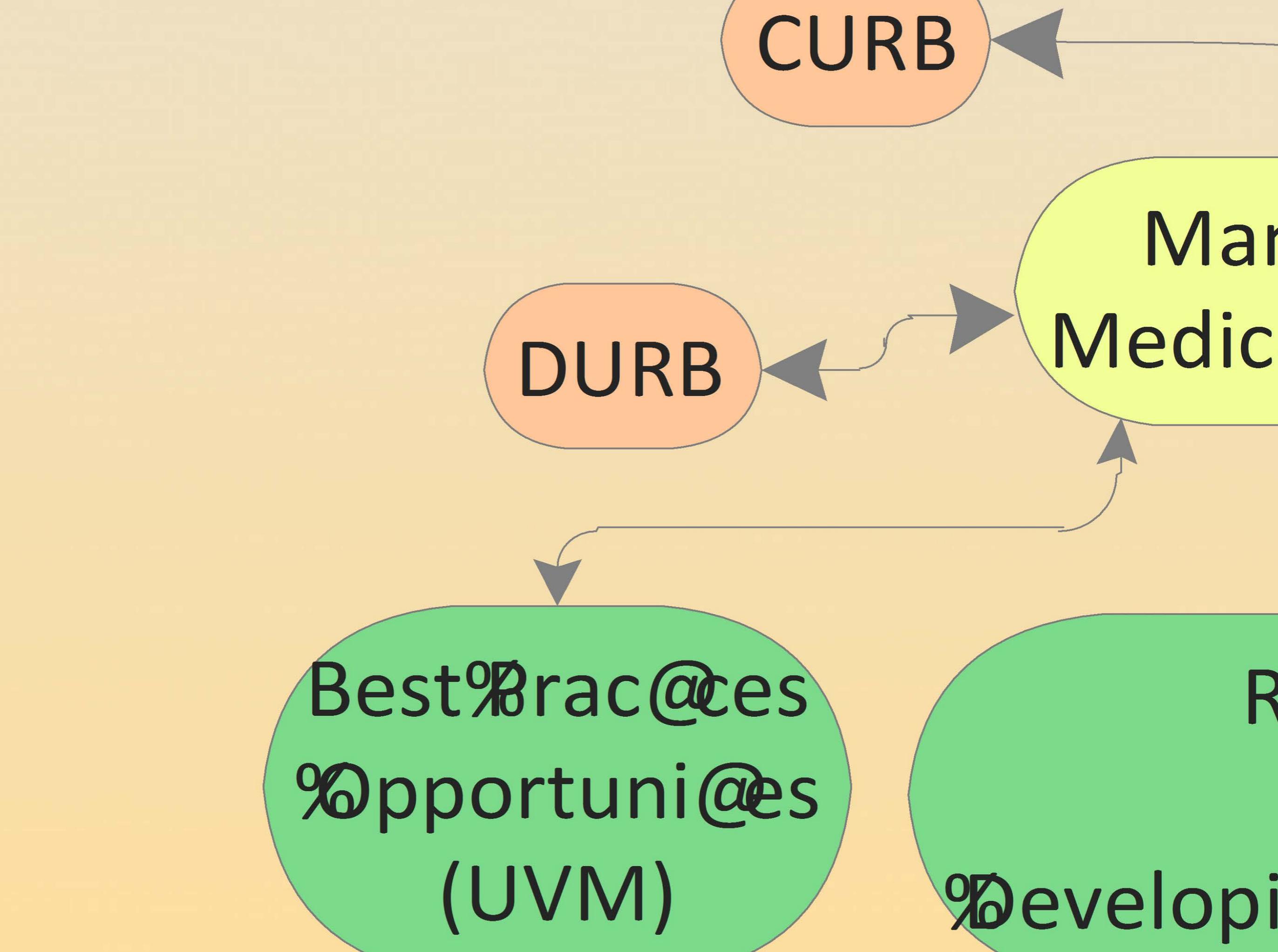
CURB

DURB

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Medic

Best%Brac@ces
%Opportuni@es
(UVM)

R
%Developi



The 7 Guiding Principles for Benefit Design & Coverage Options

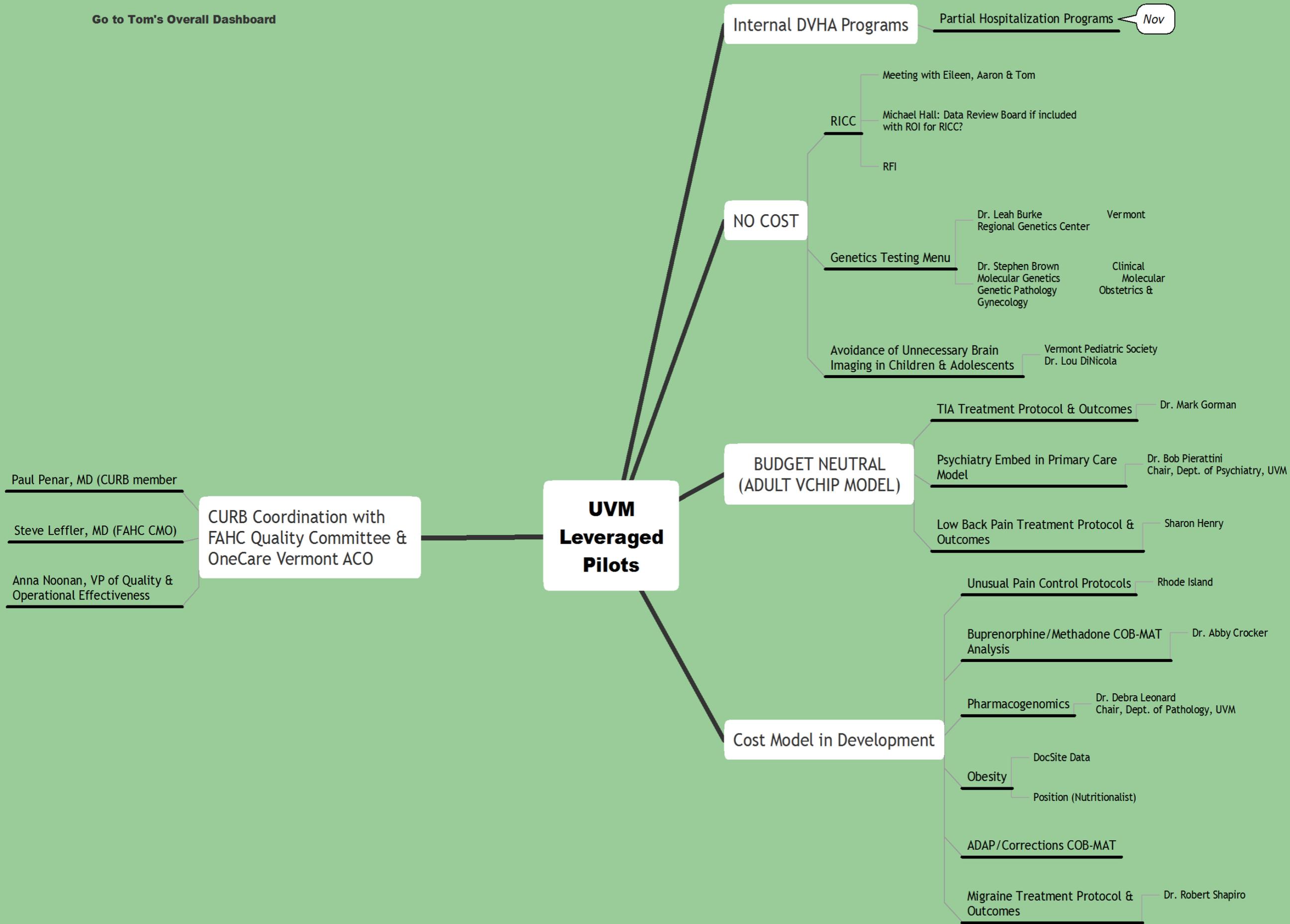
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- 1. *TRANSPARENT:*** The process for designing benefits and making coverage decisions should be transparent with the opportunity for public engagement.
- 2. *EVIDENCE-BASED:*** Decisions should be based on research evidence, with priority given to the best available evidence as determined by an established hierarchy of evidence quality (e.g. AHRQ, GRADE).
- 3. *CONTINUOUSLY IMPROVING:*** Covered benefits should be continuously monitored for effectiveness and reviewed and reevaluated as appropriate.

The 7 Guiding Principles for Benefit Design & Coverage Options

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- 4. FOCUSED ON WELLNESS:** Benefit design and coverage decisions should maximize population health and the prevention of illness.
- 5. BALANCED:** Benefit decisions should balance value, cost, and access.
- 6. ETHICAL:** Benefit decisions should be ethical.
- 7. HOLISTIC:** Benefit decisions will recognize that healthcare is only one factor affecting health and must be balanced with other needs.



Internal DVHA Programs

Partial Hospitalization Programs

Nov

RICC

Meeting with Eileen, Aaron & Tom

Michael Hall: Data Review Board if included with ROI for RICC?

RFI

NO COST

Genetics Testing Menu

Dr. Leah Burke Regional Genetics Center Vermont

Dr. Stephen Brown Molecular Genetics Genetic Pathology Gynecology Clinical Molecular Obstetrics &

Avoidance of Unnecessary Brain Imaging in Children & Adolescents

Vermont Pediatric Society Dr. Lou DiNicola

BUDGET NEUTRAL (ADULT VCHIP MODEL)

TIA Treatment Protocol & Outcomes

Dr. Mark Gorman

Psychiatry Embed in Primary Care Model

Dr. Bob Pierattini Chair, Dept. of Psychiatry, UVM

Low Back Pain Treatment Protocol & Outcomes

Sharon Henry

Cost Model in Development

Unusual Pain Control Protocols

Rhode Island

Buprenorphine/Methadone COB-MAT Analysis

Dr. Abby Crocker

Pharmacogenomics

Dr. Debra Leonard Chair, Dept. of Pathology, UVM

Obesity

DocSite Data

Position (Nutritionalist)

ADAP/Corrections COB-MAT

Migraine Treatment Protocol & Outcomes

Dr. Robert Shapiro

CURB Coordination with FAHC Quality Committee & OneCare Vermont ACO

Paul Penar, MD (CURB member)

Steve Leffler, MD (FAHC CMO)

Anna Noonan, VP of Quality & Operational Effectiveness



Best Practices

Intended
Outcomes

Academic
Detailing

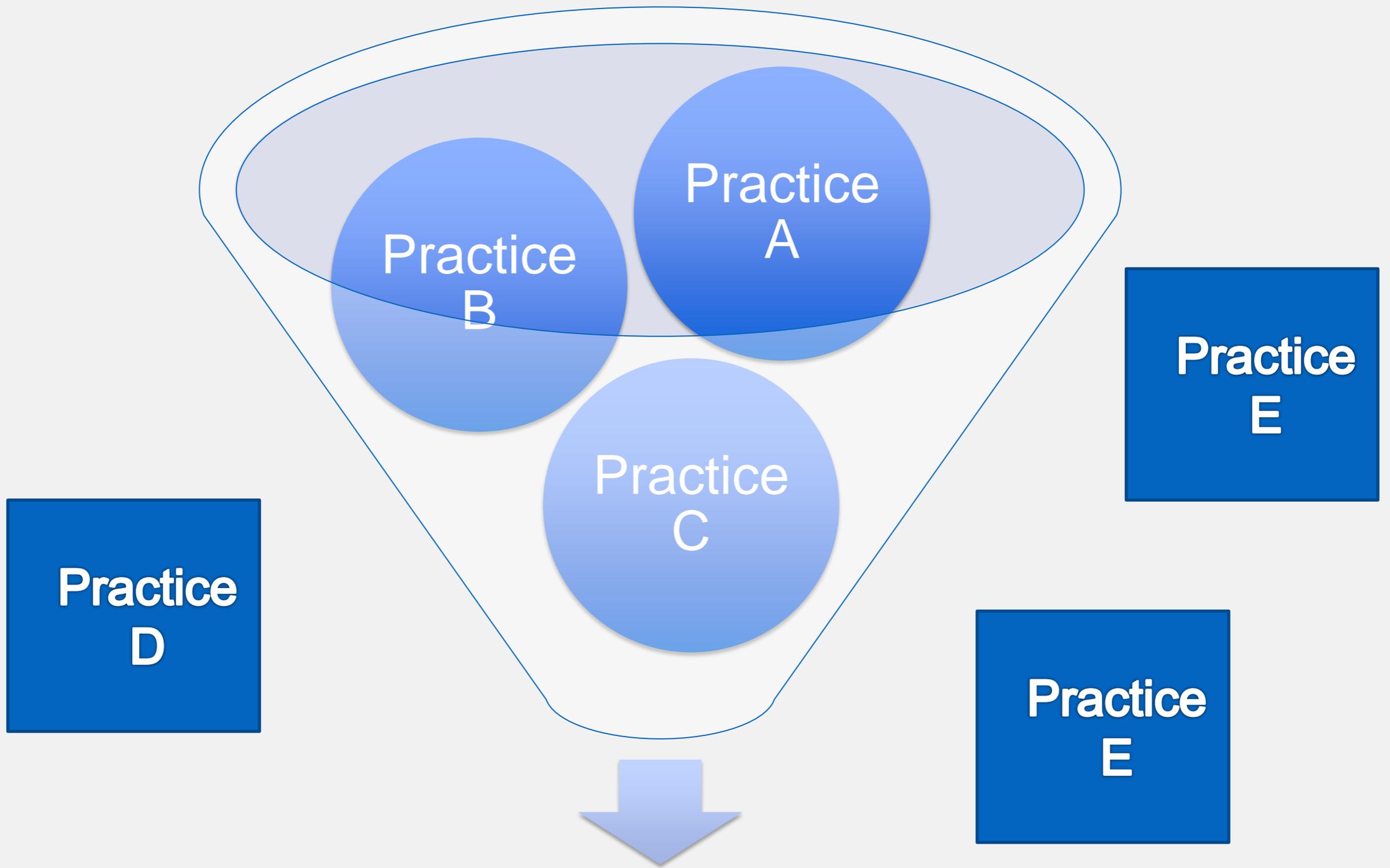
Providers &
Consumers

Track Outcomes

Triple Aim

Funding
Models
Built on
Outcomes

Sustainability,
Triple Aim



Desired Outcome



“Progress might have been
alright once, but it’s gone on
for too long.”

-Ogden Nash

Q & A

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