

State Role in the Quality Agenda

Anthony Rodgers
 Director
 Arizona Health Care Cost Containment System

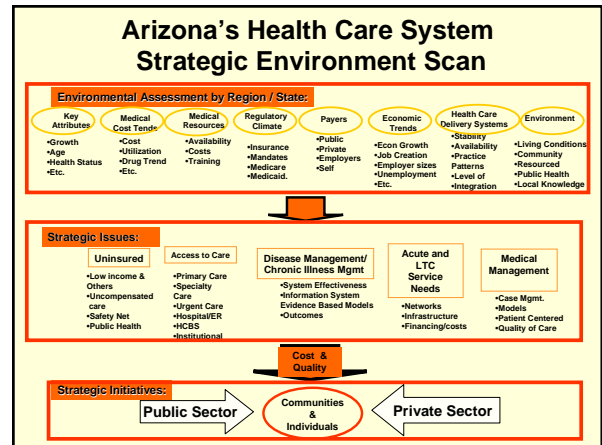
Quality and Cost Containment Rational and Focus of the State of Arizona

Statement of Rational

The State of Arizona plays a key role in quality improvement and overall health care cost containment for its citizens.

Key Factors in Arizona's Quality Improvement and Cost Containment Focus:

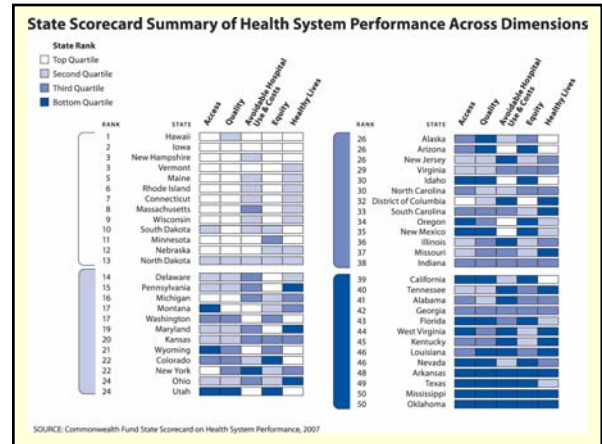
1. The State of Arizona is a key stakeholder in improving health care quality and containing cost for Arizonans.
2. Arizona has significant state budget and program resources invested in the state Medicaid program, SCHIP, state employee health programs.
3. Health care quality and cost have a significant impact on the state's business environment and overall competitiveness.

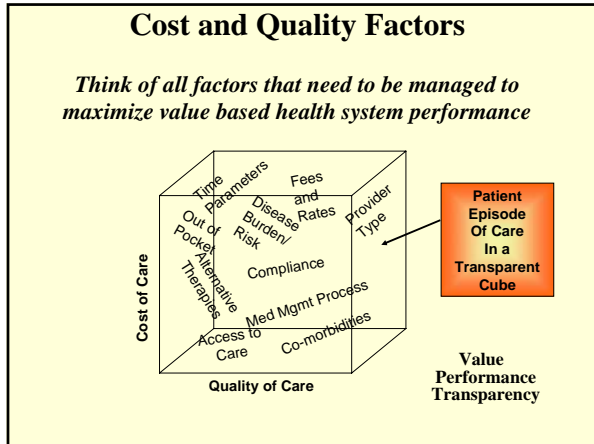


H E D I S M e a s u r e m e n t s

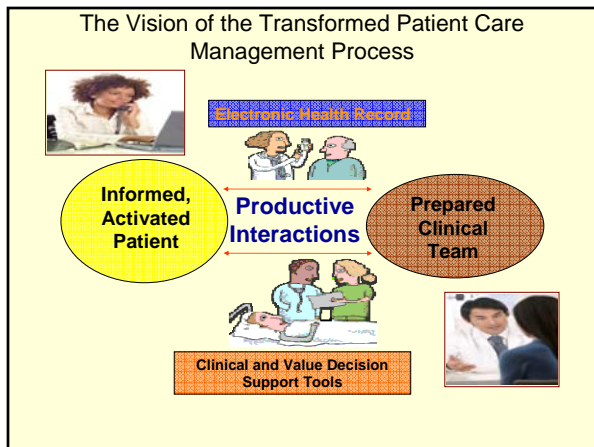
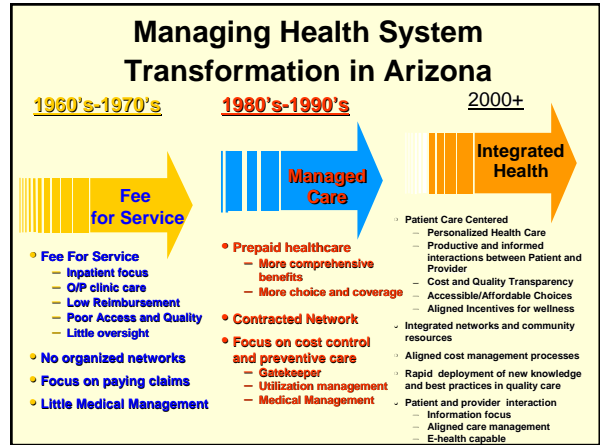
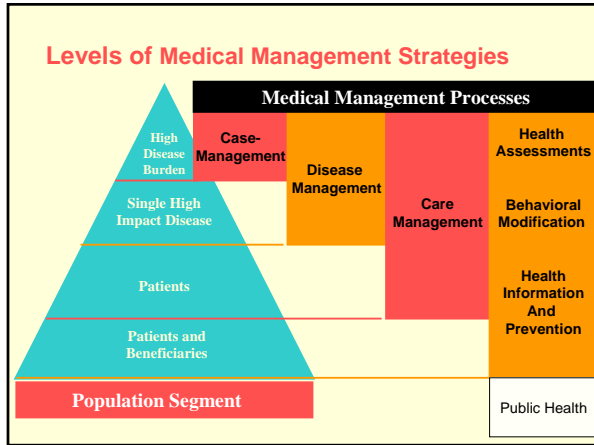
Typical System Performance Measures

- Effectiveness of Care**
 - > Childhood Immunization Status
 - > Adolescent Immunization Status
 - > Treat Child w/Upper Respiratory Infection
 - > Test Child w/Pharyngitis
 - > Breast Cancer Screening
 - > Cervical Cancer Screening
 - > Chlamydia Screening in Women
 - > Controlling High Blood Pressure
 - > Beta Blocker
 - > Cholesterol Management
 - > Comprehensive Diabetes Care
 - > Appropriate Meds for Asthmatics
- Access & Availability**
 - > Adults' Access
 - > Children's Access
 - > Annual Dental Visits
- Health Plan Stability**
 - > Practitioner Turnover
 - > Claims Timeliness
 - > Calls
- Use of Services**
 - > Frequency of Prenatal Care
 - > Well-Child First 15 Months
 - > Well-Child 3-6
 - > Adolescent Wellcare
 - > Inpatient Utilization - General Hospital
 - > Ambulatory Care
 - > Inpatient Utilization - Nonacute
 - > Discharge & ALOS - Maternity
 - > C-Section Rates
 - > Vaginal Birth After C-Section
 - > Births & ALOS - Newborns
 - > Outpatient Drug Utilization
 - > Board Certification/Residency Comp.

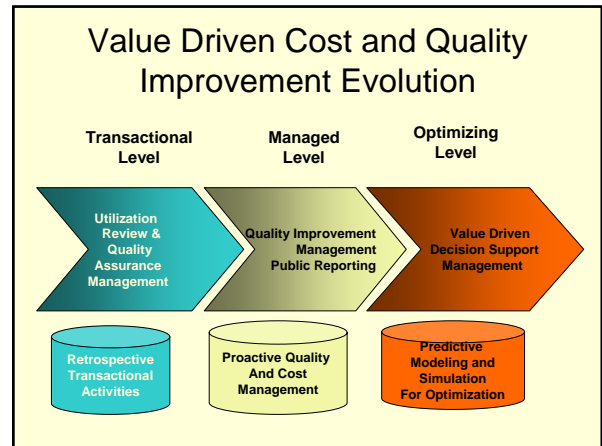
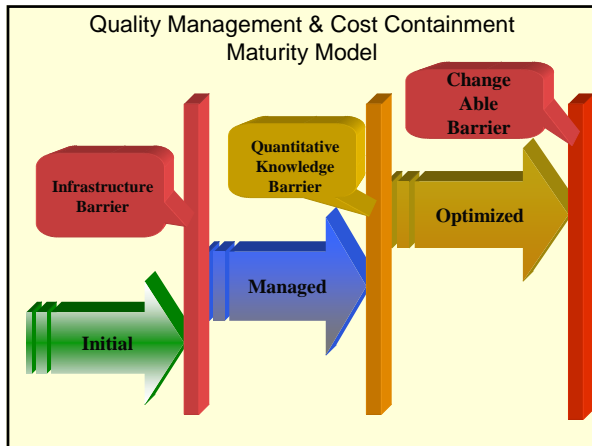




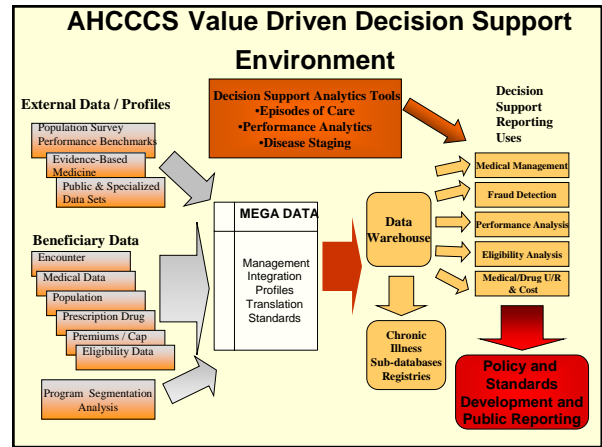
- ### Managed Care Cost and Quality Management Tools
- Benefits packages
 - Benefit limitations
 - Co-pays
 - Deductibles
 - Administrative cost controls
 - Provider contracting
 - Medical Risk Management
 - Provider rate setting
 - General administrative expenses
 - Pay of Performance
 - Clinical management
 - Utilization management
 - Disease and care management
 - Case management of high risk cases
 - Quality improvement management
- These tools have not driven health system transformation.



Overcoming Barriers to Quality Improvement and Cost Containment



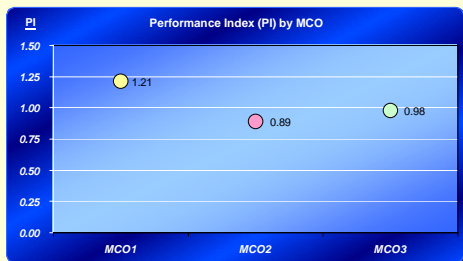
Maturity Barriers		
Infrastructure Barriers	Quantitative Knowledge Barriers	Optimized Health Barriers
Information Systems do not support medical management data	Limited medical management organization core competencies and know how	Maintenance of effort is more important than optimizing results
Telecommunication technology does not adequately support customer care	Quantitative analysis of data is limited and poorly integrated with evidence based medical knowledge	Future view is limited
Information systems within network are not linked for transfer of medical information	Data is not timely and integrated with other relevant information	Organization becomes focused on internal processes only
Data from various parts of the health care system is not integrated	No formal processes to convert information into useful disease management data	No systematic organizational maturity plan
Limited web based applications and functionality	Decision support systems are limited in capability and not part of executive decision making	Limited integration of organizational goals
Limited performance and decision support capability	No formal process to improve organizations core competencies	No continuous and systematic evaluation process



Aligning Arizona Quality and Cost Containment Strategies between Policy Makers, Payers, Providers, and Patients

Process	Effectiveness		
	Routine	Moderate	Highly Effective
Utilization Management	Traditional UM focusing on prior authorization and concurrent review with standard industry criteria. No overall UM or relationship with providers, no assignment of staff to specific providers.	Assignment of UM staff to each hospital, good relationships with hospital staff and providers.	"Gold Standard" providers identified for least intensive UM. UM integrated with CM, DM, outreach, and contracting. Optimal use of tiered UM data with appropriate benchmark data.
Case Management	Catastrophic, high cost cases	Incorporate CM with contracting department initiatives, focus on cost management; connect with member profiling and provider feedback.	ROI analysis at case and program wide level.
Disease Management / Health Maintenance	Broad non-specific health management programs and/or the presence of an OB program.	OB (60% of cases), Asthma, 1-2 additional targeted health management programs based on volume.	Broad multi category programs based on epi studies, ROI analysis for all programs, OB program "touch" 50%+ cases.
ER and High Utilizers focus	No focus specific to ER utilization as evidenced by profiling reports or outreach efforts	Non-interventive workgroups in place to determine opportunities to decrease costs for ER and high cost utilizers; ER utilization trended and monitored frequently; root cause analysis rates analyzed; ER and cost triggers for CM with sub-specialty outcome measurements for ER.	Member and provider profiling, outreach, and noted reduction in costs.
Data Analysis	Broad category UM reporting with little benchmarking and trend analysis	Trend analysis by volume, costs, disease categories, member, provider, hospital, geographic issues.	Cost driver reduction analysis using data (diagnosis, pharmacy, outpatient, ER, and pervasive throughout organization, Risk adjusted member charges).
Health Promotion and Management	Broad outreach with blind mailings; no focused DM	Outreach and interventions tied to the efforts of the UM, CM programs.	Predictive modeling to identify potential high cost members before these costs are incurred; tied to UM, CM, and outreach interventions.
Contracting	Contracting with all providers regardless of cost or quality outcome.	Feedback from UM and CM intricately tied to contracting.	Network based on quality improvement and cost reduction; incentives for targeted cost reduction.
Profiling	No profiling	Profiling of providers and members for monitoring purposes but with minimal improvement in outcomes or costs due to profiling efforts	Profiling data used for provider and member outreach; Cost savings noted in ROI analysis of outreach interventions; Focused provider networks; noted improvement in appropriate utilization; results due to member outreach from profiling.
Pharmacy Reimbursement (Management)	Non-competitive AWP and MAC reimbursement pricing (Based on industry standards)	Moderately competitive AWP and MAC reimbursement pricing (based on industry standards)	Aggressive AWP and MAC reimbursement pricing (based on industry standards)
Pharmacy Structure	Open formulary	Closed formulary	Closed formulary; 72 hour drug supply and subsequent physician follow-up.
Medication Utilization Management Programs	Standard concurrent DUR program	Standard Step Therapy; Standard Quantity Limit Lists; Prior Authorization for high cost medications	Aggressive utilization management programs; Enhanced/Aggressive Step Therapy; Expanded Quantity Limit Lists; Physician Education Programs on Profiling; Targeted Fraud/Abuse Programs (polypharmacy, polyphysician, pharmacy focus)

Hypothetical Illustration: Performance by MCO



* Performance Index equals the Expected Paid divided by the Actual Paid and is controlled by ETG Case mix.

MCO Performance Quality and Cost Analysis

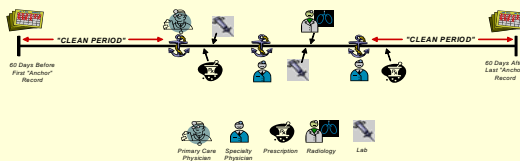
- Assign a score of 0-1-2 or 0-1/2-1 for Routine-Moderate-Highly Effective. Scoring rule depends on the process assessed.
- Total up the scores for each MCO (adjustment for relative risk across MCOs)

MCO	Pharmacy 0 – 4 points	Medical 0 – 16 points	Total 0 – 20 points
MCO 1	1.25	4.50	5.75
MCO 2	2.50	6.50	9.00
MCO 3	3.50	8.75	12.25
MCO 4	2.00	6.00	8.00
MCO 5	3.25	7.75	11.00
Weighted (based upon revenue)			10.20

Point system
0 = Routine Med. Man.
10 = Enhanced Med. Man.
20 = Highly Effective Med. Man.

The Life of a Care Episode

THE LIFE OF A CHRONIC SINUSITIS (w/o SURGERY) EPISODE



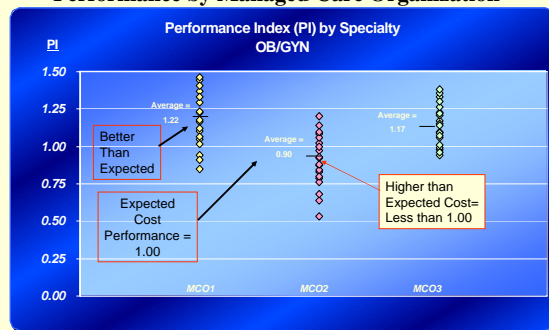
First Anchor: You visit your Primary Care Physician for sinusitis. He gives you a prescription and orders blood work. He is concerned that you have a history of sinus infections, so he refers you to an ENT. The PCP visit becomes the first anchor and, because it has been more than 60 days since you have visited him for sinusitis, it begins the episode. The PCP visit, prescription and lab work together form a cluster within the episode.

Second Anchor: You visit the ENT. She orders a sinus X-ray and more blood work. You schedule a follow-up appointment. The ENT visit, X-ray and lab work form another cluster within the same episode.

Third Anchor: You visit the ENT for your follow-up appointment. She tells you that the results of the tests came back negative. She prescribes a preventative medication to help reduce the occurrence of sinusitis. The ENT visit and prescription form another cluster within the same episode.

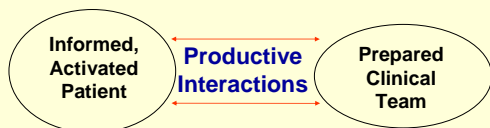
Conclusion: The medication worked and you have not been back to either doctor within 60 days from your last visit for this illness. Since it has been 60 days since the last anchor record for this illness, the episode is now considered concluded.

Hypothetical Illustration: Provider Cost Performance by Managed Care Organization



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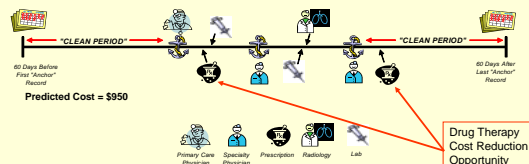
The Patient and Provider Quality Improvement and Cost Containment Alignment as the Essential Driver of Health System Transformation



Individual Patient Episode of Care Life Cycle Tracked through an EHR

THE LIFE OF A CHRONIC SINUSITIS (w/o SURGERY) EPISODE

Outcome Cost = \$1,020



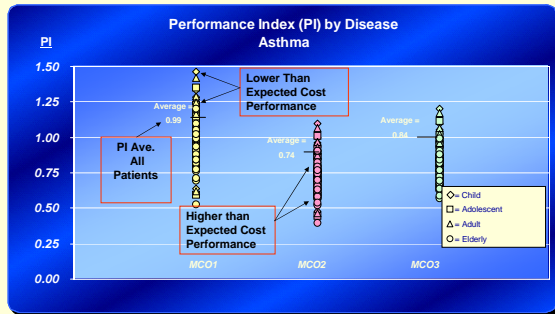
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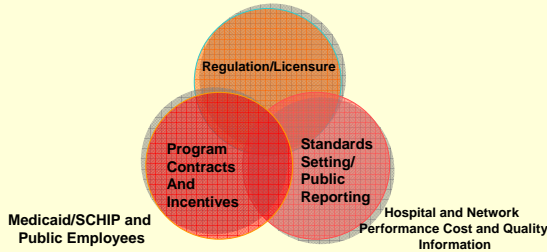
**Hypothetical Illustration:
Performance by Disease by Patient (Asthma)**



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**Tools the State of Arizona
Has to Drive Quality
Improvement and Cost
Containment**

**State Tools to Improve
Health System Quality and Control Cost**



**Policy and Programmatic Tools For
Driving State Level Health System
Transformation**

**Current State Level Tools
For Driving Quality Improvement**

- Regulation
- Licensure
- Public Reporting
- Setting Standards
- Medicaid and SCHIP Program Contracting
- Public Employee Health Care Contracts

**Future Health System
Transformation Tools**

- Health information technology and Public Private E-Health Initiatives
- New mega databases
- New decision support tools for policy makers, payers, providers, and patients/consumers
- Aligned incentives for patients and providers

**The Next Generation of Electronic Health
Information Supported Decision Support Tools**

- The next generation of health care decision support applications will be provide payers, MCOs, providers, and patients the tools for value driven decision making .
 - Electronic health record will be used to populate the next generation of Health Care Decision Support tools.
 - Provide providers and patients with a common point of reference during the care episode that can provide patient care roadmap and a personal Performance Index with both quality and cost information.
 - New health care quality and cost simulation tools will provide policy makers, payers, providers, and patients common information and more personalized data.
 - New integrated decision support tools will create a whole new dimension of interaction at all levels of the care continuum
 - Support consumer directed care and self management
 - Provides the opportunity for alignment of patient and provider incentive programs



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