The Journey Toward a Sustainable Health Care System

July 27, 2013
U.S. Health Care

- Great Skills
- Great Science
- Great Expense
- Poor Integration / Delivery
• **Patients:** Problems with access to specialists, poorly coordinated care

• **Physicians:** Sporadic communication with colleagues, increasing amount of non-reimbursed work

• **Purchasers:** Increasing costs of care, employee health outcomes not apparent

• **Health plans:** Widely varying performance on key metrics
The typical primary care physician interfaces with 229 other physicians

HMSA’s Response

• Shift focus away from FFS
  – Initial target of 15% of reimbursement tied to value and outcomes

• Shift focus away from tertiary and specialty care
  – Invest in primary care
    • PCMH
    • Pay for performance programs
    • Systems and tools
    • Care coordination
    • Physician Organizations
  – Materially increase earning capacity of primary care physicians
Aiming for a Better Health Care System

The IHI Triple Aim

Health of a Population

Experience of Care

Per Capita Cost

The IHI Triple Aim

8/6/13
Goal - Top 10% of Health Plans in Quality by 2014

HMO: Top 22%; PPO: Top 14%

2010
Goal: Baseline Year

HMO: Top 48%

2011*
Goal: Top 25%; Top 20%

HMO: Top 27%; PPO: Top 21%

2012
Goal: Top 22%; Top 18%

2013
Goal: Top 15%; Top 13.5%

2014
Goal: Top 10% Both Plans

* NCQA HIP Rankings began including PPO in 2011.
• At the end of 2012, 1,096 providers and 512,743 members were in our Commercial P4Q program.

• All 22 Measures improved over CY 2011

• HMSA’s providers delivered ~11,000 more of the tests, screenings, and immunizations that our members need

• 9 of the 22 measures improved one percentile
  – 2 measures improved to the 90th Percentile
    • Chlamydia Screening for Pediatrics
    • Annual Monitoring of Persistent Medication for Diuretics
PCP Participation and Progress in PCMH
PCMH Outcomes

+/- 95% Confidence Interval

![Graph showing P4Q Pay Rate across different levels of PCMH outcomes]
## Thomas Davis's HMSA Quality Profile

### Preventive Health Screening

<table>
<thead>
<tr>
<th>Condition</th>
<th>Coverage (%)</th>
<th>Percentage</th>
<th>Patients</th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer</td>
<td>76.9%</td>
<td></td>
<td>327 of 425</td>
<td>+1 to 75th percentile</td>
</tr>
<tr>
<td>Cervical cancer</td>
<td>83.8%</td>
<td></td>
<td>408 of 487</td>
<td>+12 to 90th percentile</td>
</tr>
<tr>
<td>Colorectal cancer</td>
<td>80.9%</td>
<td></td>
<td>555 of 686</td>
<td>+131 to 100%</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>57.1%</td>
<td></td>
<td>12 of 21</td>
<td>+2 to 90th percentile</td>
</tr>
</tbody>
</table>

### Diabetes Screening

<table>
<thead>
<tr>
<th>Test</th>
<th>Coverage (%)</th>
<th>Percentage</th>
<th>Patients</th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye exam</td>
<td>41%</td>
<td></td>
<td>68 of 166</td>
<td>+11 to 25th percentile</td>
</tr>
<tr>
<td>HbA1C testing</td>
<td>71.1%</td>
<td></td>
<td>118 of 166</td>
<td>+23 to 10th percentile</td>
</tr>
<tr>
<td>LDL-C Screening</td>
<td>62.7%</td>
<td></td>
<td>104 of 166</td>
<td>+29 to 10th percentile</td>
</tr>
<tr>
<td>Nephropathy</td>
<td>74%</td>
<td></td>
<td>125 of 169</td>
<td>+2 to 10th percentile</td>
</tr>
</tbody>
</table>

### Heart Disease

<table>
<thead>
<tr>
<th>Test</th>
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<th>Percentage</th>
<th>Patients</th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>LDL-C Screening</td>
<td>66.7%</td>
<td></td>
<td>18 of 27</td>
<td>+5 to 10th percentile</td>
</tr>
<tr>
<td>Annual Monitoring – ACE/ARB</td>
<td>59.3%</td>
<td></td>
<td>48 of 81</td>
<td>+14 to 10th percentile</td>
</tr>
<tr>
<td>Annual Monitoring – Diuretics</td>
<td>55.6%</td>
<td></td>
<td>40 of 72</td>
<td>+15 to 10th percentile</td>
</tr>
</tbody>
</table>

### Asthma

<table>
<thead>
<tr>
<th>Condition</th>
<th>Coverage (%)</th>
<th>Percentage</th>
<th>Patients</th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate Rx for Asthma</td>
<td>100%</td>
<td></td>
<td>3 of 3</td>
<td>+0 to 100%</td>
</tr>
</tbody>
</table>

### Appropriate Respiratory Care

<table>
<thead>
<tr>
<th>Condition</th>
<th>Coverage (%)</th>
<th>Percentage</th>
<th>Patients</th>
<th>Percentile</th>
</tr>
</thead>
</table>
Where are we going from here?

- **Sustainability**
  - Continued shift of focus away from FFS
    - Previous target of 15% of revenue
    - New targets of 20 – 30% for hospitals and specialists and 30 – 40% for PCPs
    - Capitation option (for FFS component) for PCPs
  - Layering in efficiency (cost) metrics in 2014 for PCPs
    - Potential areas of focus for PO’s include:
      - ER utilization (Risk Adjusted)
      - Avoidable hospitalizations (Risk Adjusted)
      - Drug utilization
  - Layering in access metrics in 2014 for PCPs
Where are we going from here?

• Sustainability
  – Pay for Performance programs
    • Moving from process to outcomes metrics
    • Moving from outcome metrics to bundles
  – Payment based on number of gaps closed
    • Recognizes the effort and skill to care for complex patients
Where are we going from here?

• **Sustainability**

  – Development of Medical Neighborhoods
    • Form Medical Neighborhood Advisory Committees composed of Specialists and PCPs
    • Hold discussions with physician organizations and various groups of specialists
    • Develop health information technology to coordinate information and clinical care
Where are we going from here?

• Unrelenting innovation
  – How we interact with providers
    • Policies, authorizations, pre-certifications
  – Timeliness of data and results
    • Real time where possible
  – Advanced Care Planning Video Program
  – Supportive Care
    • Access where appropriate to both life sustaining and hospice care
  – Total Population Health Management
    • Care, resources and systems across the care continuum
Risk Adjustment

- A method used to adjust payment to the health plan based on demographics (age, sex) and health status of individuals
- Payments are higher for medically complex members and lower for healthier members
- Diagnoses from the base year are used to predict the health status and payments for the following year
• Payment to plan is based on **Risk Adjustment Factor** (RAF) Score assigned for each member.

• Each patient is assigned a RAF Score based on:
  – Demographics: Age and Gender
  – Additional Risk Factors: Medicaid, Medicare due to disability status
  – Total of all chronic conditions and some disease interactions (**Hierarchical Condition Categories**)
Hierarchical Condition Categories

- CMS risk adjustment model incorporates presence of chronic conditions, or HCCs.
- Diagnoses with similar resource utilization are categorized together

Source: Optum

8/6/13
CMS designed the model so that the average Medicare FFS patient has the RAF score of 1.00

<table>
<thead>
<tr>
<th>RAF Score &lt;1.00</th>
<th>RAF Score &gt; 1.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicate a healthier population OR Indicate members with increased health risks</td>
<td></td>
</tr>
<tr>
<td>Falsely indicate a healthier population due to:</td>
<td>OR</td>
</tr>
<tr>
<td>• Inadequate chart documentation</td>
<td>• Reported diagnoses not documented</td>
</tr>
<tr>
<td>• Incomplete/inaccurate ICD-9 coding</td>
<td>• Overcoding</td>
</tr>
</tbody>
</table>

Source: Optum
8/6/13
### Case Example

<table>
<thead>
<tr>
<th></th>
<th>No conditions coded</th>
<th>Some conditions coded - poor specificity</th>
<th>All conditions coded appropriately</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ICD9</td>
<td>RAF Points</td>
<td>ICD9</td>
</tr>
<tr>
<td>75- year old female</td>
<td>N/A</td>
<td>0.457</td>
<td>N/A</td>
</tr>
<tr>
<td>Medicaid Eligible</td>
<td>N/A</td>
<td>0.131</td>
<td>N/A</td>
</tr>
<tr>
<td>Diabetes w/ neurological complications (HCC16)</td>
<td>-</td>
<td>-</td>
<td>250.00</td>
</tr>
<tr>
<td>Neuropathy in diabetes (HCC 71)</td>
<td>-</td>
<td>-</td>
<td>355.9</td>
</tr>
<tr>
<td>CHF (HCC 80)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Disease Interaction (DM + CHF)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td>0.588</td>
<td></td>
</tr>
</tbody>
</table>

**Reimbursement Rate to Health Plan (per month)**

- No conditions coded: $470.40
- Some conditions coded - poor specificity: $600.00
- All conditions coded appropriately: $1,509.60
Risk Adjustment
Consequences

• **Medicare Advantage**: Decreased resources available for the plan to take care of its enrolled members

• **Small group and individual plans in the exchange starting 2014**: Redistributes premium dollars from plans with relatively lower-risk members to plans with relatively higher-risk members to offset costs of sicker-than-average population
Best Practices in Medical Record Documentation

- Chronic diseases that coexist at the time of the encounter/visit and require or affect patient care treatment or management, should be documented and coded.

- Chronic conditions need to be reported every calendar year.

- Each diagnosis needs to conform to the ICD-9 coding guidelines until transition to ICD-10.

Source: BCBSA
The journey continues...