

ROADMAP TO QUALITY AND VALUE: ONE HEALTH PLAN'S PERSPECTIVE



Objectives of this talk:

By end of the session you will explore,

- Building blocks of Quality
- Drivers of Quality
- Strategies to achieve your Quality goals

Building Blocks of Quality

Consumer Assessment of Healthcare Providers and Systems

CAHPS

- A series of patient surveys rating health care experiences in the United States.
- Conducted annually since 1995, are available to the public and focus on consumer satisfaction from the enrollees' perspective. Include domains such as communication with doctors, care coordination, access to care and customer information.
- Questions roll up to inform the answer of two main questions: How do you rank your health plan, how do you rank your health care (or how do you rank your hospital-HCAPHS
- CAHPS surveys are funded and overseen by the [Agency for Healthcare Research and Quality \(AHRQ\)](#), a government organization.
- There is CG-CAHPS (provider group level), H-CAHPS (Hospital level) and CAHPS (plan level)

Healthcare Effectiveness Data and Information Set

HEDIS

- Used by 90% of America's health plans
- Managed by NCQA
- Measures dimensions of care and services
- 92 measures across 6 domains
- Allows "apples to apples" value based comparison of performance
- Reported annually in June, final audited rates based on prior calendar year's dates of service.
- New and revised HEDIS specifications (including revised codes and medical record documentation) are distributed in August of the calendar year.
- Current calendar year revised benchmarks released in late summer of the current calendar year

Types of HEDIS Data Collection methods

HEDIS measures are specified for one or more data collection methods:

- Administrative (gathered from claims, encounter, enrollment and provider systems).
- Hybrid (gathered from administrative and medical record data).
- Survey (gathered from a survey).
- Electronic Clinical Data Systems (ECDS) (gathered from electronic databases).

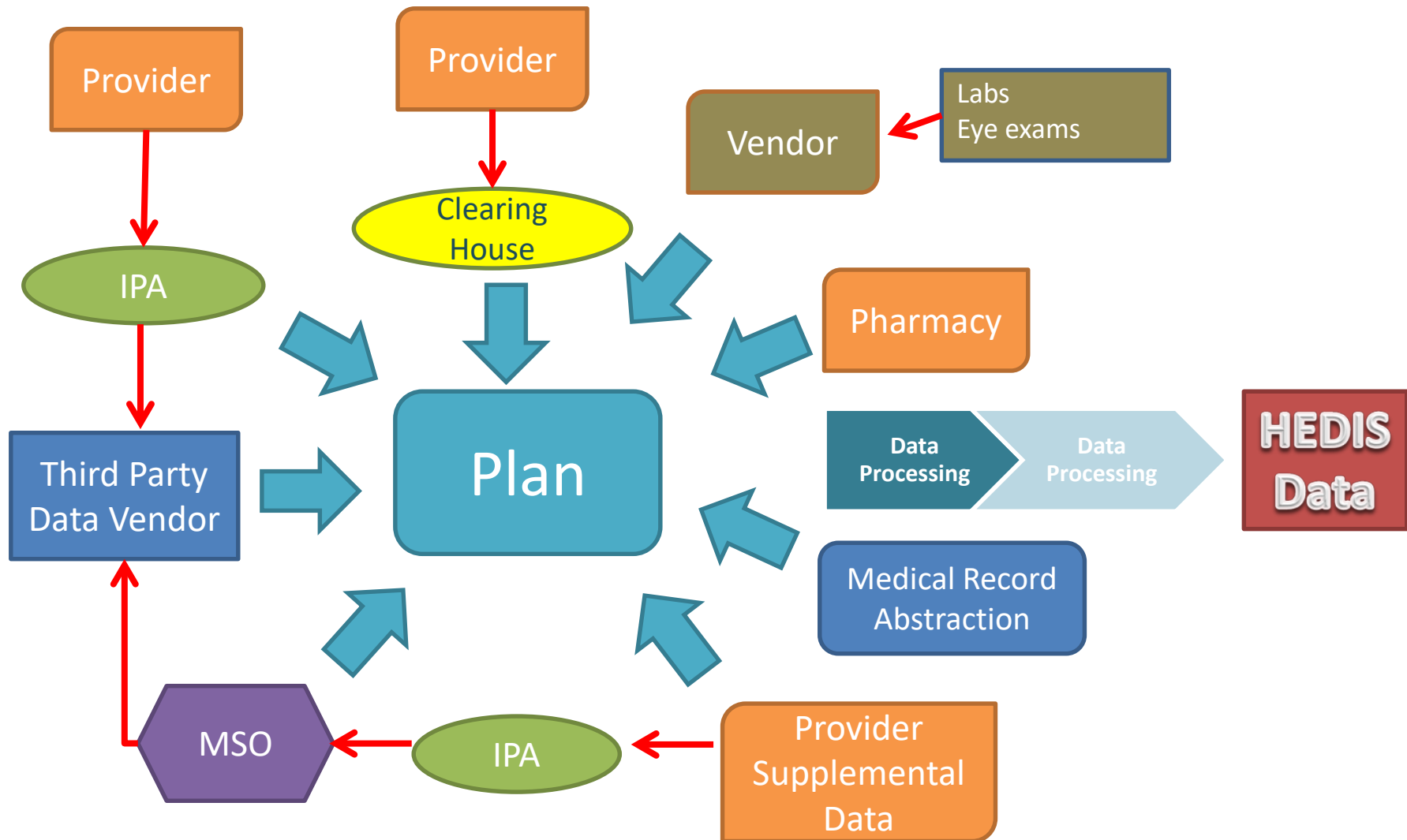


The HEDIS data collection is built on a set of standards: ICD10, CPT, LOINC, HL7, etc
The NCQA technical specifications and Value Sets have all the current information

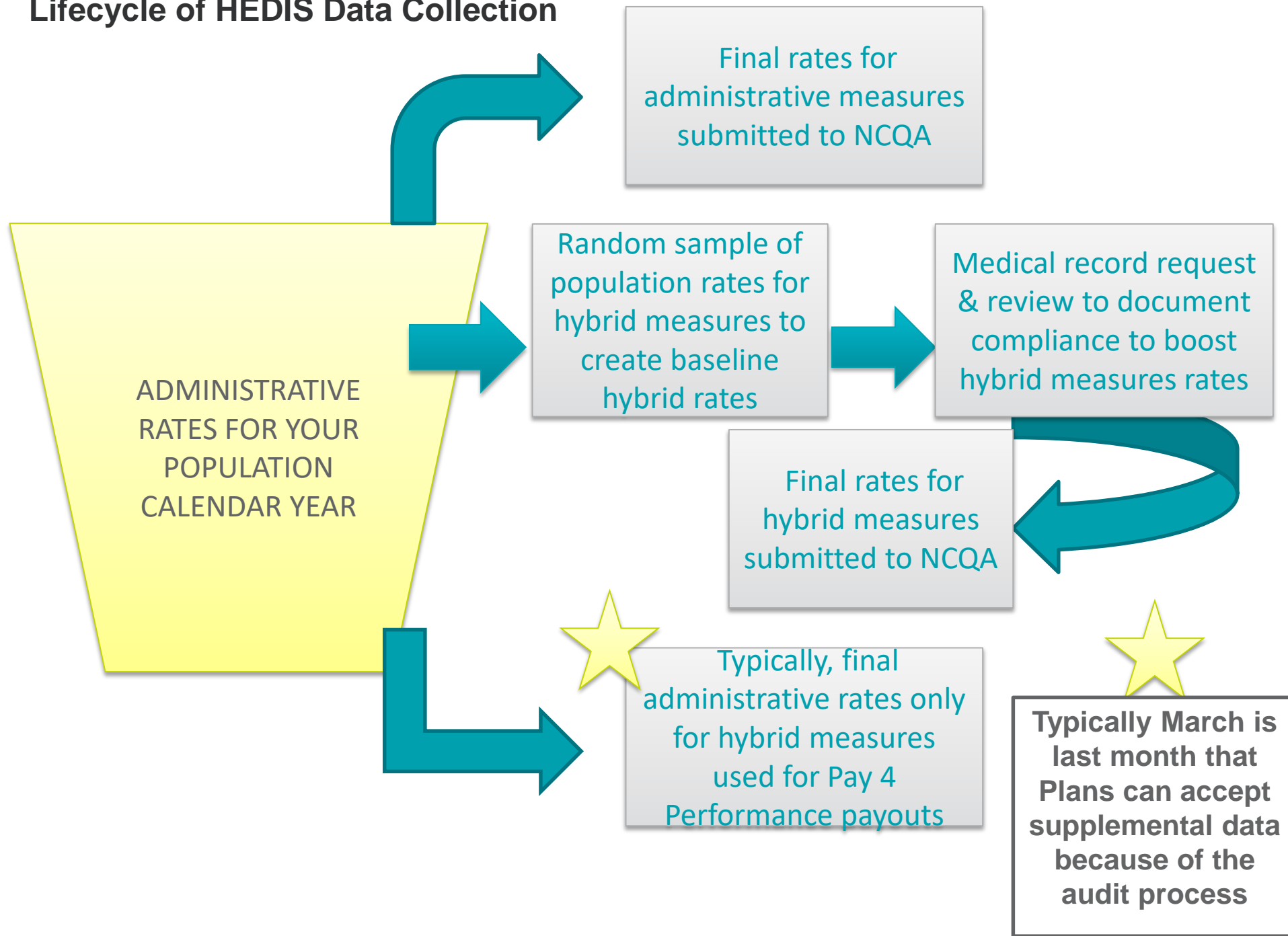
Key Questions:

- ✓ How do my patients get into the denominator of a measure:
 - ✓ What is the denominator eligibility criteria?
 - ✓ Does my denominator match the health plans?
 - ✓ Does my EMR have the right denominator so I can flag?
- ✓ What is the “VALUE SET” (set of standard codes) that makes my measure compliant?
- ✓ Does my EMR have the right codes? Is my biller coding correctly?
- ✓ What are the anchor dates (start and end dates for the measure)?
- ✓ What should be documented in my medical records for numerator compliance?

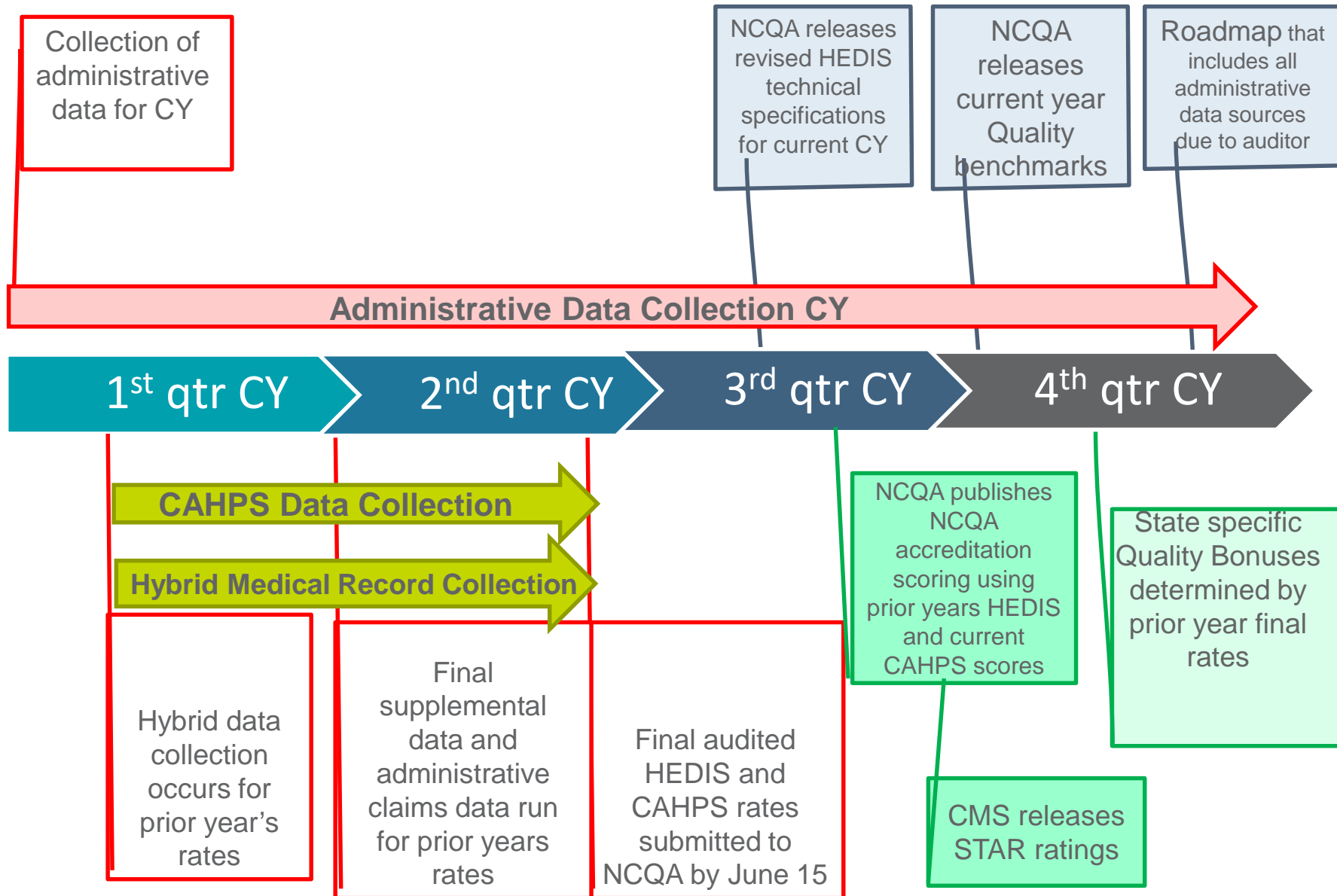
Health Information Management Flow



Lifecycle of HEDIS Data Collection



Lifecycle of Quality

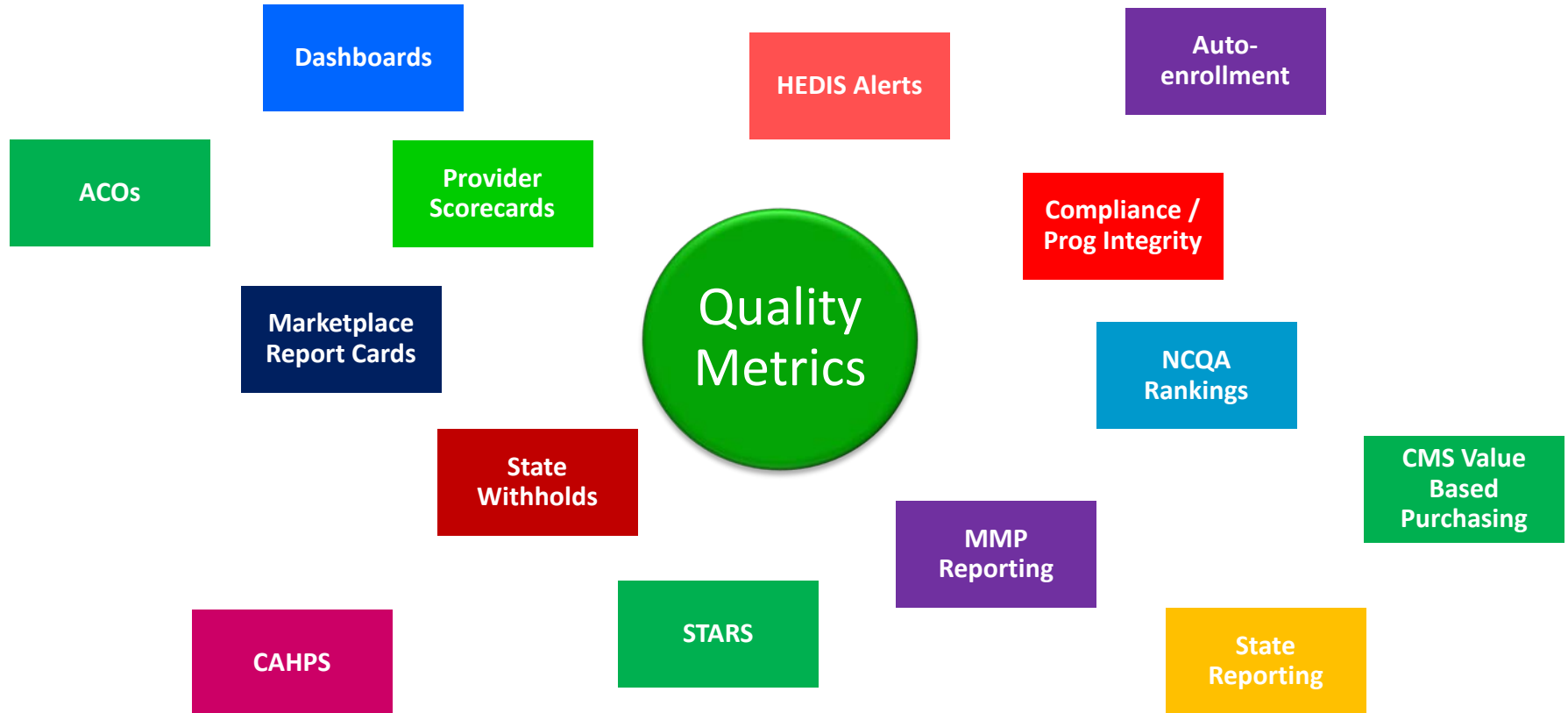


Drivers of Quality



How Quality Data impacts an organization

Patient care: Are patients getting the right care?

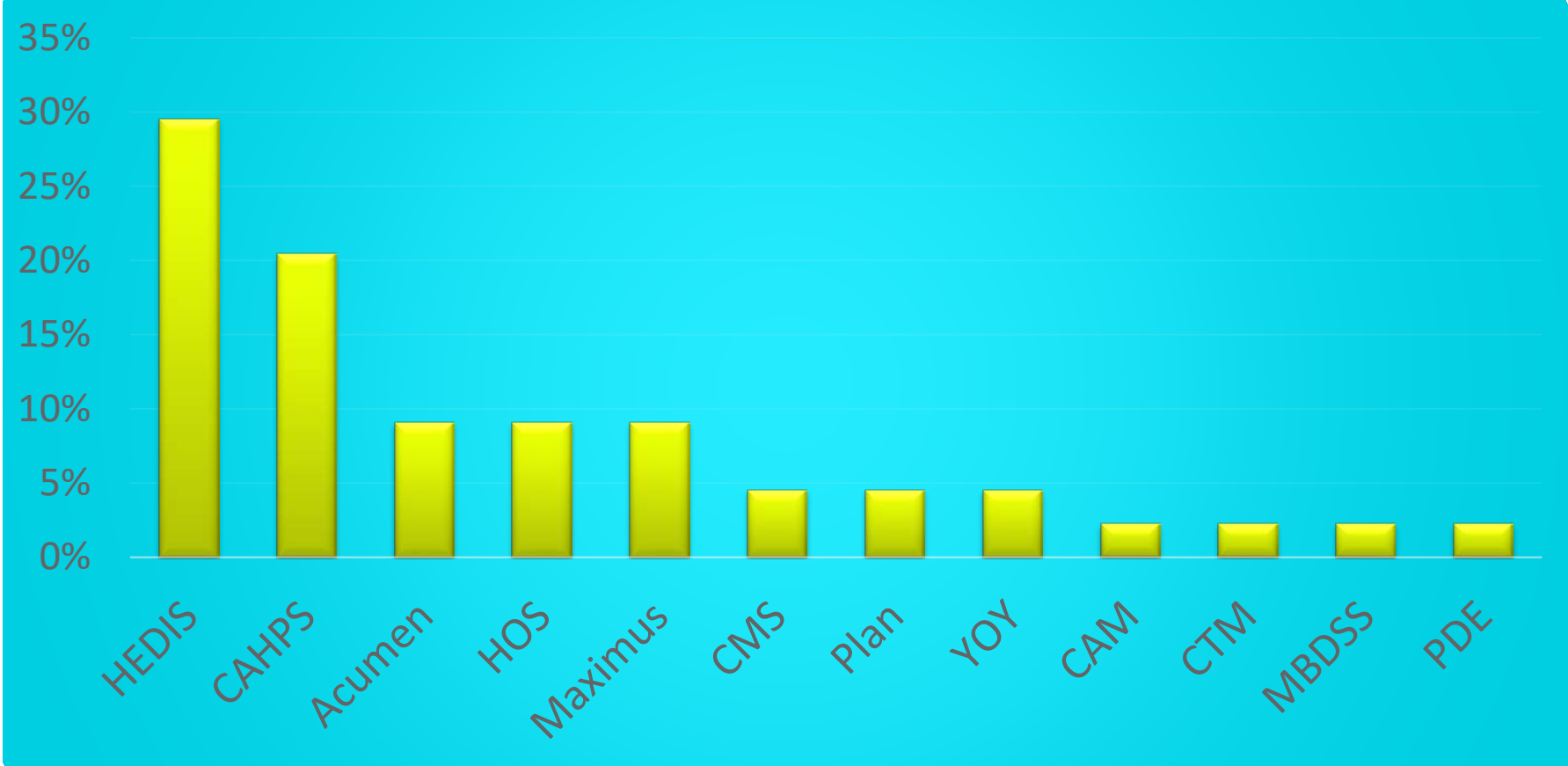


Stars Measure Areas

- Part C – Medical
 - HEDIS
 - CAHPS
 - HOS
 - Care Management
 - Quality Improvement
 - Operations/Audit
- Part D – Pharmacy
 - Operations/Audit
 - Quality Improvement
 - CAHPS
 - MPF Price Accuracy
 - High Risk Medications
 - Medication Adherence
 - MTM Completion Rate

**50% of Stars rating due to HEDIS
and CAHPS selected scores**

Overall Impact by Source



Weights

Weight	Part C	Part D
5	<ul style="list-style-type: none"> Health Plan Quality Improvement 	<ul style="list-style-type: none"> Drug Plan Quality Improvement
3	<ul style="list-style-type: none"> Improving or Maintaining Physical Health Improving or Maintaining Mental Health Diabetes Care – Blood Sugar Controlled Controlling Blood Pressure Plan All-Cause Readmissions 	<ul style="list-style-type: none"> High Risk Medication Medication Adherence for Diabetes Medications Medication Adherence for Hypertension (RAS antagonists) Medication Adherence for Cholesterol (Statins)
1.5	<ul style="list-style-type: none"> Getting Needed Care Getting Appointments and Care Quickly Customer Service Rating of Health Care Quality Rating of Health Plan Care Coordination Complaints about the Health Plan Members Choosing to Leave the Plan Beneficiary Access and Performance Problems Plan Makes Timely Decisions about Appeals Reviewing Appeals Decisions Call Center – Foreign Language Interpreter and TTY Availability 	<ul style="list-style-type: none"> Call Center – Foreign Language Interpreter and TTY Availability Appeals Auto–Forward Appeals Upheld Complaints about the Drug Plan Members Choosing to Leave the Plan Beneficiary Access and Performance Problems Rating of Drug Plan Getting Needed Prescription Drugs

Weights Continued

Weight	Part C	Part D
1	<ul style="list-style-type: none"> Breast Cancer Screening Colorectal Cancer Screening Annual Flu Vaccine Monitoring Physical Activity Adult BMI Assessment Special Needs Plan (SNP) Care Management Care for Older Adults – Medication Review Care for Older Adults – Functional Status Assessment Care for Older Adults – Pain Assessment Osteoporosis Management in Women who had a Fracture Diabetes Care – Eye Exam Diabetes Care – Kidney Disease Monitoring Rheumatoid Arthritis Management Reducing the Risk of Falling 	<ul style="list-style-type: none"> MPF Price Accuracy MTM Program Completion Rate for CMR

Complaints about the Health Plan, Members Choosing to Leave the Plan, and Beneficiary Access and Performance Problems are in both Part C and Part D, but only count once in the Overall score.

CA Dept of Health Care Services Measures and Goals

Medi-Cal HEDIS Measures: External Accountability Set

1. Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB)
2. Annual Monitoring for Patients on Persistent Medication (ACE/ARB) (MPM-ACE)
3. Annual Monitoring for Patients on Persistent Medication (ACE/ARB) (Diuretics)
4. Asthma Medication Ratio (AMR)
5. Breast Cancer Screening (BCS)
6. Cervical Cancer Screening (CCS) *
7. Childhood Immunizations (CIS) CO3 *
8. Controlling Blood Pressure (CBP) *
9. Depression Screening and Follow-up (DSF)
10. Diabetes Care (MEDICAID) - HbA1c > 9.0% (CDC)
11. Diabetes HbA1c - < 8.0% (CDC)
12. Diabetes HbA1c Test (CDC) *
13. Diabetes Nephropathy Test (CDC-N)
14. Diabetes Retinal Eye Exam (CDC-E)
15. Diabetes Controlling Blood Pressure (CDC-BP)
16. Immunizations for Adolescents (IMA-2)
17. Low Back Pain (LBP)
18. Prenatal Care Timeliness (PPC) *
19. Postpartum Care (PPC)
20. Weight Assessment and Counseling- Nutrition (WCC)
21. Weight Assessment and Counseling- Physical Activity (WCC)
22. Well Child Visits 3-6 Years (W34) *

State Goals

Auto-enrollment

1. 6 measures (red) contribute to increase or decrease in auto-enrollment by county

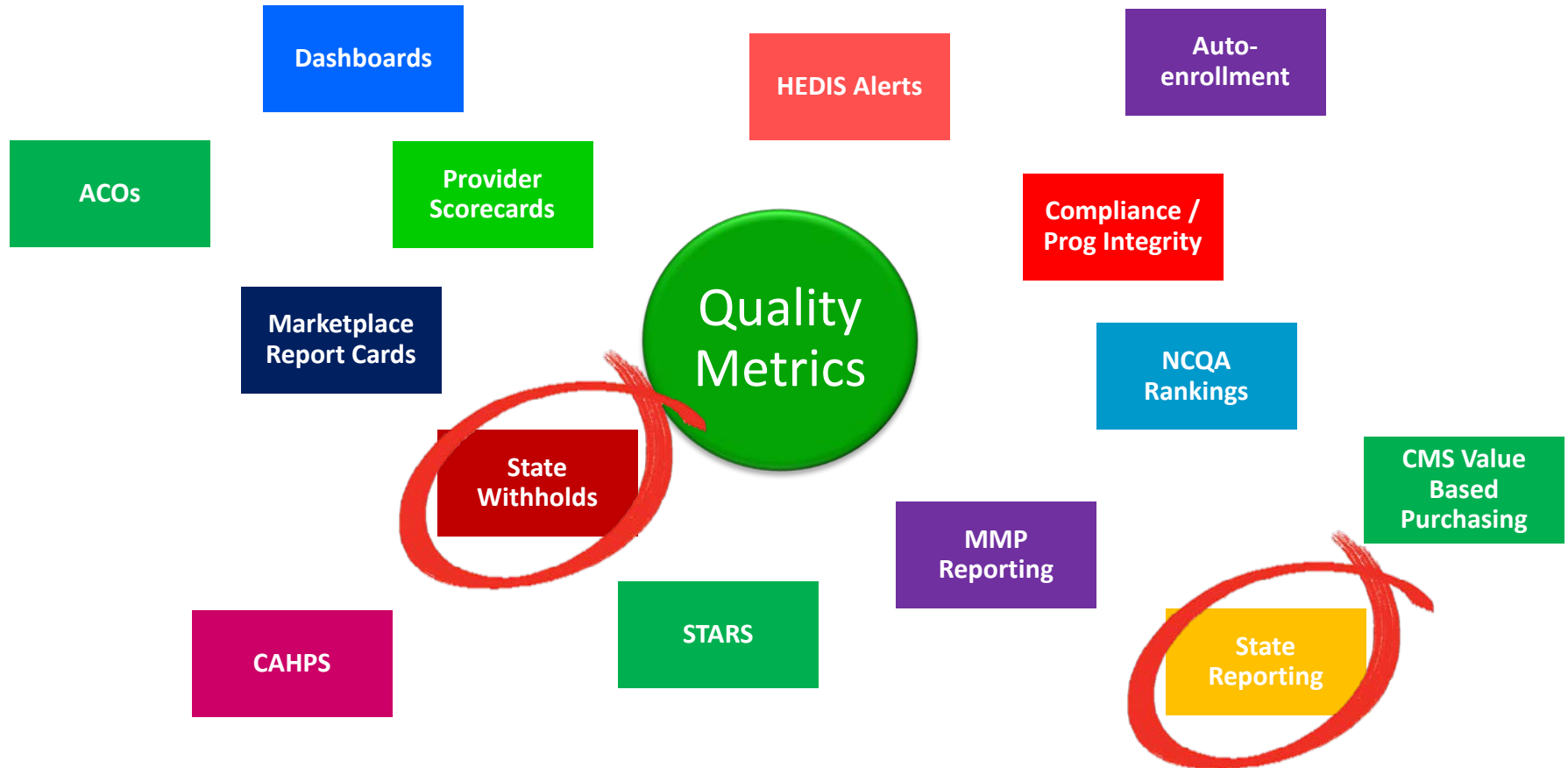
State reporting

1. Minimum 25th NCQA percentile for reportable measures by county
2. Uses current NCQA percentiles
3. State reporting.
4. Three measures in one county under the 25th percentile three years in a row triggers a CAP
5. Over 50% of measures below the 25th NCQA percentile in one region triggers a CAP

CMS final rule

1. CMS final rule selected Health Disparity measures to set goals to improve

How Quality Data impacts an organization



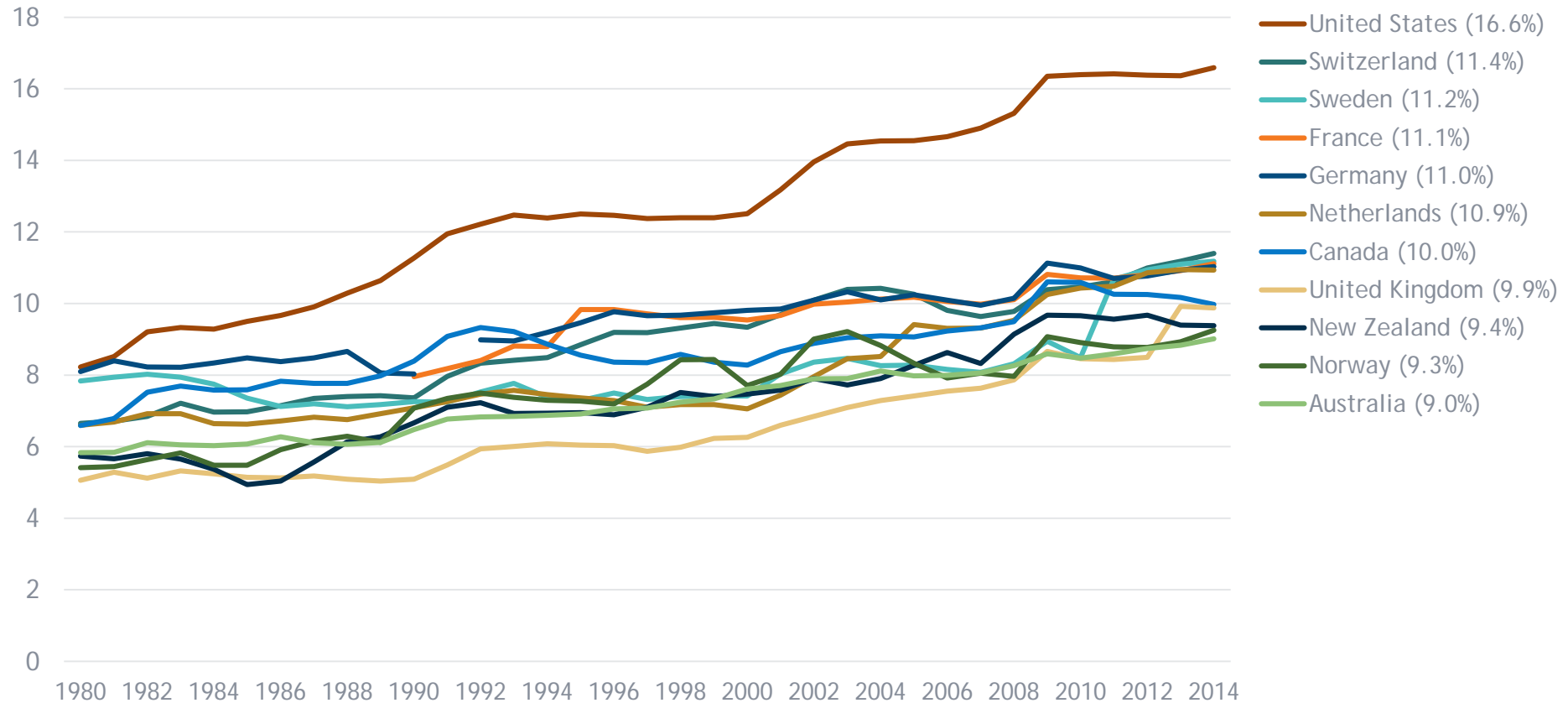


The forces that have led to a global epidemic of overtesting, overdiagnosis, and overtreatment are easy to grasp. Doctors get paid for doing more, not less. We're more afraid of doing too little than of doing too much. And patients often feel the same way. They're likely to be grateful for the extra test done in the name of "being thorough"—

Overkill, Atul Gawande, The New Yorker, 2015

Health Care Spending as a Percentage of GDP, 1980–2014

Percent

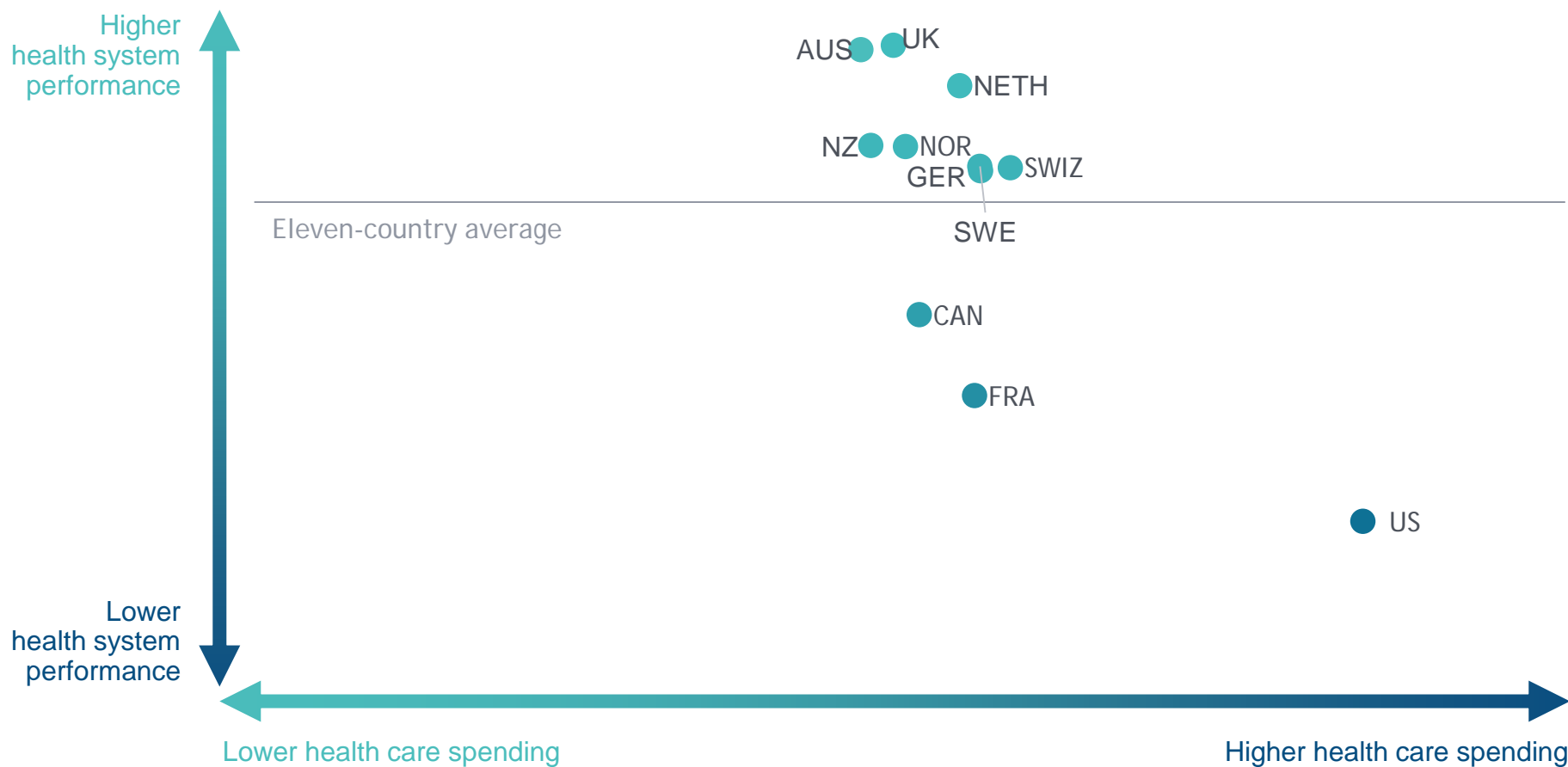


GDP refers to gross domestic product. Data in legend are for 2014.

Source: OECD Health Data 2016. Data are for current spending only, and exclude spending on capital formation of health care providers.



Health Care System Performance Compared to Spending



Note: Health care spending as a percent of GDP.

Source: Spending data are from OECD for the year 2014, and exclude spending on capital formation of health care providers.



A health system that provides better care, spends dollars more wisely, and has healthier people

Focus Areas	Description
INCENTIVES	<ul style="list-style-type: none">▪ Promote value-based payment systems<ul style="list-style-type: none">– Test new alternative payment models– Increase linkage of Medicaid, Medicare FFS, and other payments to value▪ Bring proven payment models to scale▪ Align quality measures
CARE DELIVERY	<ul style="list-style-type: none">▪ Encourage the integration and coordination of clinical care services▪ Improve individual and population health▪ Support innovation including for access
INFORMATION	<ul style="list-style-type: none">▪ Bring electronic health information to the point of care for meaningful use▪ Create transparency on cost and quality information▪ Support consumer and clinician decision making



CMS committed to value based payment goals

Year	Program Implemented
2012	Accountable Care Organizations
2012	Hospital Value Based Purchasing Program (HBVP)
2012	Hospital Readmission Reduction Program (HRRP)
2014	Hospital Acquired Condition Reduction Program (HACRP)
2016	Medicare/Medicaid Plan (MMP) Quality Withhold
2016	Medicaid Quality Withhold Programs
2018	Skilled Nursing Facility Value Based Purchasing Program
2019	Alternative Payment Models (APM)
2019	Merit-Based Incentive Payment System (MIPS)

Source: Burwell SM. Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.

Example of a Quality Withhold

1.5% annual premium withhold: payback dependent Quality final scores

Table 6
Measure Weights, Target Measure Scores and Mean Measure Scores for PY 2018

	Quality Measure	Quality Measures Description	Measure Weight w(l)	Target Measure	Mean Measure
Adult Measures	CDC	Comprehensive Diabetes Care - Poor HbA1c Control (>9%)	14.29%	70.77%	54.65%
	CDC	Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	14.29%	75.73%	59.04%
	CBP	Controlling High Blood Pressure (<140/90)	14.29%	70.69%	54.74%
	AMM	Antidepressant Medication Management –Effective Acute Phase Treatment	7.14%	67.57%	54.45%
	AMM	Antidepressant Medication Management - Effective Continuation Phase Treatment (6 Months)	7.14%	54.3%	39.44%
Pediatric Measures	CIS	Childhood Immunization Status - Combo 10	14.29%	46.47%	33.24%
	W34	Well-child visits in the 3rd, 4th, 5th and 6th years of life	14.29%	82.97%	71.27%
	MMA	Medication Management for people with Asthma: Medication Compliance 75% (Ages 5-11)	7.14%	41.18%	28.33%
	MMA	Medication Management for people with Asthma: Medication Compliance 75% (Ages 12-18)	7.14%	37.63%	26.33%

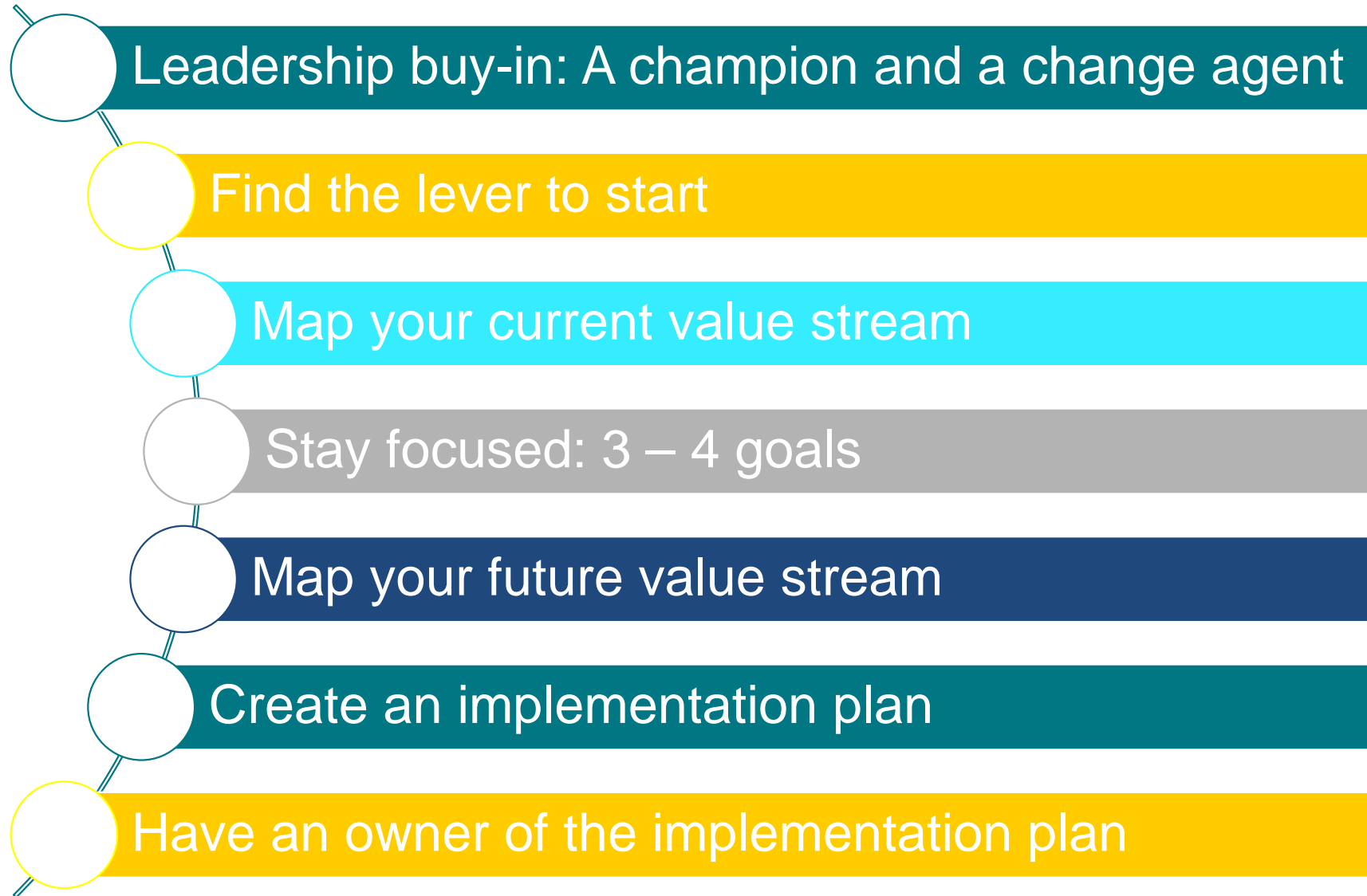
Path to Execution

- Getting patients in for the right care at the right time at the right cost
- Accurate and complete data documentation and flow



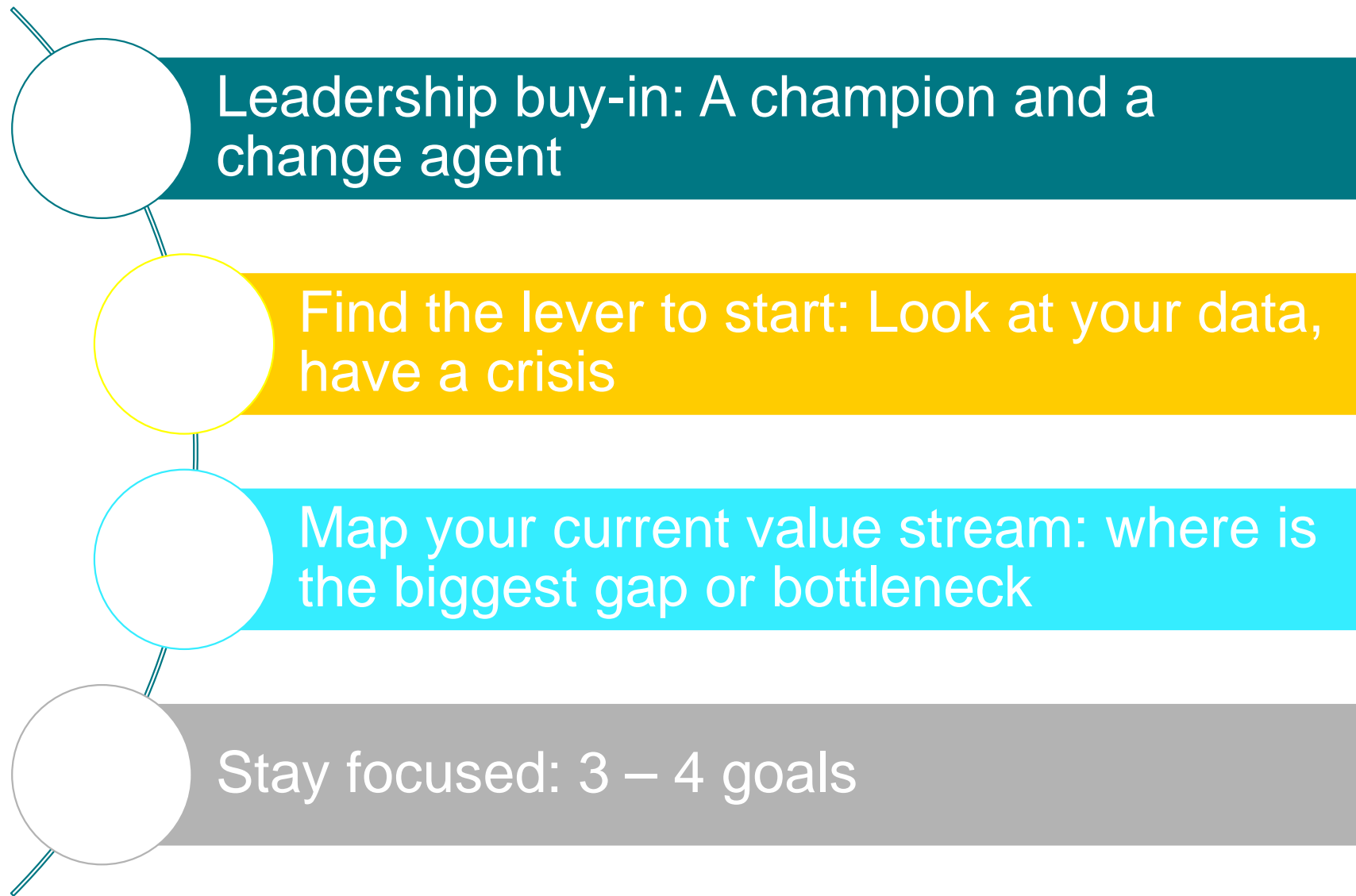
Building a Culture of Quality=Building a Culture of Excellence

LEADERSHIP AND OPERATION PLAN



Building a Culture of Quality=Building a Culture of Excellence

LEADERSHIP



Building a Culture of Quality=Building a Culture of Excellence

OPERATION PLAN



The diagram consists of three circles arranged vertically, connected by lines. The top circle is white with a teal outline and is connected to a teal rectangular box. The middle circle is white with a yellow outline and is connected to a gray rectangular box. The bottom circle is white with a yellow outline and is connected to a yellow rectangular box. Each box contains a step in the operation plan.

Map your future value stream, find the gaps

Create an implementation plan that includes data collection, monitoring and milestones

Have an owner of the implementation plan

Questions?



Building Alignment

Create a use case communication strategy

Communication strategy tips

Decision Makers: Who are the decision makers? Who needs to hear this?

Goal Clarity: What is the problem that we are solving? Why does it matter?

Urgency: Why now? Cost of not taking action.

Solution and Research: What is your solution? How has the strategy been vetted? What is the proposed return on investment?

Call to Action: Create the path. What do you expect or need your audience to do?