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# **MMA, Private Plans and Competition: Integrating Data and Integrating Care**

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# Outline

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- What data to be integrated
- The use of integrated data
- The incremental value of integrated data

# What Data to be Integrated – Health Plan Perspective

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- Demographic information, insurance type, employer, benefits
- Medical claims data
- Pharmacy claims data
- Behavioral claims data
- Laboratory values (lab claims are in medical)
- Case manager or member self-reported information
- Results of Health Risk Appraisals

# Use of Integrated Health Plan Data

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- Population based analyses
  - ◆ Predictive models
  - ◆ Medical costs and health outcomes analyses – natural experiment
  - ◆ Surveillance (public health, drug, device)
- Provider profiling (for accountability or improvement)
  - ◆ Quality profiling (AQA see attached)
  - ◆ Episode-based efficiency profiling (as opposed to unit cost)
- Individual Care improvement
  - ◆ Errors, gaps and omissions
  - ◆ Member and/or provider care facilitation (cholesterol rx program attached)
  - ◆ Personal health record
  - ◆ Electronic medical record

# Physician Profiling – Ambulatory Care Quality Alliance (AQA)

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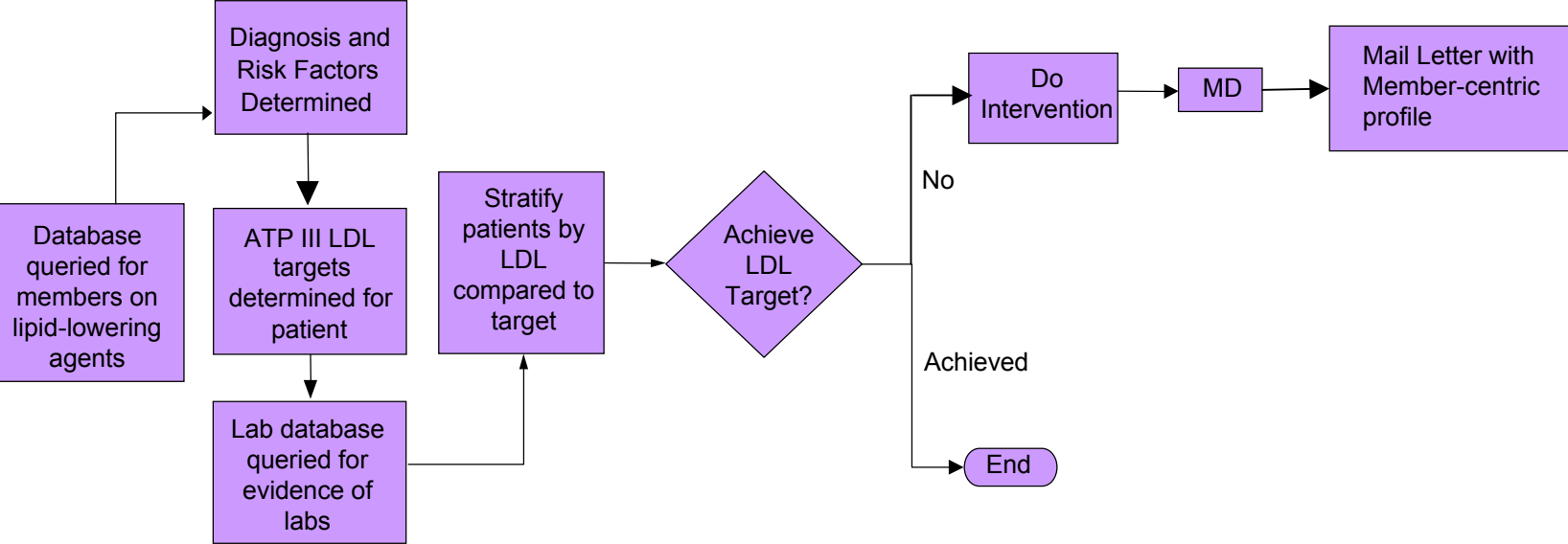
- Alliance representing physicians (AMA, AAFP, ACP, etc.), employers, CMS and health plans
- National physician measurement standards (technical specifications for measurement)
- Pool all-payor claims data – in particular need, at a minimum, both medical and pharmacy
- In the long run health plans will not compete on how we measure physician performance, but rather on how we use the results from a public (or quasi governmental) group (e.g., the UNOS model for organ transplant) and then compete on benefit design, member incentives, provider incentives

# Cholesterol Treatment-to-Goal

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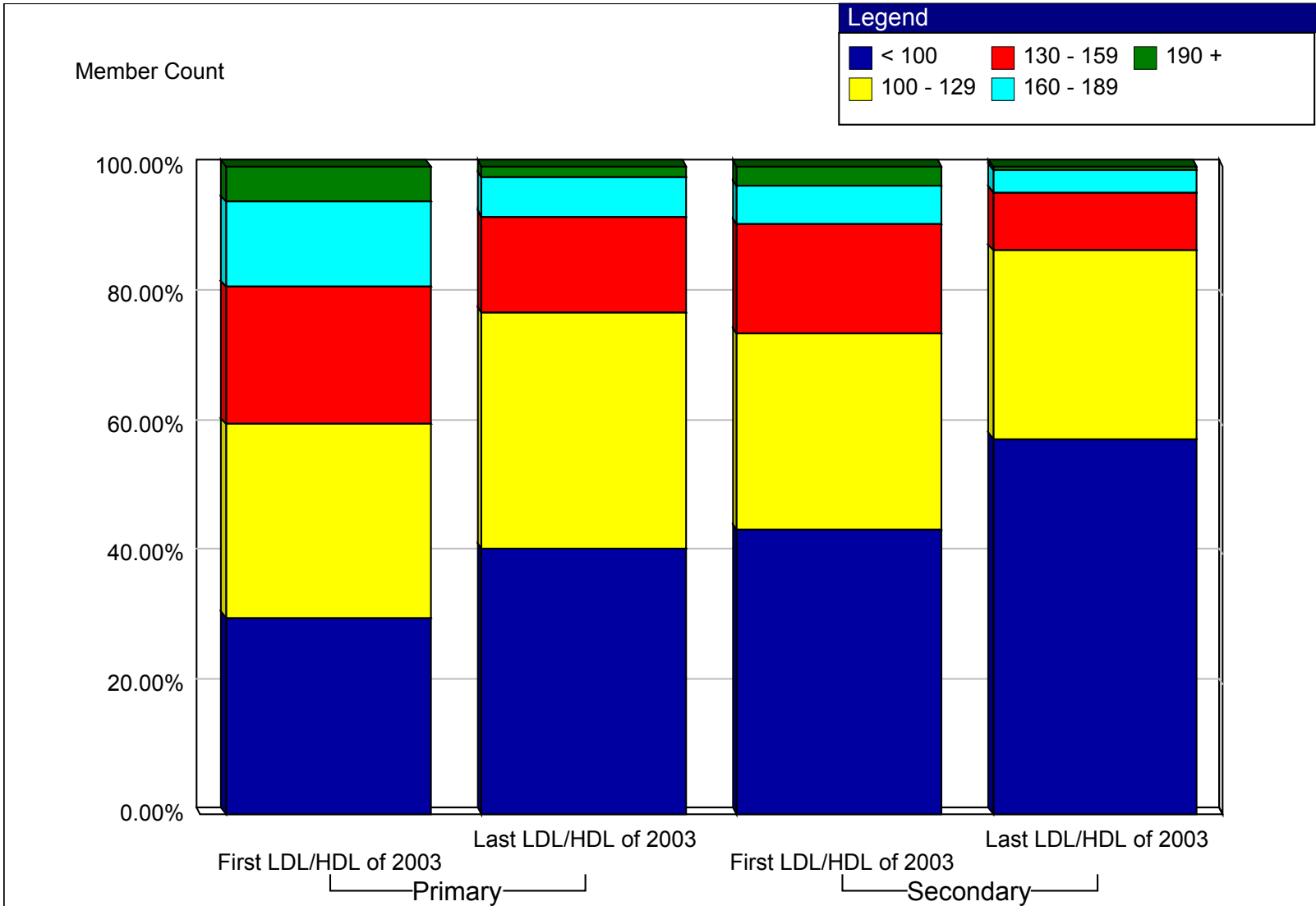
- Program Goal:
  - ◆ Facilitate treatment to personal LDL cholesterol goals for members who have initiated cholesterol reduction therapy
- Program Scope:
  - ◆ 2003 - HMO-based Rx members
  - ◆ 2004 - Expansion to all products
  - ◆ 2005 – Enhanced laboratory data and profile document
  - ◆ >750,000 profiles evaluated
- Program Results:
  - ◆ 74% of targeted patients had cholesterol reduction
  - ◆ >40% achieved cholesterol goal
  - ◆ Treatment-to-goal = 35% projected relative risk reduction in CHD events

# Cholesterol Treatment to Goal Program



# Rx Facilitation Analysis

% of Patients at LDL Targets, Before and After Intervention



# Disease Management – The Program

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- Typical diseases are Heart Failure, Coronary Artery Disease, High Risk Pregnancy, Respiratory, muscular skeletal and Cancer.
- Proactive, population-based nurse outreach programs that promote, assist, facilitate member compliance with evidence based guidelines and/or the treating physician's care plan
- Ad Hoc Patient-Specific Faxes/Reports – When trends or clinical changes appear that might be of interest to the physician,
- Standards of Care Reminder Report – A semi-annual report reminding the physician of standards of care that are due on their patients.
- High acuity patients get electronic home monitoring with nurse alerts to treating physician

# The Problem with Medical Claims Only in Disease Management Programs

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- Under-identification of illness due to under-reporting or under coding leads to missing patients who could benefit from the program
- Inability to determine and thus stratify the severity of the member. Thus trying to target limited resources and interventions to the sickest member is impossible, leading to wasted resources and lowered effectiveness
- Can identify if certain clinical processes are performed (e.g., HbA1c, diabetic retinal exam) but not all (e.g., ACE inhibitor for CHF, steroid inhaler for asthma) thus inability to detect errors, gaps or omissions.
- Unable to assess intermediate outcomes without the actual lab value and determine which members maybe non-compliant or deteriorating.

# Diabetes Disease Management – The Results

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- Villagra and Ahmed, Effectiveness of a Disease Management Program for Patients with Diabetes, Health Affairs Vol. 23, No. 4, pp 255 – 266, July/Aug 2004
- Significant improvement in HEDIS results
- Significant decrease in total medical costs (at least 8%)
- Most savings occurred through decreased hospitalizations (22 to 30% decreased rate of admission)
- Pharmacy costs mixed results ( -7% to +3.1%)
- Total medical savings greater than program costs

# The Incremental Value of Lab Values and Pharmacy Data

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- With medical claims only, the definition of a high risk diseased member is typically one that has a recent hospitalization or is a high utilizer.
- The addition of claims laboratory values and pharmacy data typically allows us to stratify 25% more of the diseased population into high risk
- The nurse intervention is typically up to 25% more effective because she has access to the laboratory values and pharmacy/compliance information
- Thus laboratory values and pharmacy data can improve ROI (return on investment) of disease management programs (estimate anywhere of 15 - 25% improvement)

# Medicare Health Support

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- CIGNA won the CMS award to provide diabetes and CHF disease management for Medicare FFS beneficiaries in Georgia
- Physician community in Georgia extremely positive
- We are running the program with medical claims only from CMS
- We are supplementing the program with nurse or member self reported (sometimes through the physician practice) lab results and/or pharmacy information.

# In Summary

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- What data? (demographics, claims data, lab values, HRA, self-reported)
- The use of integrated data (Populations analyses, provider profiling, individual care improvement)
- The incremental value of integrated data – in particular pharmacy and lab value

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# Discussion