

State Role in the Quality Agenda

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Arizona Health Care Cost Containment
System

Quality and Cost Containment Rationale 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:

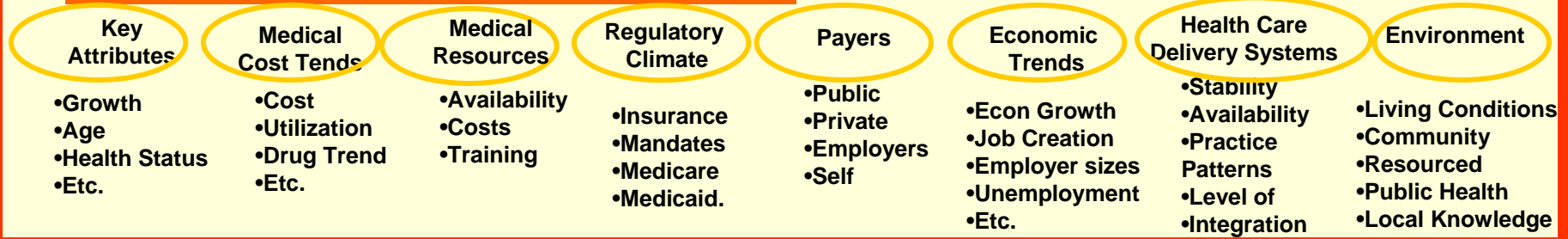
1. The State of Arizona is a key stakeholder in improving health care quality and containing cost for Arizonans.

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.

Arizona's Health Care System Strategic Environment Scan

Environmental Assessment by Region / State:



Strategic Issues:

Uninsured

- Low income & Others
- Uncompensated care
- Safety Net
- Public Health

Access to Care

- Primary Care
- Specialty Care
- Urgent Care
- Hospital/ER
- HCBS
- Institutional

Disease Management/ Chronic Illness Mgmt

- System Effectiveness
- Information System
- Evidence Based Models
- Outcomes

Acute and LTC Service Needs

- Networks
- Infrastructure
- Financing/costs

Medical Management

- Case Mgmt.
- Models
- Patient Centered
- Quality of Care

Cost & Quality

Strategic Initiatives:

Public Sector

Communities & Individuals

Private Sector

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

E f f e c t i v e n e s s o f C a r e

- > C h i l d h o o d I m m u n i z a t i o n S t a t u s
- > A d o l e s c e n t I m m u n i z a t i o n S t a t u s
- > T r e a t C h i l d w / U p p e r R e s p i r a t o r y I n f e c t i o n
- > T e s t C h i l d w / P h a r y n g i t i s
- > B r e a s t C a n c e r S c r e e n i n g
- > C e r v i c a l C a n c e r S c r e e n i n g
- > C h l a m y d i a S c r e e n i n g i n W o m e n
- > C o n t r o l l i n g H i g h B l o o d P r e s s u r e
- > B e t a B l o c k e r
- > C h o l e s t e r o l M a n a g e m e n t
- > C o m p r e h e n s i v e D i a b e t e s C a r e
- > A p p r o p r i a t e M e d s f o r A s t h m a t i c s

A c c e s s & A v a i l a b i l i t y

- > A d u l t s ' A c c e s s
- > C h i l d r e n s ' A c c e s s
- > A n n u a l D e n t a l V i s i t s

H e a l t h P l a n S t a b i l i t y

- > P r a c t i t i o n e r T u r n o v e r
- > C l a i m s T i m e l i n e s s
- > C a l l s

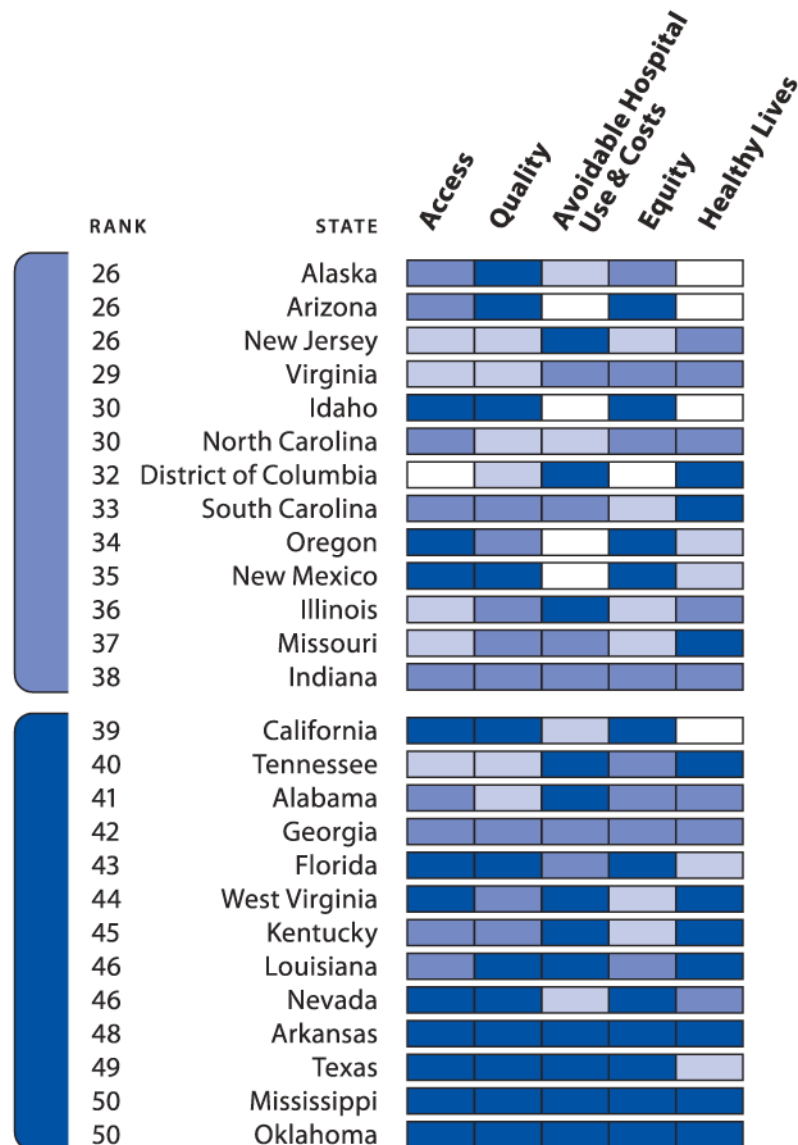
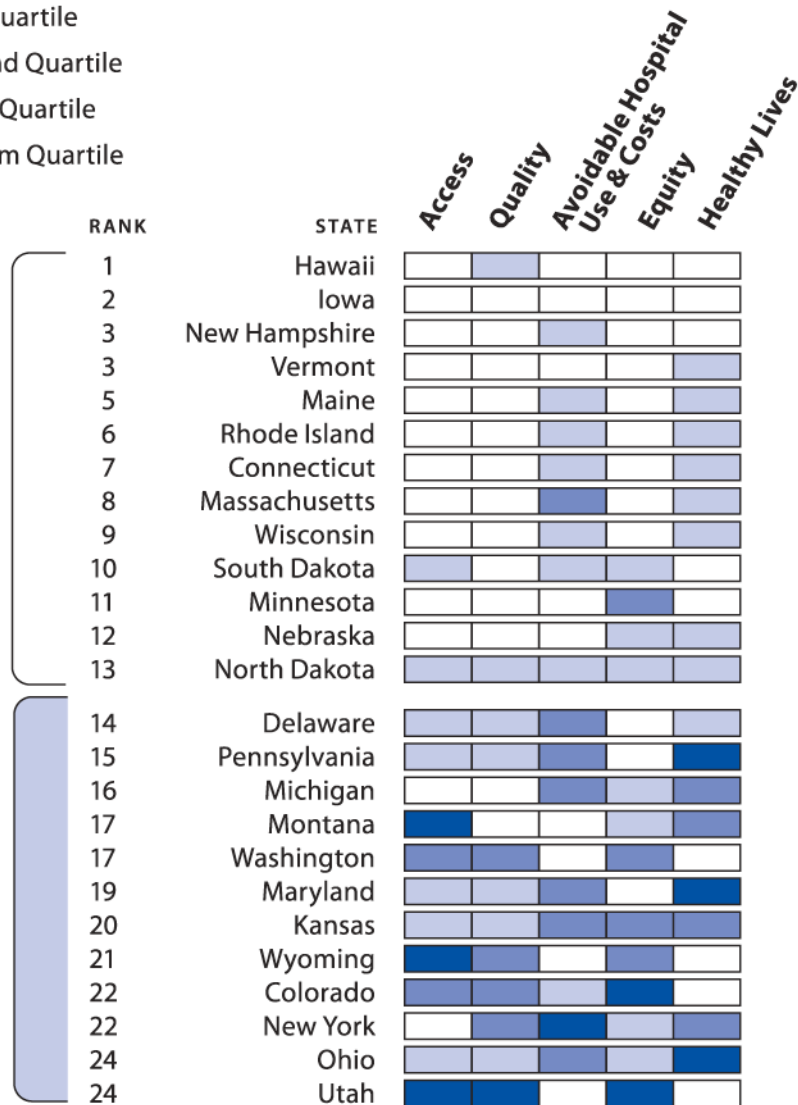
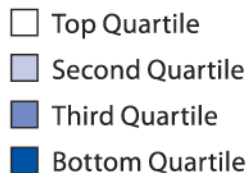
U s e o f S e r v i c e s

- > F r e q u e n c y o f P r e n a t a l C a r e
- > W e l l - C h i l d F i r s t 1 5 M o n t h s
- > W e l l - C h i l d 3 - 6
- > A d o l e s c e n t W e l l c a r e
- > I n p a t i e n t U t i l i z a t i o n - G e n e r a l H o s p i t a l
- > A m b u l a t o r y C a r e
- > I n p a t i e n t U t i l i z a t i o n - N o n a c u t e
- > D i s c h a r g e & A L O S - M a t e r n i t y
- > C - S e c t i o n R a t e s
- > V a g i n a l B i r t h A f t e r C - S e c t i o n
- > B i r t h s & A L O S - N e w b o r n s
- > O u t p a t i e n t D r u g U t i l i z a t i o n
- > B o a r d C e r t i f i c a t i o n / R e s i d e n c y C o m p .

**Typical
System
Performance
Measures**

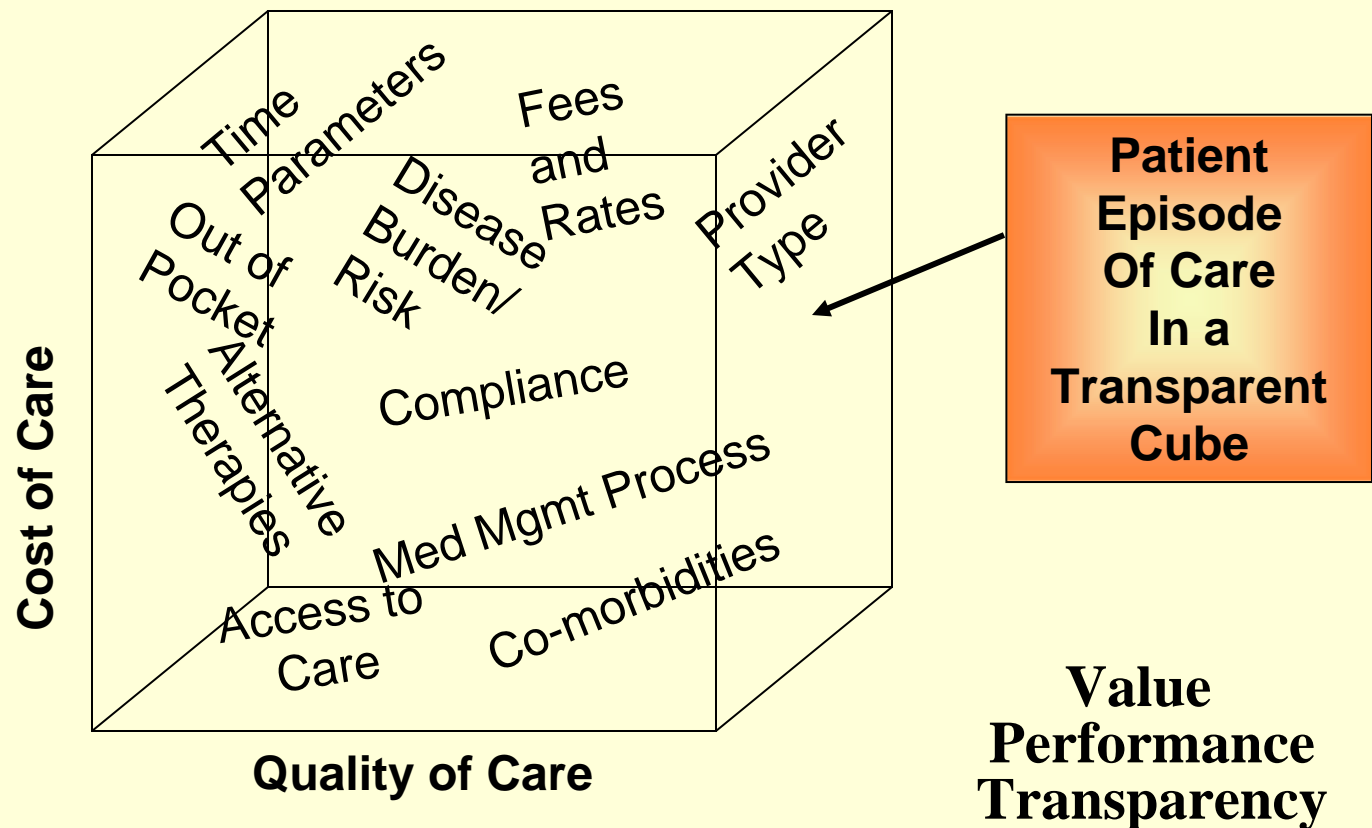
State Scorecard Summary of Health System Performance Across Dimensions

State Rank



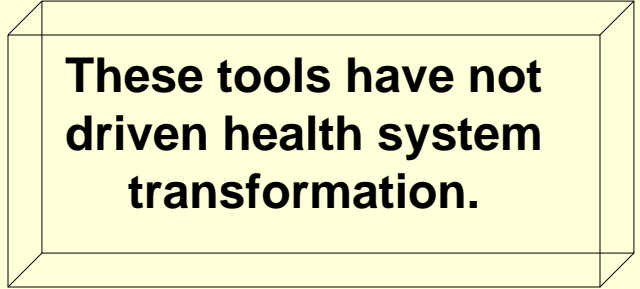
Cost and Quality Factors

Think of all factors that need to be managed to maximize value based health system performance



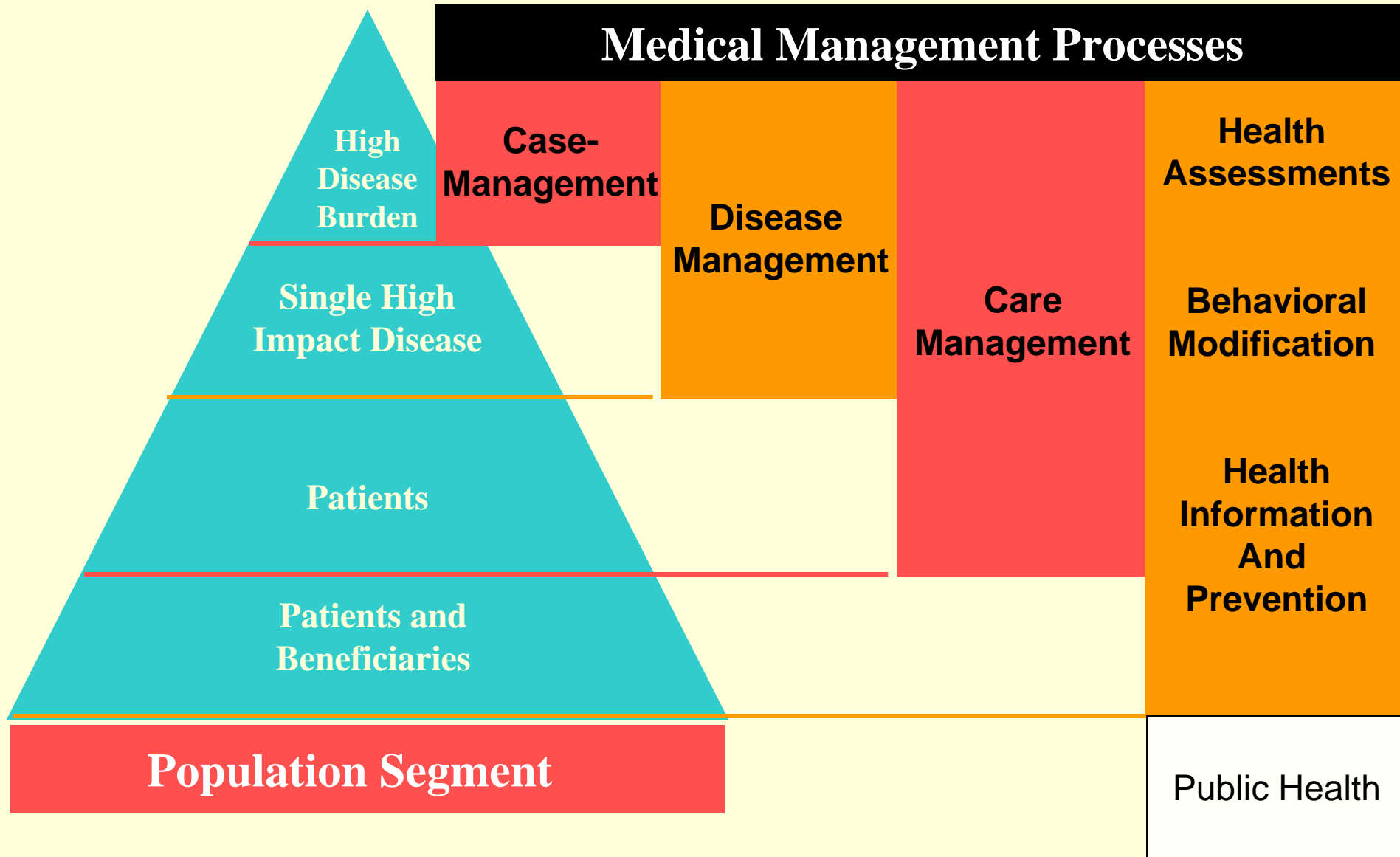
Managed Care Cost and Quality Management Tools

- 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.

Levels of Medical Management Strategies



Managing Health System Transformation in Arizona

1960's-1970's



**Fee
for Service**

- **Fee For Service**
 - Inpatient focus
 - O/P clinic care
 - Low Reimbursement
 - Poor Access and Quality
 - Little oversight
- **No organized networks**
- **Focus on paying claims**
- **Little Medical Management**

1980's-1990's



**Managed
Care**

- **Prepaid healthcare**
 - More comprehensive benefits
 - More choice and coverage
- **Contracted Network**
- **Focus on cost control and preventive care**
 - Gatekeeper
 - Utilization management
 - Medical Management

2000+



**Integrated
Health**

- **Patient Care Centered**
 - Personalized Health Care
 - Productive and informed interactions between Patient and Provider
 - Cost and Quality Transparency
 - Accessible/Affordable Choices
 - Aligned Incentives for wellness
- **Integrated networks and community resources**
- **Aligned cost management processes**
- **Rapid deployment of new knowledge and best practices in quality care**
- **Patient and provider interaction**
 - Information focus
 - Aligned care management
 - E-health capable

The Vision of the Transformed Patient Care Management Process



Electronic Health Record



**Informed,
Activated
Patient**

**Productive
Interactions**

**Prepared
Clinical
Team**

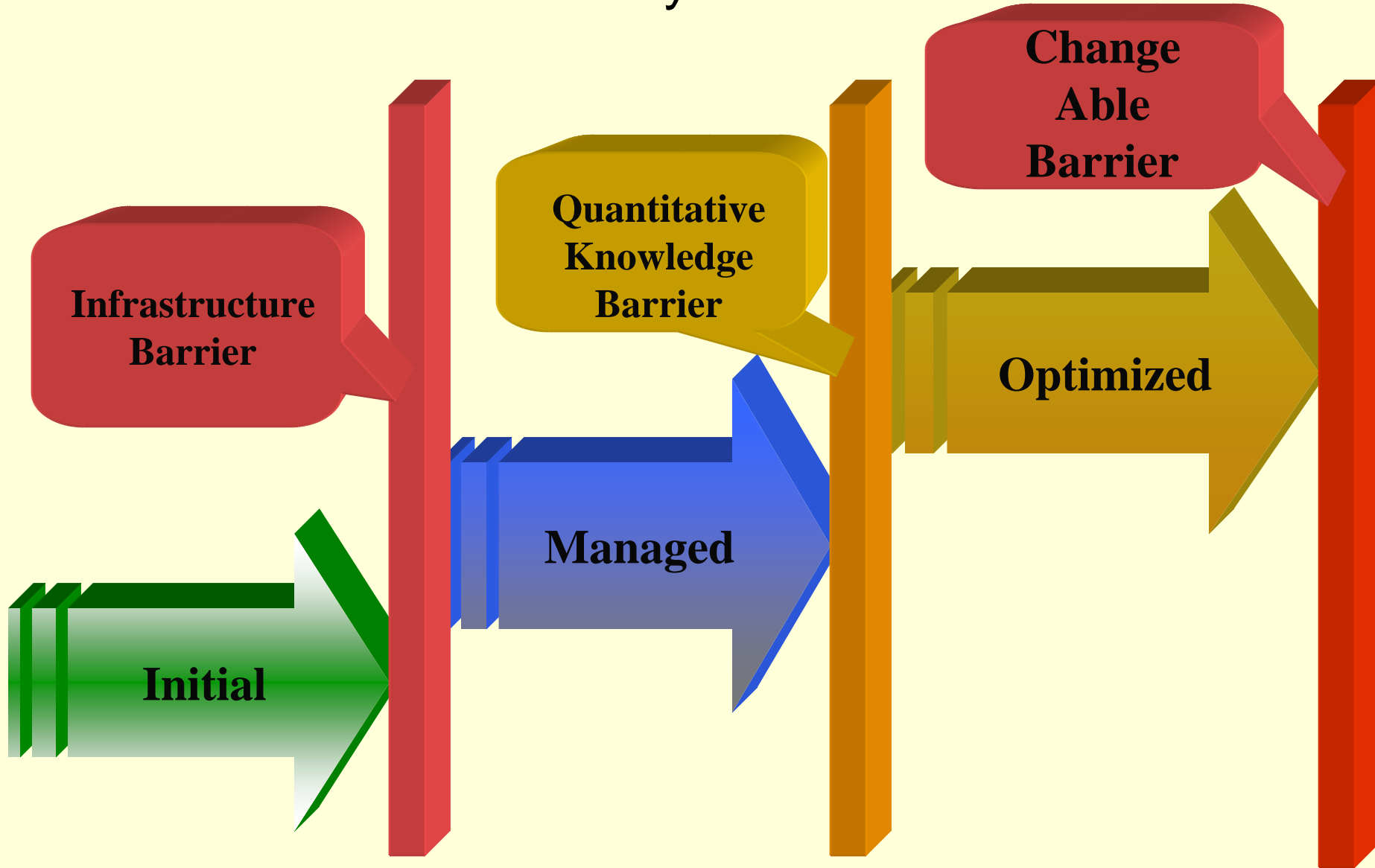


**Clinical and Value Decision
Support Tools**

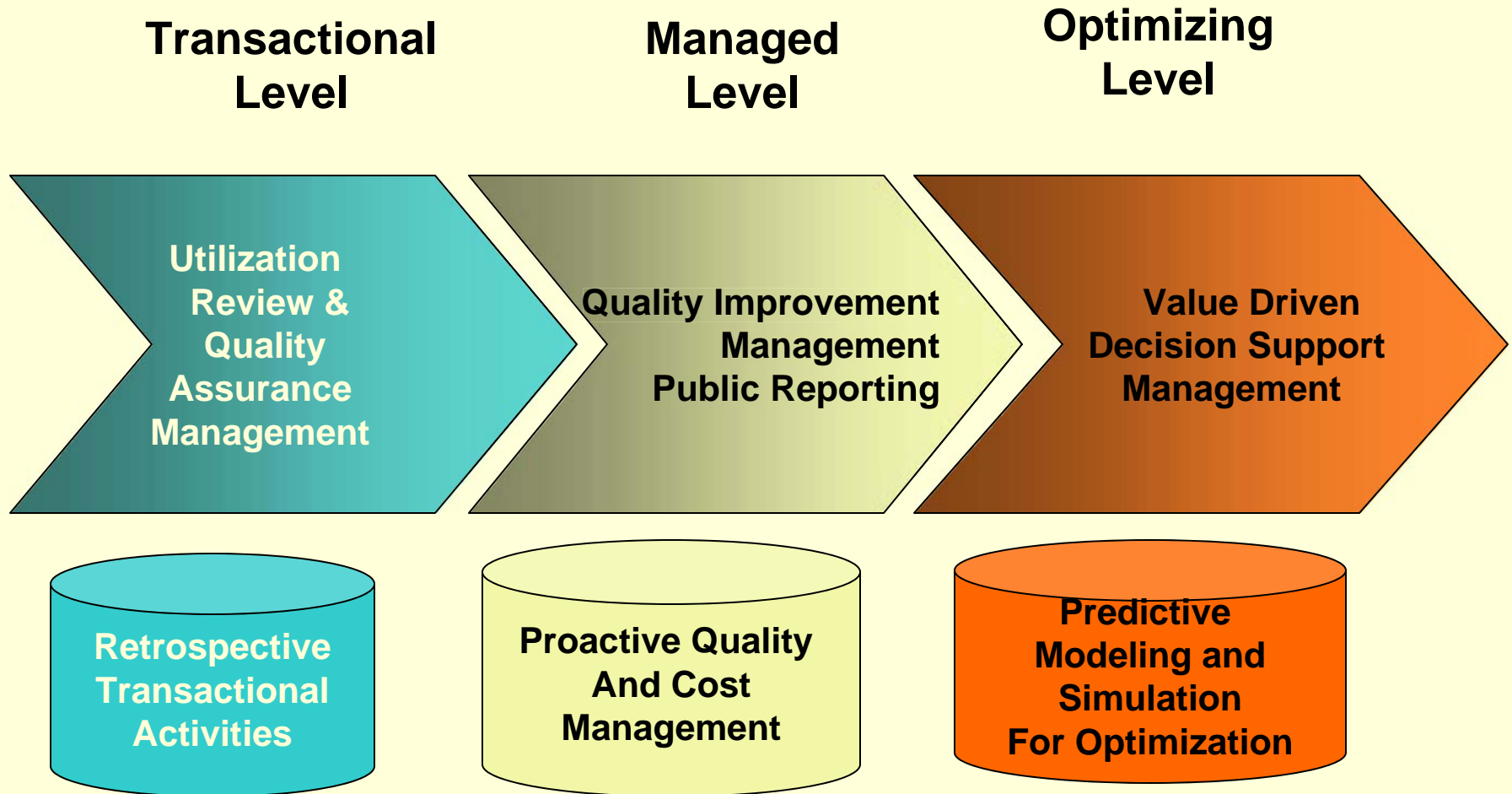


Overcoming Barriers to Quality Improvement and Cost Containment

Quality Management & Cost Containment Maturity Model



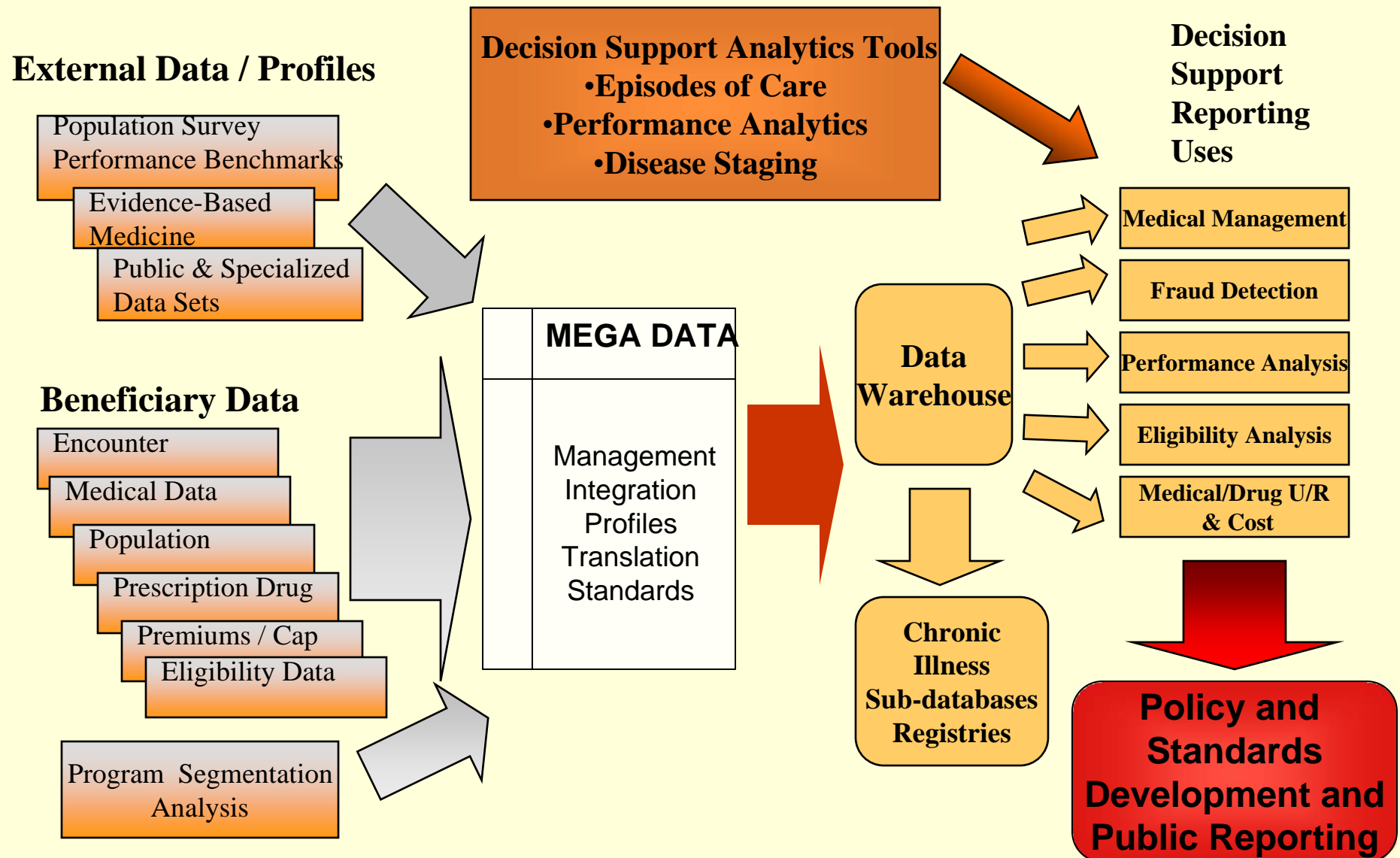
Value Driven Cost and Quality Improvement Evolution



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

AHCCCS Value Driven Decision Support Environment

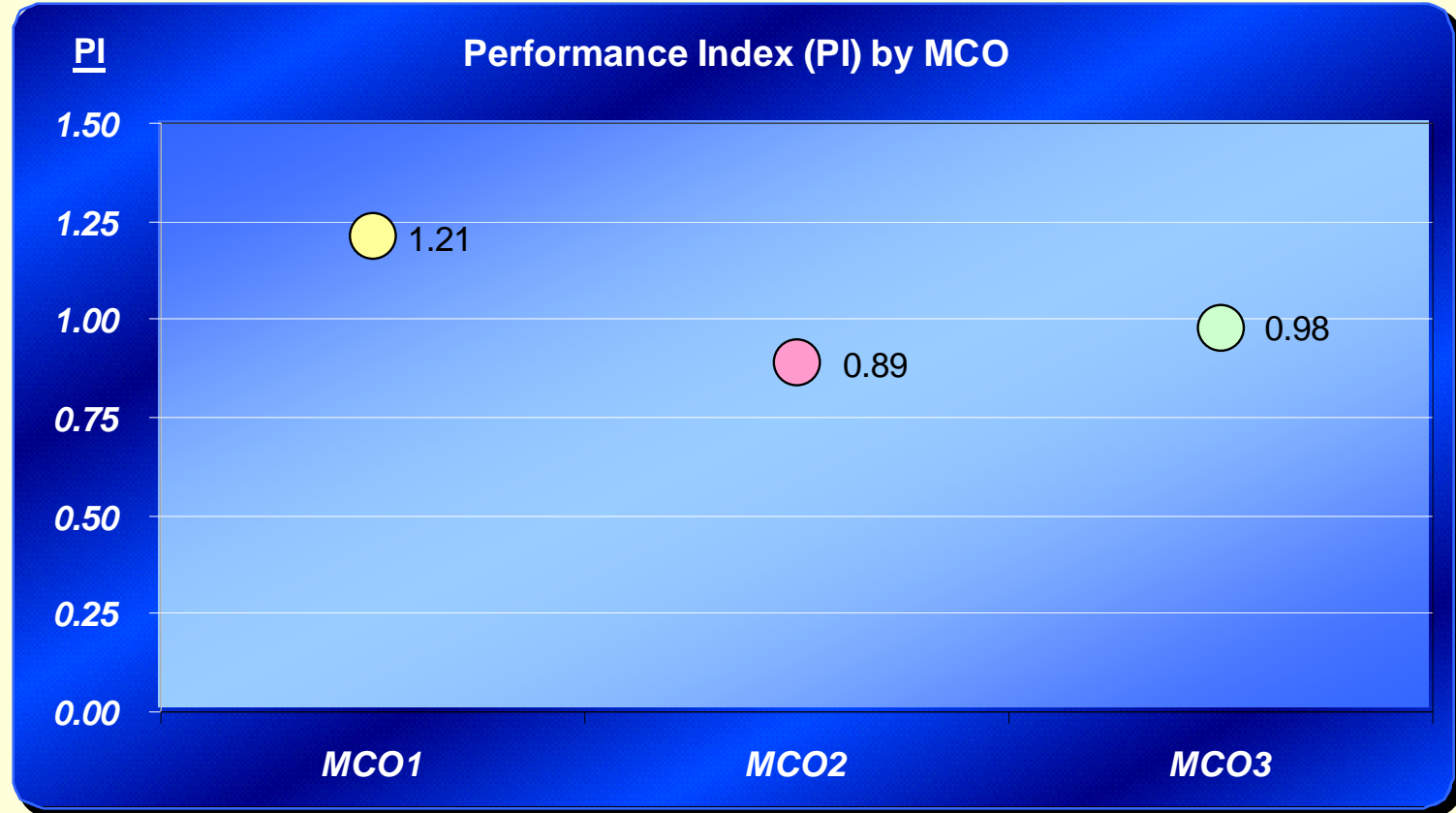


Aligning Arizona Quality and Cost Containment Strategies between Policy Makers, Payers, Providers, and Patients

MCO Levels of Cost and Care Management Effectiveness

<i>Process</i>	<i>Routine</i>	<i>Moderate</i>	<i>Highly Effective</i>
Utilization Management	Traditional UM focusing on prior authorization and concurrent review with standard industry criteria. No onsite UM; no 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 less intensive UM; UM integrated with CM, DM, outreach, and contracting. Optimal use of trended 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 analyses at case and program wide level
Disease Management / Health Management	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 analyses for all programs. OB program "touches" 80% + cases.
ER and High Utilizers focus	No focus specific to ER utilization as evidenced by profiling reports or outreach efforts	Committees/workgroups in place to examine opportunities to decrease costs for ER and high cost utilizers; ER utilization trended and monitored frequently; root cause behind rates analyzed; ER and cost triggers for CM with associated outcome measures for C	Member and provider profiling, outreach, and noted reduction in costs
Data Analysis	Broad category UM reporting with little benchmarking and trend analysis	Trend analyses by volume, costs, disease categories, member, provider, hospital, geographic issues.	Cost driver reduction analyses using data (inpatient, pharmacy, outpatient, ER, etc) pervasive throughout organization. Risk adjusted methodologies.
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 outcomes	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 documented in outcomes or costs due to profiling efforts	Profiling data used for provider and member outreach; Cost savings noted in ROI analyses of outreach interventions; Focused provider network; noted improvement in appropriate utilization results due to member outreach from profiling
Pharmacy Reimbursement Arrangements	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)
Formulary Structure	Open formulary	Closed formulary	Closed formulary, 72 hour bridge supply and subsequent physician follow-up
Medication Utilization Management Programs	Standard concurrent DUR program	Standard utilization management programs: 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 or Profiling; Targeted Fraud/Abuse Programs (polypharmacy, polyphysician, pharmacy lock-in)

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)

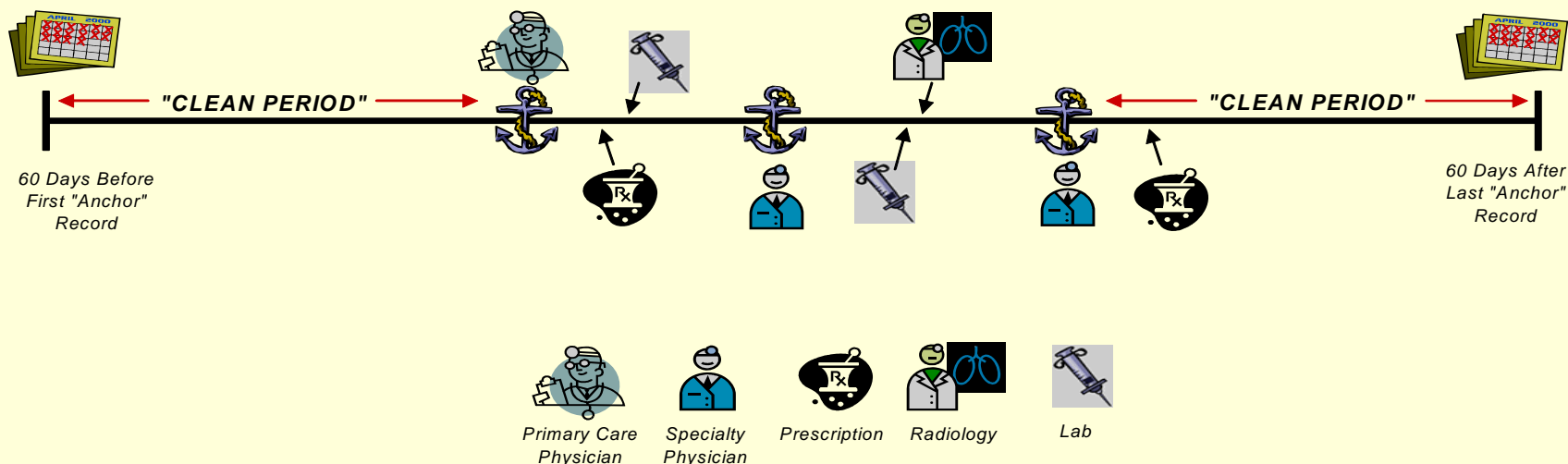
MCO	Pharmacy 0 – 4 points	Medical 0 – 16 points	Total 0 – 20 points
MCO 1	1.25	4.50	5.75
MCO 2	2.50	6.50	9.00
MCO 3	3.50	8.75	12.25
MCO 4	2.00	6.00	8.00
MCO 5	3.25	7.75	11.00
Weighted (based upon revenue)			10.20

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



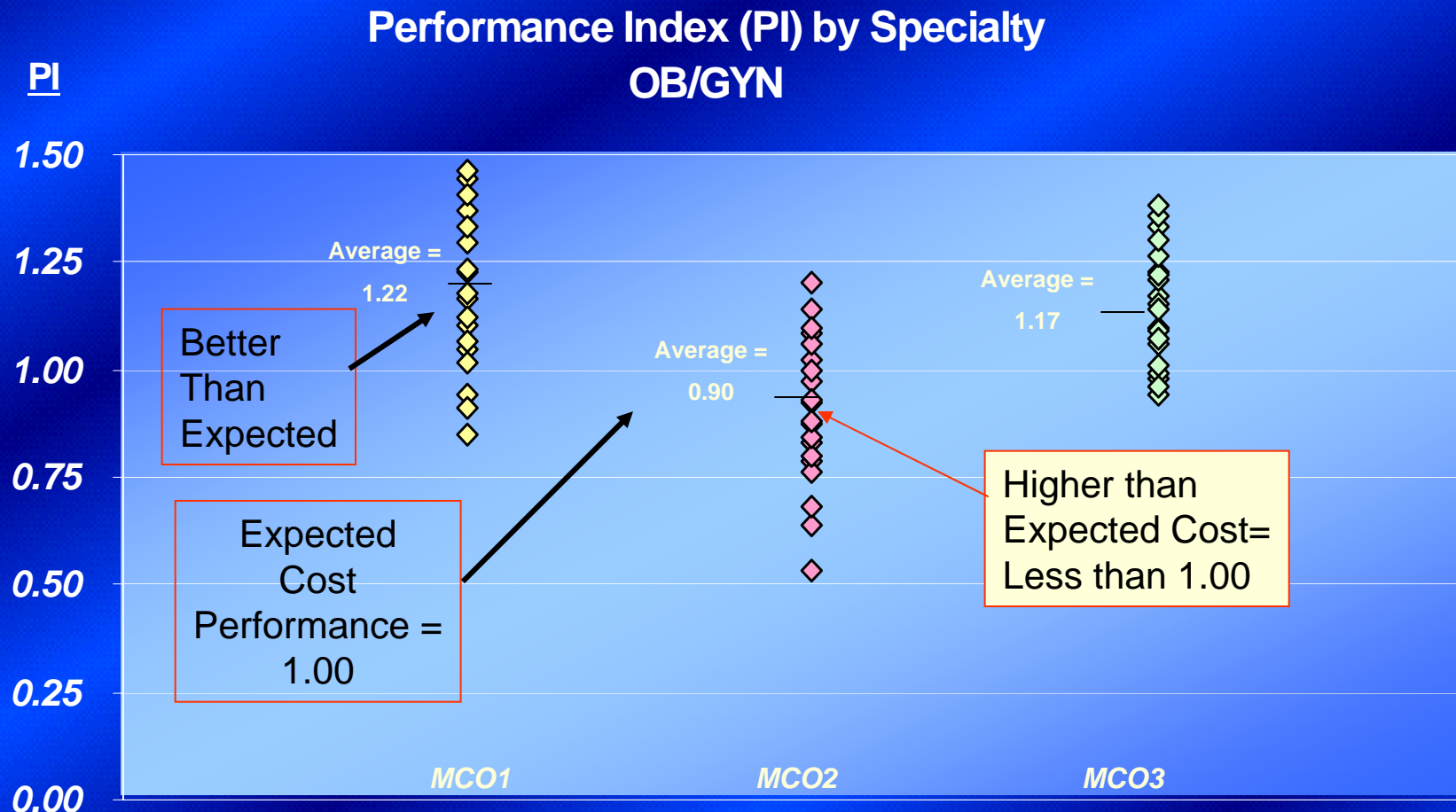
First Anchor: You visit your Primary Care Physician for sinusitis. He gives you a prescription and orders blood work. He is concerned that you have a history of sinus infections, so he refers you to an ENT. The PCP visit becomes the first anchor and, because it has been more than 60 days since you have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



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

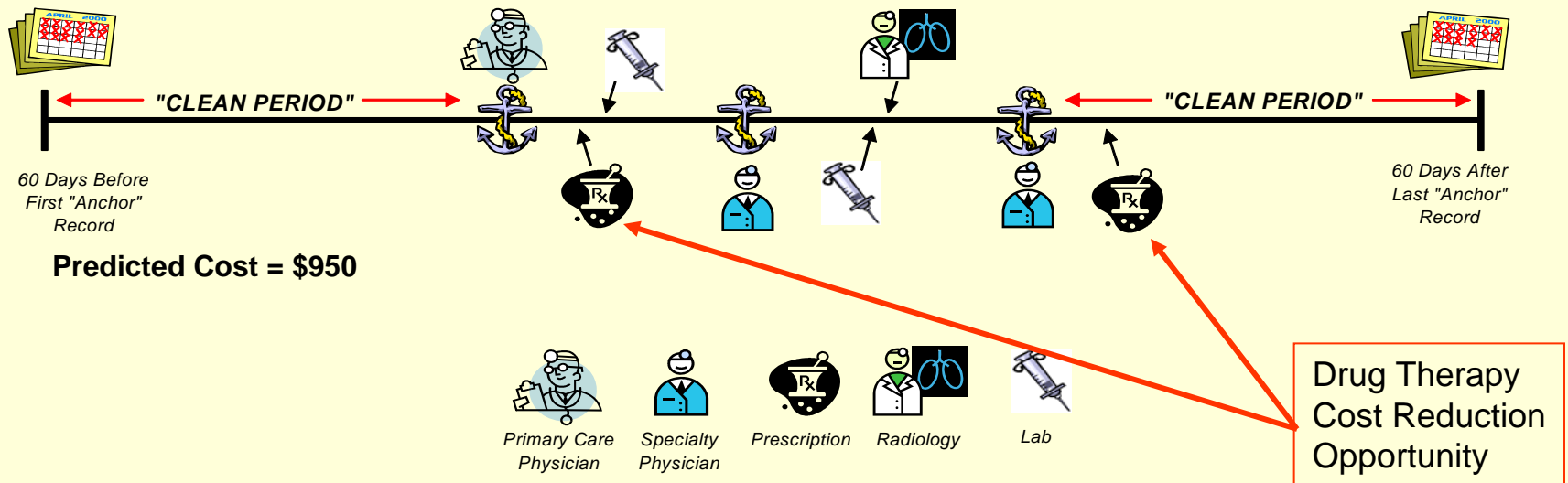
The Patient and Provider Quality Improvement and Cost Containment Alignment as the Essential Driver of Health System Transformation



Individual Patient Episode of Care Life Cycle Tracked through an EHR

Outcome Cost = \$1,020

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.

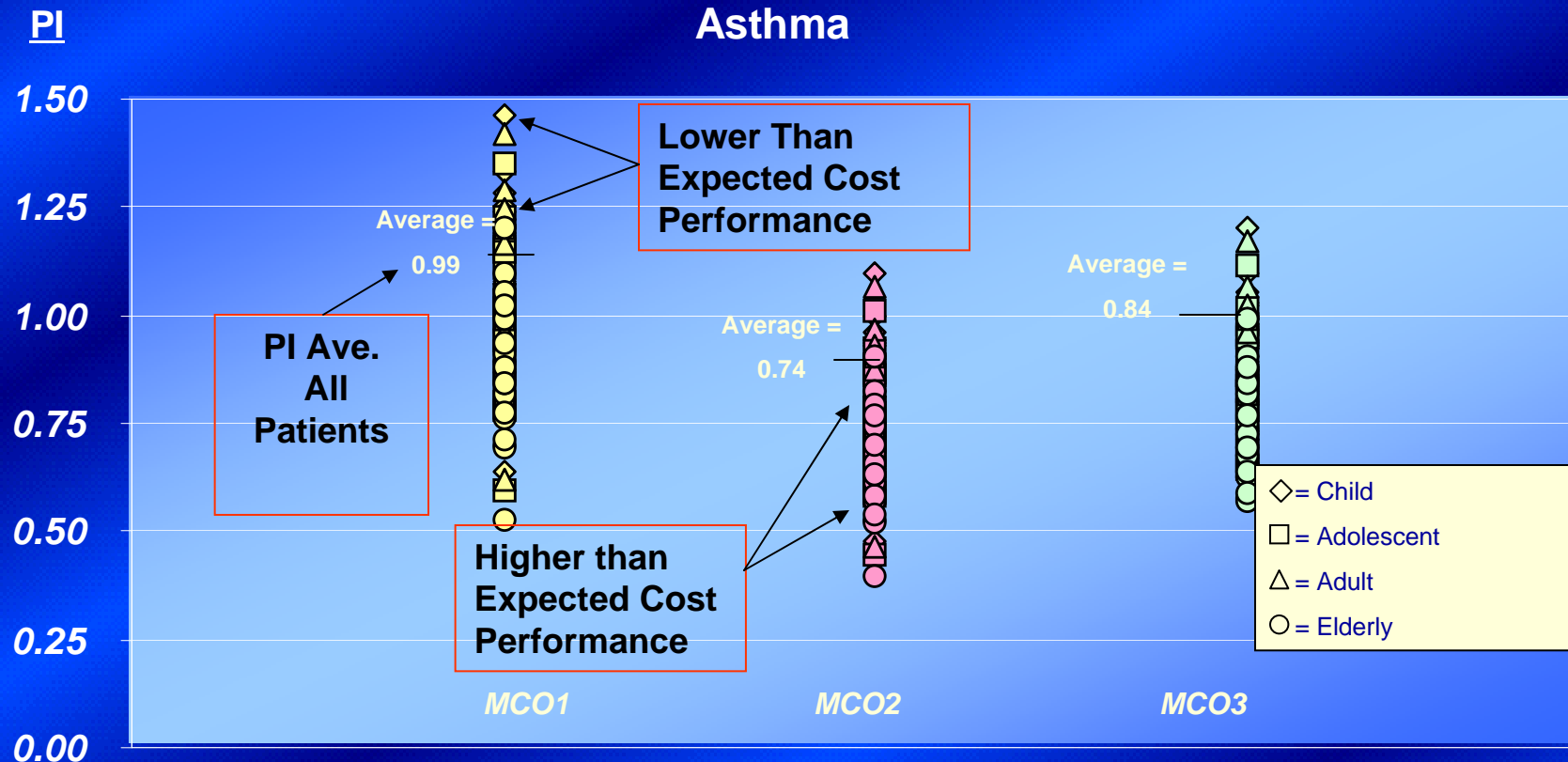
Second Anchor: You visit the ENT. She orders a sinus X-ray and more blood work. You schedule a follow-up appointment. The ENT visit, X-ray and lab work form another cluster within the same episode.

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: Performance by Disease by Patient (Asthma)

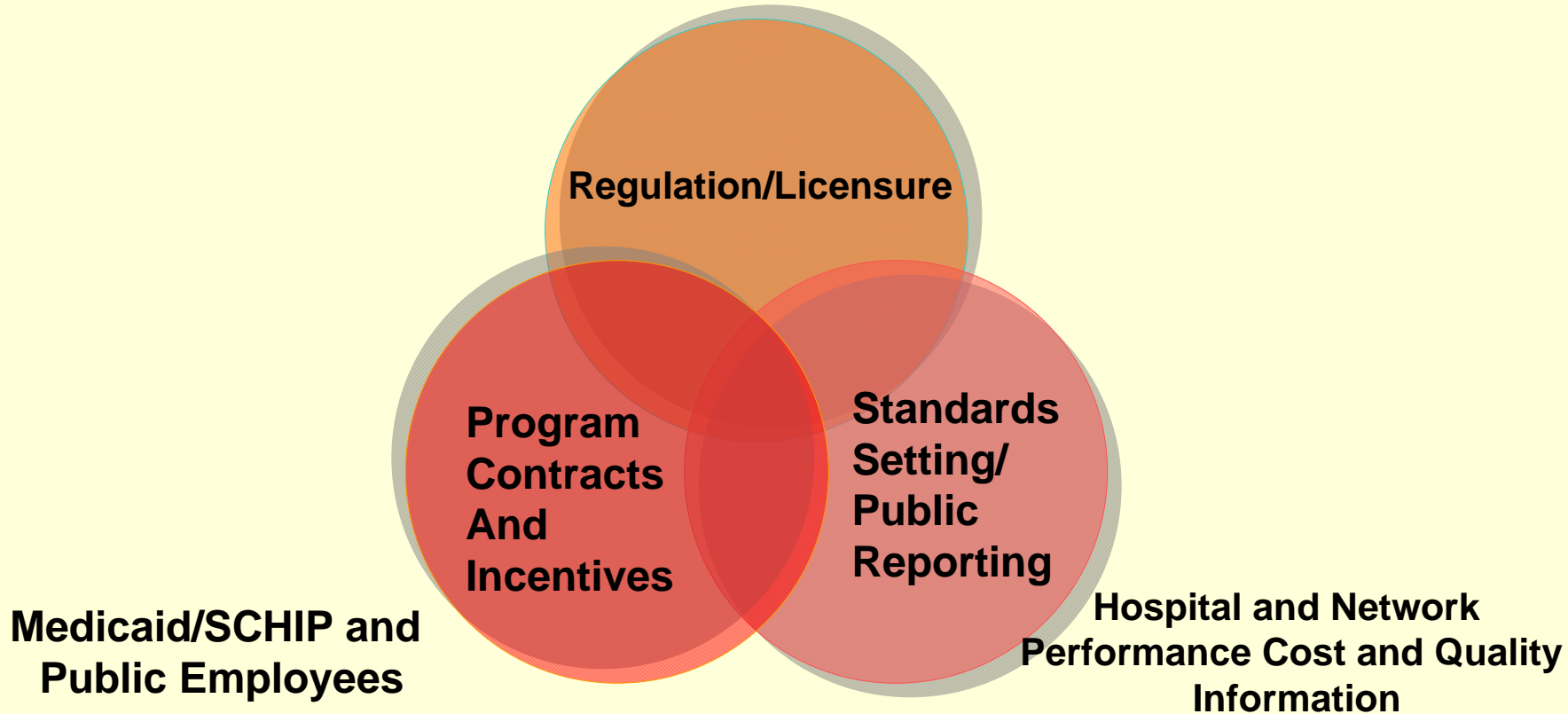
Performance Index (PI) by Disease
Asthma



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

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

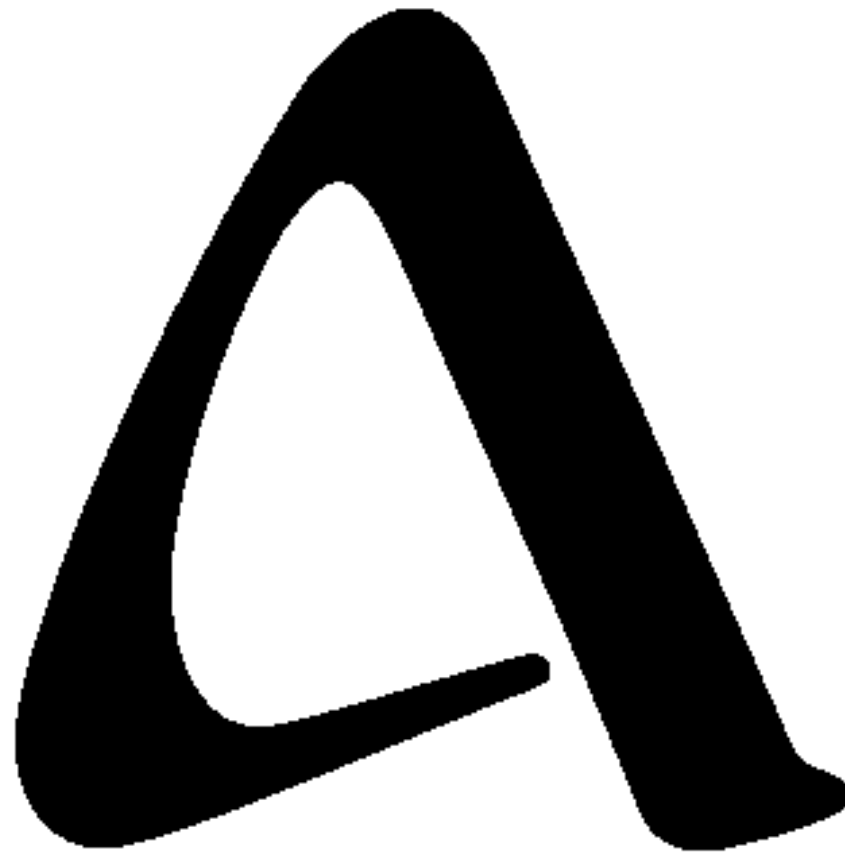
- **Regulation**
- **Licensure**
- **Public Reporting**
- **Setting Standards**
- **Medicaid and SCHIP Program Contracting**
- **Public Employee Health Care Contracts**

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



AHCCCS

Our first care is your healthcare