Using Medicare Star Ratings & HEDIS Scores To Develop New Opportunities With Health Plans

June 2016
Session Agenda

- Welcome
- Pharmacy perspective - “Moving to Value based reimbursement”
  - Melissa Odorzynski – Genoa
- Health Plan perspective – “Implementing Health Plan and Provider Medicare Star Rating Improvement Collaborative Programs”
  - Tom Lindquist - Molina of South Carolina
- Community Health Clinic perspective – “Provider / Health Plan Partnerships to improve quality while decreasing overall cost of care”
  - Orville Mercer – Chestnut Health Systems
- Panel discussion and Q/A
Company Overview

Overview

- Genoa is the largest pharmacy operator in the United States specialized in serving the needs of the behavioral health community
  - Manages complex and chronic mental illnesses through a combination of specialty pharmaceuticals and high touch patient care
  - Full service pharmacy dispenses mental health and primary care medications
- Partners with Community Mental Health Centers (CMHCs) to provide an “on-site” integrated, consumer experience
  - High touch pharmacy service model working in conjunction with CMHC providers
  - Overall pharmacy design is customized based on needs of CMHC
Who we serve: Consumers with behavioral healthcare needs and complex conditions

Genoa services are designed to be customized and integrated within an individual’s overall plan of care

**Most Severe**
- Hospital
- Residential

**Severe**
- Residential
- Intensive Case Management
- ACT/PACT/FACT
- Community Support Services (CSS)

**Moderately Severe**
- Case Management, CSS
- Higher ratio of staff to clients
- Services vary greatly on need

**Outpatient**
- Psychiatry and Medication Management
  - Key Services: Prior authorization, data, mail/delivery, convenience refill synchronization, call center, reminder calls
  - Telepsychiatry to reduce wait times

Level of independence will lead to a different mix of services based on consumer needs and preferences

Key Pharmacy and Telepsychiatry Services:
- eMARs, blister card packaging, delivery, med carts, consulting, Pyxis
- 24/7 ER Psychiatry Triage Telemedicine Services
Genoa provides pharmacy and telepsychiatry services in 41 states and the District of Columbia

State | Number of Pharmacies
--- | ---
Indiana | 27
Ohio | 26
Arizona | 24
Illinois | 14
Florida | 13
Georgia | 12
Minnesota | 12
Missouri | 12
Kansas | 11
Michigan | 11
Pennsylvania | 11
Washington | 11
Connecticut | 10
Tennessee | 9
Texas | 8
Virginia | 8
Colorado | 7
Wisconsin | 7
Alabama | 6
Louisiana | 6
New Jersey | 6
North Carolina | 6
Rhode Island | 6
Other | 30
**Total Pharmacies** | **293**

Note: Pharmacy count as of 4/1/2016
Shift from Fee-for-service to Performance-based Models
Focus on Quality and Performance

- HEDIS Measures
- Star Ratings
- More fully at-risk payors
- Medicaid movement towards Managed Care

The Star Ratings measures span five broad categories:
- Outcomes
- Intermediate Outcomes
- Patient Experience
- Access
- Process

What the “Star” Ratings Mean

<table>
<thead>
<tr>
<th>Star Rating</th>
<th>Plan Quality Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>★★★★★</td>
<td>Excellent</td>
</tr>
<tr>
<td>★★★</td>
<td>Above Average</td>
</tr>
<tr>
<td>★★★</td>
<td>Average</td>
</tr>
<tr>
<td>★★</td>
<td>Below Average</td>
</tr>
<tr>
<td>★</td>
<td>Poor</td>
</tr>
</tbody>
</table>

Adherence Metrics: PDC vs. MPR

- **Our services have been specifically designed to improve adherence**
- **Genoa has been tracking for over 10 years**

### PDC: Proportion of Days Covered
- **PDC = Number of Days in Period “Covered” by Medication / Number of Days in Period**
  - The PDC examines each day in the report period to determine if the consumer was “covered”; meaning did they have the medication on hand
  - When PDC is used within a performance reporting program, the “adherence rate” that is reported reflects the percent of patients who achieved a high level of adherence to the target class of drugs

### MPR: Medication Possession Ratio
- **MPR = Days’ Supply Provided/Days Between Fills**
- The MPR is the ratio of how many days’ supply of a medication a consumer was given compared to the total number of days between fills of the medication

### Comparison: PDC vs. MPR
- The PDC and MPR will provide nearly identical results when examining adherence to a single drug
- PDC provides a more conservative estimate of adherence compared to MPR when consumers are switching drugs or using dual-therapy in a class because the PDC value cannot be higher than 1.0 or 100%, where MPR can

*Data from http://www.pqaalliance.org/images/uploads/files/PQA%20PDC%20vs%20MPR.pdf*
National Quality of Care Concerns

- More than half of Medicaid beneficiaries with disabilities have a behavioral health disorder.
- 80 percent of beneficiaries with schizophrenia or bipolar disorder received psychiatric medications during the year, but only about half maintained a continuous supply of those medications.

**Improving Medicaid Behavioral Health Care**

- **Monitor care**
  - Use data to assess trends and disparities in care

- **Develop quality measures**
  - Fill gaps in measurement to inform quality improvement

- **Identify innovative care models**
  - Determine the key ingredients of care coordination and integration
Presentation Learning Objectives

• Understand more about HEDIS and Key Medicare Star Rating Concepts
• Consider key factors in implementing effective collaborations
• Review real-life health plan improvement collaborative case studies
• Evaluate lessons learned and strategies for implementation
Who is Molina Healthcare

Founded in 1980 by Dr. C. David Molina

Single clinic

Commitment to provide quality healthcare for those most in need and least able to afford it

Fortune 500 company that touches over 4.5 million Medicaid beneficiaries

16 states & 2 Territories
Who We Are: Molina Healthcare

• Molina Healthcare, Inc. (MOH) is a Fortune 500, publicly traded company focused on providing quality care to members in government-sponsored programs.

• Molina focuses on members with health and psychosocial challenges through its Medicaid, Medicare dual Special Needs Plan, Medicare-Medicaid Demonstration Plan, and Marketplace products.

• State Health Plans operate with Corporate oversight and leadership.
Our Footprint Today

Health plan footprint includes 4 of 5 largest Medicaid markets

1. Total enrollment relates to effective membership as of June 30, 2015
Key Concepts: HEDIS & Medicare Star Ratings
What is HEDIS?

• The Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of performance measures developed by the National Committee for Quality Assurance (NCQA).

• Used by more than 90 percent of health plans to assess important aspects of care and service provided to members.

• Allows consumers to compare the performance of health plans on an “apples-to-apples” basis.

• HEDIS® results used to identify where to focus quality improvement efforts.

• Measures include acute care, preventive care, chronic care measures and member experience (satisfaction).

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
How is HEDIS® Data Collected?

• **Administrative data** - claims, encounters, pharmacy, lab
  - Specified ICD-9/ICD-10, CPT, HCPCS, UB Revenue codes are used to identify eligible members.
  - These codes are also used to determine if members received the HEDIS® service.

• **Hybrid data** - administrative data + medical record info
  - Allowed to use administrative data and medical record data for some measures.
  - Random sample of eligible members chosen for each measure.

• **Member survey data** - CAHPS member experience (satisfaction) survey and Medicare Health Outcomes Survey (HOS)
Medicare Star Ratings and HEDIS®

• Medicare members have the option to choose their own Medicare health plan.

• CMS Medicare Star Ratings help members compare quality among health plans. (1= worst to 5=best).

• Five domains
  • Staying Healthy: Screenings, Tests and Vaccines
  • Managing Chronic Conditions
  • Member Experience with Health Plan
  • Member Complaints, Problems Getting Services, & Improvement
  • Health Plan Customer Service

• HEDIS® contributes to about 30% of the Star Ratings score.
## Medicare Star Ratings Measure Everything

<table>
<thead>
<tr>
<th>Part C</th>
<th>Part D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staying Healthy: Screenings, tests and vaccines.</td>
<td>Drug plan customer service</td>
</tr>
<tr>
<td>Managing chronic (long-term) conditions.</td>
<td>Member complaints and changes in the drug plan’s performance</td>
</tr>
<tr>
<td>Member experience with the health plan</td>
<td>Member experience with plan’s drug services</td>
</tr>
<tr>
<td>Member complaints and changes in the health plan’s performance</td>
<td>Drug safety and accuracy of drug pricing</td>
</tr>
<tr>
<td>Health plan customer service</td>
<td></td>
</tr>
</tbody>
</table>
Impact of Star Rating Distribution

Percent Contribution to Star Ratings

- Part C Clinical (HEDIS): 31%
- Survey Measures (CAHPS & HOS): 26%
- Part D Clinical (Med Adherence & Appropriate Prescribing): 18%
- Member experience (Disenrollment, Complaints/CTM, CMS Audit): 6%
- Appeals/IRE: 7%
- Inside Sales Line: 4%
- Performance Improvement: 7%
- Part D Administrative: 1%
Because Star Ratings measure key areas across a health plan, Star Ratings performance depends on all stakeholders – health plan, providers and members.
Role of Provider Services and Contracting

• Case Study
  – A Provider Services Representative learns that a provider’s phone number is disconnected, then updates the provider’s contact information in the online directory.
  – When we publish bad provider information, and a member uses it to try to make an appointment the member loses confidence in Molina.
  – Worse, the member often gives up and doesn’t get needed care.

Measures potentially impacted: member satisfaction measures, complaints, and disenrollment.
Role of Case Manager

• Case Study
  – A Health Plan or Physician Office Case Manager prepares to call a health plan member/patient. He/she notices that the individual has high blood pressure. There is a Medicare Star Rating measure related to medication adherence for this condition.
  – The Case Manager asks if the member is having trouble taking their medications. The member responds yes.
  – He/she refers the member to the health plan Pharmacy team for:
    • Medication counseling (purpose of medications, side effects)
    • Discussion about changing prescription fills to 90-day/Mail order
    • Delivery of pill boxes
    • Pursuit of additional strategies for medication adherence

Measures potentially impacted: member satisfaction measures, Controlling High Blood Pressure, and medication adherence.
Medicare Star Ratings Improvements

Collaborating with Providers to Improve Medicare Star Ratings
Select a topic that is critical for the health plan’s Star Ratings improvement.

Ensure that the interventions are based on strong clinical evidence.

Engage providers in implementation through ongoing feedback, barrier identification and measurement.

Re-measure to determine effectiveness.

Modify interventions to address barriers and drive improvement.
Molina Healthcare Case Studies

Implementing Multi-faceted and Effective Provider Improvement Collaboratives
Case Study 1: High Blood Pressure Management

- Controlling High Blood Pressure was Selected as Key National Quality Improvement Intervention for Molina Medicare and MMP Plans.

- Why was this Intervention Selected?

  Timely and appropriate high blood pressure management is clinically relevant and is linked to improved outcomes.

  This is a three-times weighted Star Rating measure that can strongly impact overall Star Ratings.

  Quality Improvement intervention was based on literature review and identified study outcomes.

  Intervention is based on provider engagement and collaboration.

  Ongoing barriers are identified and modifications to intervention are made.
# High Blood Pressure Management

<table>
<thead>
<tr>
<th>Phase I Intervention</th>
<th>Phase II Interventions Modified from Phase I</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider hypertension toolkit includes guidelines, tools to ensure accurate BP</td>
<td>Quarterly goals established to conduct provider engagement visits checklist documenting provider feedback and questions.</td>
</tr>
<tr>
<td>readings and tips to improve BP control.</td>
<td>Blood pressure reading result repository is being created.</td>
</tr>
<tr>
<td>Provider Engagement Visits includes measure education, toolkit discussion, provision</td>
<td>Provider Web-based seminar on high blood pressure measurement will be distributed to reach a larger number of providers.</td>
</tr>
<tr>
<td>of training stethoscopes and review of medical record documentation.</td>
<td></td>
</tr>
<tr>
<td>Provider hypertension fax back includes lists of members with hypertension. Providers</td>
<td></td>
</tr>
<tr>
<td>then submit back blood pressure results for tracking of compliant members.</td>
<td></td>
</tr>
<tr>
<td>Member mailing includes pill box, education and medication adherence survey.</td>
<td>Collaboration is increasing to ensure access to Electronic Medical Records for blood pressure control tracking.</td>
</tr>
</tbody>
</table>
Case Study 2: Medicare and MMP Quality Partner Program

• Provider-based Incentive Intervention for Molina Medicare and MMP Providers.

• Key Intervention Components

Use of provider-based incentives have been shown to be effective within Molina and through review of research studies.

Incentive program includes ongoing communication and measurement.

• Missing services lists are distributed to providers every month so they can get their patients in for required health care tests and exams.
• Internal health plan staff also review existing rate trends each month to determine appropriate topics for Provider Engagement Visits.
Case Study 2: Manage Quality and Risk Adjustment Together to Improve Quality

• Molina thinks about risk adjustment as an overall quality of care member-based strategy.
• Collaboration internally on tools and processes to meet multiple goals has helped us reduce provider disruption and improve member compliance.
• Errors and gaps across the care continuum are being reduced by thinking about processes from the member’s perspective.
Example #1: Improving Care for Older Adults (COA) Assessments

Challenge

• Members were receiving Care for Older Adult evaluations infrequently and randomly.

Opportunity

• All metrics can be performed by face-to-face visit using a Nurse Practitioner, Physician Assistant or an MD/DO.
Example #1: Improving Care for Older Adults (COA) Assessments

Solution

- Molina started both a PCP-based annual visit program AND an in-home program for members who are homebound and/or who do not seek care regularly.
Example: Katz Functional Status Assessment

Katz Index of Independence in Activities of Daily Living

<table>
<thead>
<tr>
<th>Activities</th>
<th>Independence (1 Point)</th>
<th>Dependence (0 Points)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BATHING</td>
<td>(1 POINT) Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity</td>
<td>(0 POINTS) Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing</td>
</tr>
<tr>
<td>Points: ___________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DRESSING</td>
<td>(1 POINT) Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.</td>
<td>(0 POINTS) Needs help with dressing self or needs to be completely dressed.</td>
</tr>
<tr>
<td>Points: ___________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOILETING</td>
<td>(1 POINT) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.</td>
<td>(0 POINTS) Needs help transferring to the toilet, cleaning self or uses bedpan or commode.</td>
</tr>
<tr>
<td>Points: ___________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRANSFERRING</td>
<td>(1 POINT) Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable</td>
<td>(0 POINTS) Needs help in moving from bed to chair or requires a complete transfer.</td>
</tr>
<tr>
<td>Points: ___________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONTINENCE</td>
<td>(1 POINT) Exercises complete self control over urination and defecation.</td>
<td>(0 POINTS) Is partially or totally incontinent of bowel or bladder</td>
</tr>
<tr>
<td>Points: ___________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FEEDING</td>
<td>(1 POINT) Gets food from plate into mouth without help. Preparation of food may be done by another person.</td>
<td>(0 POINTS) Needs partial or total help with feeding or requires parenteral feeding.</td>
</tr>
<tr>
<td>Points: ___________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Points: __________

Score of 6 = High, Patient is independent.
Score of 0 = Low, patient is very dependent.

Meets HEDIS Functional Status Assessment
Functional Status Assessment Results

- Plan #1
- Plan #2
- Plan #3

Year:
- 2013
- 2014
- 2015
Pain Screening

Note: HEDIS 2014 had a change in specs that caused an increase in reported rates
Example #2: Combining Retrospective Data Collection Projects

Challenge

• Health plan found that there was provider fatigue, abrasion and confusion due to multiple medical record requests each year.

Opportunity

• Medical records were being requested for HEDIS during two cycles each year and Risk Adjustment during three cycles each year.
  • Two initiatives were not coordinated. Molina coordinated 2 of 3 cycles, merged request lists AND use Quality staff to retrieve medical records for both projects.
  • Shared scanned image repository for both projects is used.
Quantitative and Qualitative Results

• The joint process allows both units to scan records collected for each process in the event a data element is missing.
  – 2-3% incremental benefit on selected HEDIS measures seen
  – Same benefit seen on diagnosis capture for RA
  – QA was facilitated because charts could be correlated with one another and with claims and encounters

• After two years, tracking has been standardized across the two processes and provider touches have been reduced by up to 40%.
Repeated training and education of providers may be needed to ensure project success is met. Ongoing feedback is critical to success.

Opportunities for improvement still exist for intervention design and modification. Internal leadership is involved to ensure provider engagement is ongoing and effective.

Significant gaps in care were identified, especially among the cohort of members for whom no HEDIS services had been rendered recently and no annual visit could be identified.

• Ex: Bedbound member with SMI parent as sole caregiver
Provider/ Health Plan Partnerships to improve quality while decreasing overall cost of care

June 8, 2016
Overview of Chestnut Health Systems
A Non-Profit Behavioral Health Care Organization

Services in Seven Different Business Lines

- Substance Abuse Treatment and Prevention
- Mental Health Treatment
- Housing Services
- Credit Counseling Services
- Community-Based Health Center (FQHC)
- Lighthouse Institute - Research and Training
- Chestnut Global Partners, LLC
CHESTNUT HEALTH SYSTEMS
Locations and Services

A
221 W. Walton St.*
Chicago, IL 60610
312.664.4321

B
370 Houbolt Rd., Suite 101
Joliet, IL 60431
815.724.1732

C
1003 Martin Luther King Dr.
Bloomington, IL 61701
309.827.6026

D
702 W. Chestnut St.
Bloomington, IL 61701
309.827.6026

E
448 Wylie Dr.*
Normal, IL 61761
309.451.7700

F
720 W. Chestnut St.
Bloomington, IL 61701
309.557.1400

G
101 S. Main St., Suite 501
Decatur, IL 62523
800.615.3022 (Credit Counseling)

H
2148 Vadalabene Dr.
Maryville, IL 62062
618.288.3100

I
50 Northgate Industrial Dr.
Granite City, IL 62040
618.877.4420

J
12 N. 64th St.
Belleville, IL 62223
618.397.0900

K
110 Rottingham Ct., Suite B
Edwardsville, IL 62025
618.877.4420

In Illinois, Chestnut Health Systems offers a variety of affordable housing options for persons with a mental illness and/or a substance abuse problem including supervised, supported, and scattered sites in Madison, McLean and St. Clair Counties.

*Administrative office only.
Illinois Medicaid Managed Care > 2 million citizens
Overview of Illinois Managed Medicaid

“If we pull this off, we’ll eat like kings.”
Brief History of trying to pilot a TCM program for MCC

Phase I

- Multiple meetings with all Medicaid Health Plans
- Key Question - What do you need to be successful? How can we help you?
- Plans were new to Medicaid in the state, no reliable claims experience
- Over time, claims (and losses) mounted with high risk populations

- The offer the plans could NOT refuse:
  - Identification of cohort of high risk/cost members: assign to us: and measure total health claims before referral compared to post referral date on month 3, 6, 9, month intervals. NO CHARGE!
  - One plan accepted

- Within 6 months – successful outcomes led to a negotiated contract for PMPM
- Operated program on good faith with health plan to get to results
Program Design and Outcomes (44 unique high users)

Phase 2

(Pre-Referral)

- Average PMPM health spending = $3,028
- Average Medical Loss Ratio = 604.35%
- Annual spending for cohort = $1,599,280
- Estimated premium for cohort = $528,000

(Post-Referral)

At 12 months
- Average PMPM health spending = $1,621
- Average Medical Loss Ratio = 318.78%
- Annual spending for cohort = $856,025
How did we achieve outcomes?

- Reduced ED + IP
- Real Time Collaboration Between Health Plan care coordinators and our team
  - Monthly meetings
- 24 hour accessibility
- Built knowledge of where member was from hospital treatment authorization call
- Heavy reliance on CRU/Medically monitored detox for diversion and step down

Client Examples

Client A Age 47
- Client has a long history of depression, suicide attempts, hospitalizations, and alcoholism. He also had two brothers who committed suicide. He is approaching a year without a mental health hospitalization or a single suicide attempt and has maintained the same residence the entire time. He also recently completed a CNA program and is working at a community care center. The client stated he feels good for the first time in a really long time. He said he is finally on the right combination of medication and likes being able to do more with his life than where he was doing. He said he feels like he has a purpose again.

Client B Age 50
- Client has a long history of depression, substance abuse, and suicide attempts. This client now in recovery from heroin. He identified life as being in a downward spiral until he started working with Chestnut. He is receiving psych. Services, employment services, and substance abuse services, including medication assisted treatment. Client is also considering receiving primary care through Chestnut.
## Pilot Has Transitioned

### Phase 3

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Through 2/1/16</th>
<th>Program Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average PMPM Cost</td>
<td>$2,680.45</td>
<td>$975.63</td>
<td>-$1,704.82</td>
</tr>
<tr>
<td>Average MLR</td>
<td>560.49%</td>
<td>202.07%</td>
<td>-358.42%</td>
</tr>
<tr>
<td>IP Admin Average</td>
<td>3.38</td>
<td>3.03</td>
<td>-0.35</td>
</tr>
</tbody>
</table>
Pilot Has Transitioned

**Maintenance Strategies**

- Regularly consult with primary staff
- Ensure client gets to all appointments and are treated as priorities
- Continue advocating for client—especially in times of crisis (crisis post mortems)
- Identify and resolve daily issues that have resulted in crisis in the past
- Utilize the CRU for mental health and detox when available and appropriate
- Help clients with managing limited income
- Remain positive and hopeful and never give up on clients
- Help clients work through guilt and shame and continue empowering them
- Motivational approaches
- Use strengths-based approach
- Continue linking to community resources and support groups
- Cohorts PCBHIP, Dartmouth In-Shape, Stanford Chronic Disease Management Program
- Work with MC company to get medication authorizations approved quickly
ANOTHER Health Plan EXAMPLE
Cohort of 80 unique high utilizers
  • Average PMPM health spending for cohort = $2,497.00
  • Average annual spending for cohort = $2,397,120.00
  • Annualized premium for cohort = $960,000,00

First ninety day review of costs post referral
  • Average PMPM health spending = $1,086.00 (56% decrease of cost)
  • Annualized spending for cohort = $1,042,060
  • Reduction of health costs of $1,355,060
  • 39% reduction of ED visits
  • 77% reduction of Inpatient days
Conclusion:

• Transformed relationship from vendor to partner vested in long term outcome for the company in this region, and improved outcomes for clients.

• Community providers bring value; capacity to reduce costs; and have unique knowledge of communities, hospitals, resources.

• Cost cutting results can be tracked over time, are consistent over time and positive over time (so far)

• Not every client’s career and costs can be reversed…they can be impacted in a positive way

• PMPM payments release us to do the right think at the right time for the client and not be tied to FFS

• Bringing other partners like CMT will help us delve into the data more deeply for richer individualized interventions and outcomes

• To sustain this…community providers need a steady flow of unique lives. 200-300 optimal.