

Idaho Medical Home Collaborative

Preliminary Report: Quantitative/Claims Findings

TRANSFORMED, LLC

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Executive Summary

Created By Governor Otter in 2010 by Executive Order 2010-10 and overseen by the Idaho Department of Insurance (DOI), the Idaho Medical Home Collaborative (IMHC) is a collaboration of primary care physicians, private health insurers, healthcare organizations and Idaho Medicaid. They are charged with making recommendations to the governor on the development, promotion, and implementation of a patient-centered medical home (PCMH) model of care statewide- including PCMH definition, provider qualifications and standards, payment methodologies, consumer and provider engagement, care coordination and case management guidelines, health data exchange and evaluation measures, including cost- and quality-based outcomes measures.

Following an application process and notification of practice acceptance in October of 2012, a pilot project commenced in January of 2013 to assess methods and the impact of PCMH implementation. A multi-payer project including Idaho Medicaid, Blue Cross of Idaho, Pacific Source and Regence Blue Shield, the project established baseline requirements and provided both financial and technical support to 36 practices over the course of the next year. TransformMED, LLC (a wholly owned subsidiary of the American Academy of Family Physicians) was selected under a competitive-bid process to conduct a summative analysis of the pilot project. This final report provides an overview of that evaluation, including the key questions answered, data sources, analytic variables and claims-based evaluation outcomes.

This interim report discusses the findings associated with the analysis of the Medicaid provided patient claims. As such, it has inherent limitations associated with the bias of population selection and the potential for low absolute numbers of patients within an individual practice causing an unfair representation of practice performance when adjusted to industry standard population-based metrics. Additionally, some payer blends may contain a single or 2 practices, limiting the ability to generalize their results. As part of the data collection process, clinics and providers were assured that their data would only be used in aggregate form, so there is extreme caution taken to limit the ability of a reader to infer direct information about a single provider or group. After a thorough review of the data and the conduct of its analysis, I am comfortable stating that this report provides a fair and accurate description of the pilot project's financial and utilization results. I have provided a list of future project design implications, based upon my findings within this dataset. These recommendations are driven by the results within the IMHC project and my interpretation of those results against the national backdrop of healthcare reform and primary care practice transformation efforts.

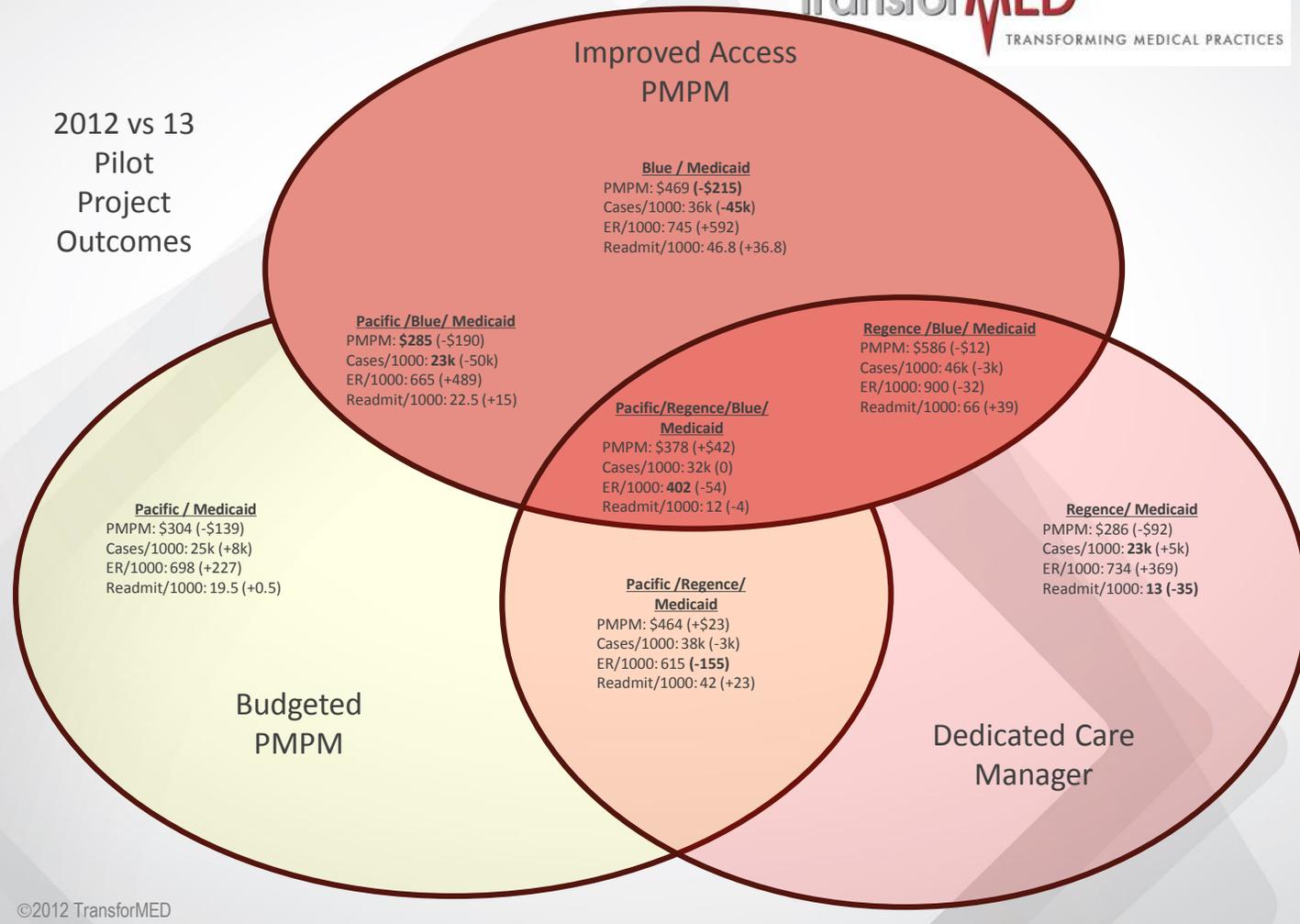
In its simplest description, the pilot project was a significant success with tremendous implications for the future of healthcare in Idaho. Despite the pilot project serving only ~9,000 patients, a \$22 per member per month (PMPM) average savings was accomplished- resulting in approximately \$2.4 million savings for IDHW over each year of the project. Extrapolating these savings to a statewide initiative has the potential for a noticeable impact on the state budget.

Russell Kohl, MD, FAAFP
Chief Medical Officer
TransformMED, LLC

Summary of Results



2012 vs 13
Pilot
Project
Outcomes



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Per Member Per Month Cost (PMPM) Results / Findings

Description of Methodology

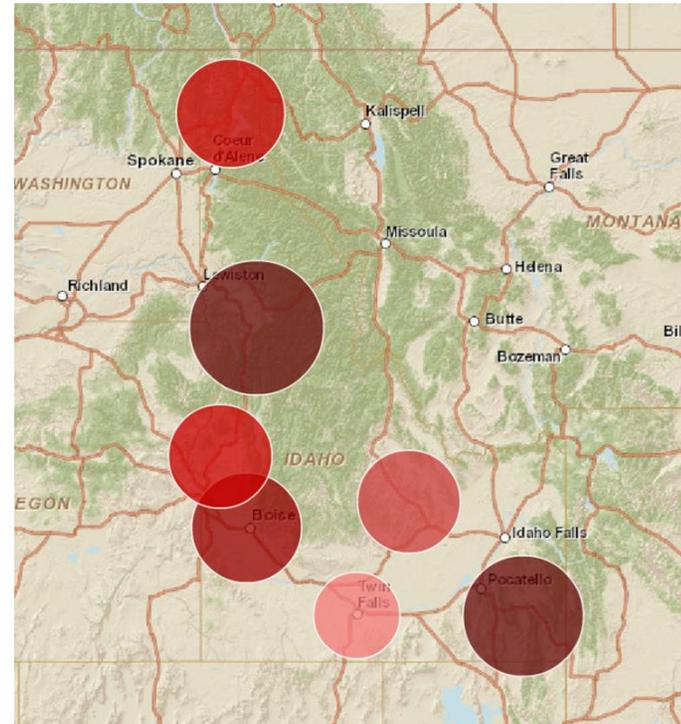
Raw Medicaid claims data from participating practices was consolidated into a proprietary analytic system developed by Cobalt-Talon of Kansas City, MO. The totality of claims were analyzed and patients were assigned to a primary care provider based upon their claims activity, based upon attribution models currently employed by CMS and CMMI in their national pilot projects. After accomplishing attribution to a PCP, total costs of care were calculated and divided by the total number of patient months during the project.

Project Results

Plan Paid \$ PMPM (2013)	Plan Paid \$ PMPM (2012)	Plan Savings PMPM	Allowed \$ PMPM (2013)	Allowed \$ PMPM (2012)	Allowed \$ Savings
\$401.14	\$423.37	\$22.23 (5.3%)	\$488.56 (\$87.42)	\$504.88 (\$81.51)	\$16.32

Regional Results

Region	Plan Paid \$ PMPM (2013)	Plan Paid \$ PMPM (2012)	Plan Savings PMPM
1	\$383.43	\$421.41	\$37.98
2	\$585.99	\$598.85	\$12.86
3	\$349.06	\$443.64	\$94.58
4	\$392.01	\$355.47	(\$36.54)
5	\$242.37	\$632.12	\$389.75
6	\$472.84	\$1,073.91	\$601.07
7	\$344.21	\$398.23	\$54.02



Payer-Mix Results

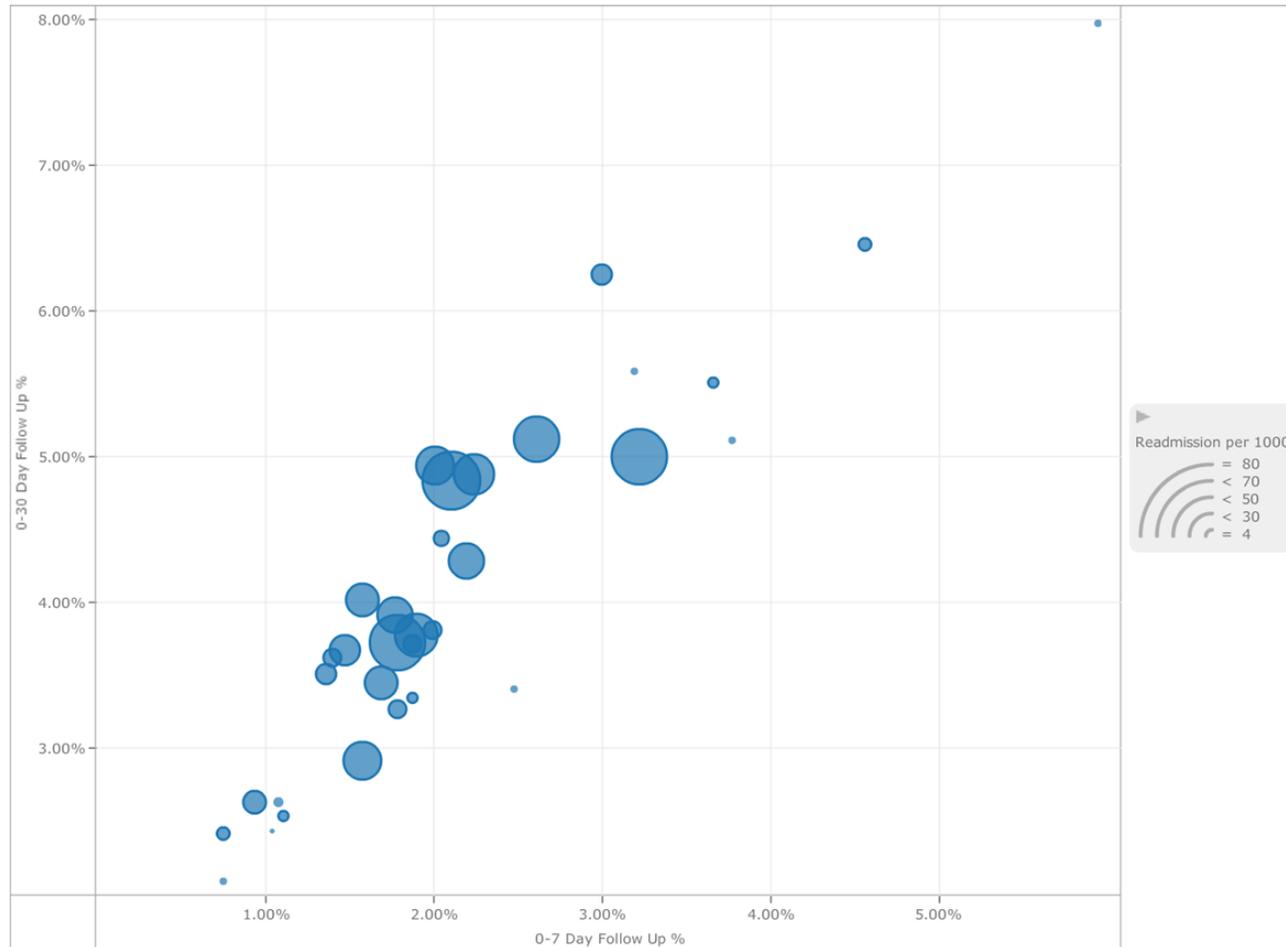
Payer Mix	Plan Paid \$ PMPM (2013)	Plan Paid \$ PMPM (2012)	Plan Paid \$ PMPM Savings
Regence / Pacific / Medicaid	\$464.25	\$441.06	(\$23.19)
Blue / Regence / Pacific / Medicaid	\$378.01	\$335.53	(\$42.48)
Blue / Regence / Medicaid	\$585.99	\$598.85	\$12.86
Pacific / Medicaid	\$304.22	\$443.64	\$139.42
Regence / Medicaid	\$286.04	\$378.67	\$92.64
Blue / Pacific / Medicaid	\$284.91	\$474.49	\$189.59
Blue / Medicaid	\$469.56	\$684.27	\$214.71

Implications for Future Projects

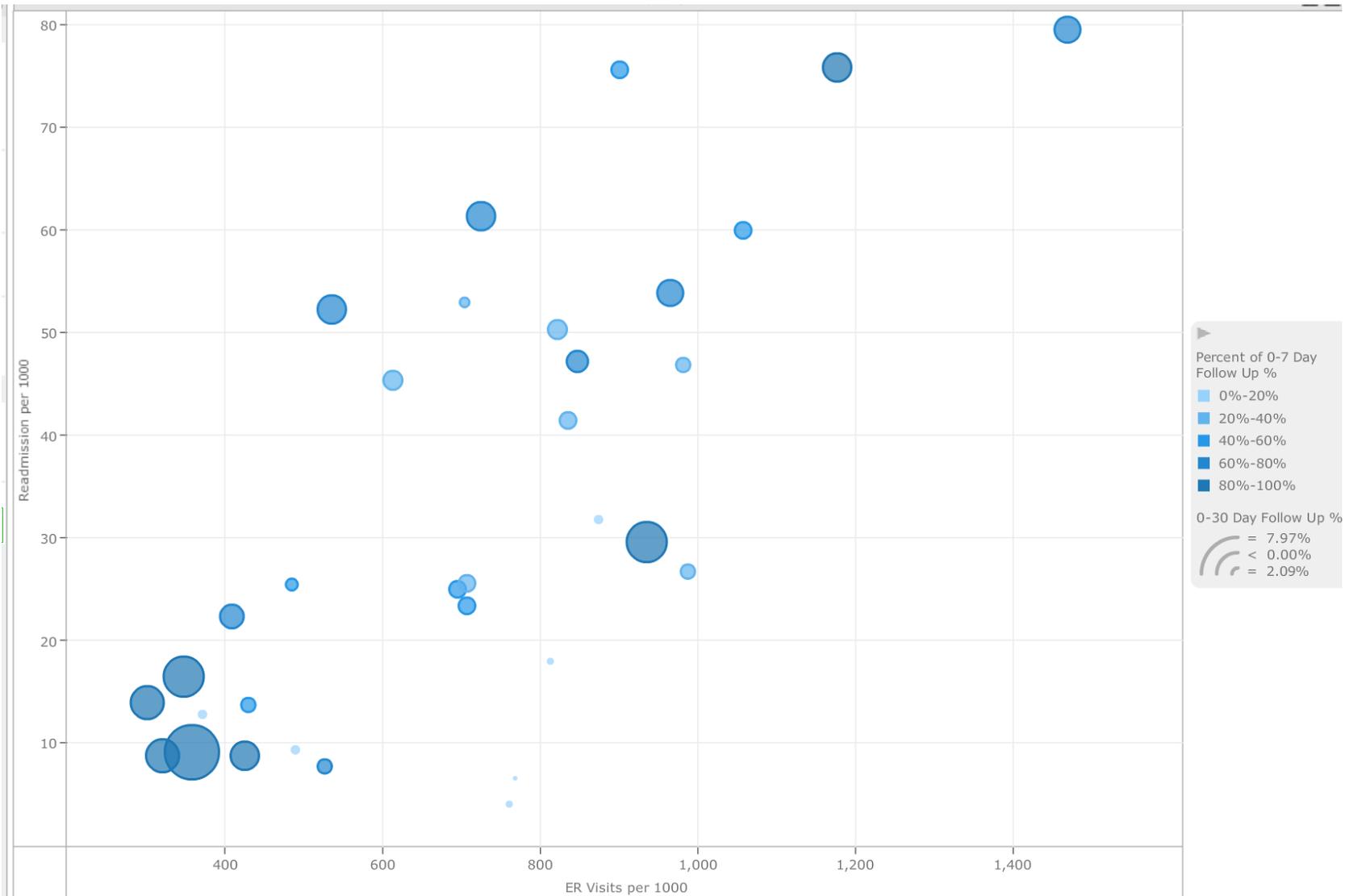
All regions demonstrated a reduction in per Member per Month (PMPM) costs, with the exception of Region 4. However, the limited populations in regions 5 and 6 resulted in a wide variance, due to statistical normalization, which may not truthfully represent the extent of direct impacts within those regions. There was a suggestion of slightly higher PMPM costs within urban regions, but this did not reach significance. Project-wide “allowed” decreased, but less than the proportion of “paid”- suggesting that while the total price was reduced, there was a slight increase in the amount of money paid directly from patients. This cannot be confirmed by our data set. The regional comparisons suggest that practice costs of care appear roughly equivalent across the state, implying that a uniform program may be applied statewide.

The broad number of payer mixes makes conclusions difficult to draw, but indicate that the greatest savings are likely to be accomplished within practices with this highest PMPM costs at the outset. Interventions within low PMPM baseline practices had mixed results, but inclusion of the PacifiSource incentive program appeared to have a positive impact within these practices. The implication, is that a budgeted approach to additional funds for practices incents the practice to truly evaluate how they could improve care and to take a more introspective view around the costs of care. While Care Management was shown to reduce readmissions, it had a limited impact on reducing overall costs of care or ER usage.

Impact of Pt Follow-Up

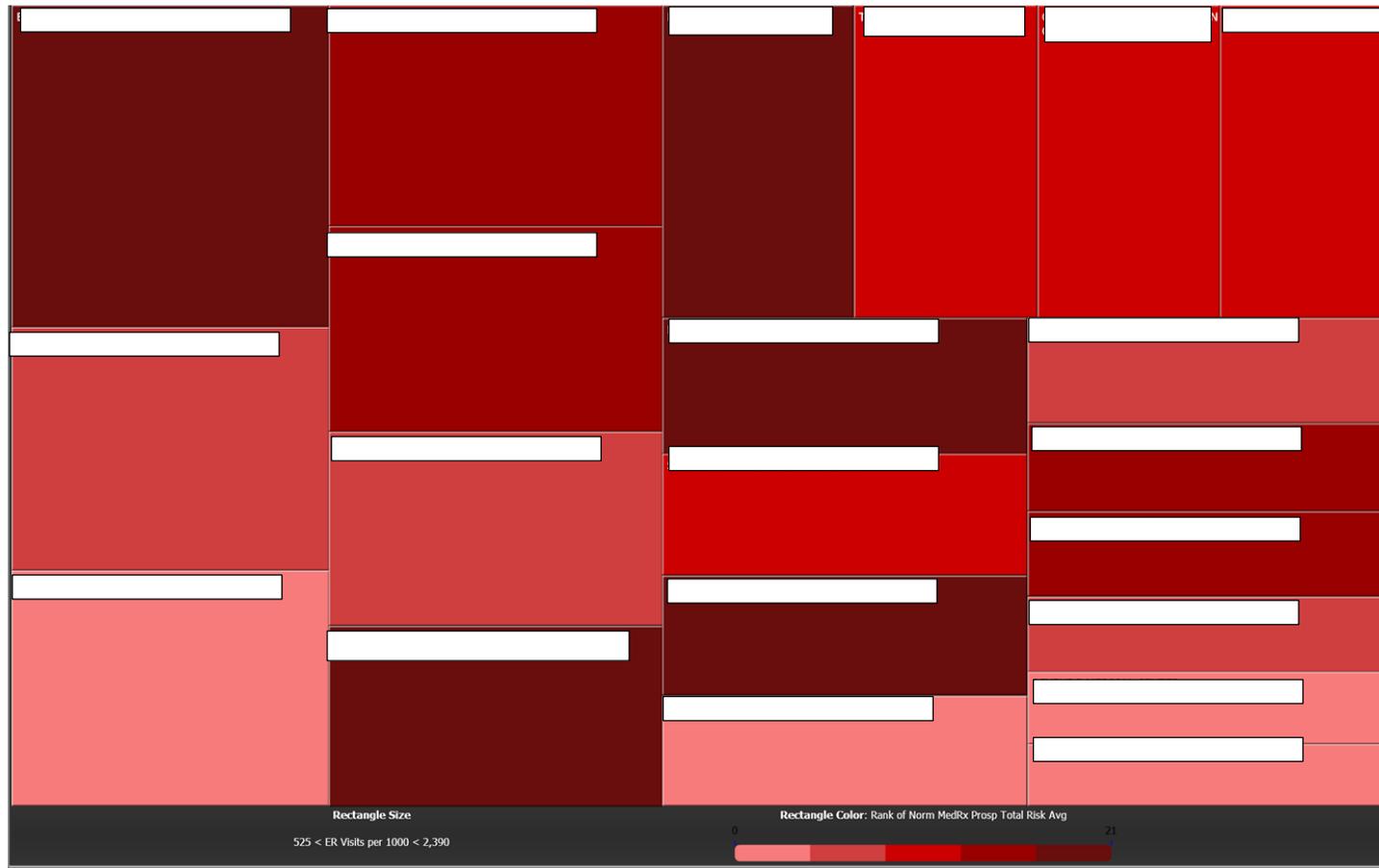


Practices with an E/M code for a visit within 30 days following discharge from inpatient admission were noted to be equally likely to have coded a visit within 7 days following discharge, suggesting a systematic process that can be applied in either case. Results were still noted to be very low, but had a direct impact on reducing hospital readmission rates.



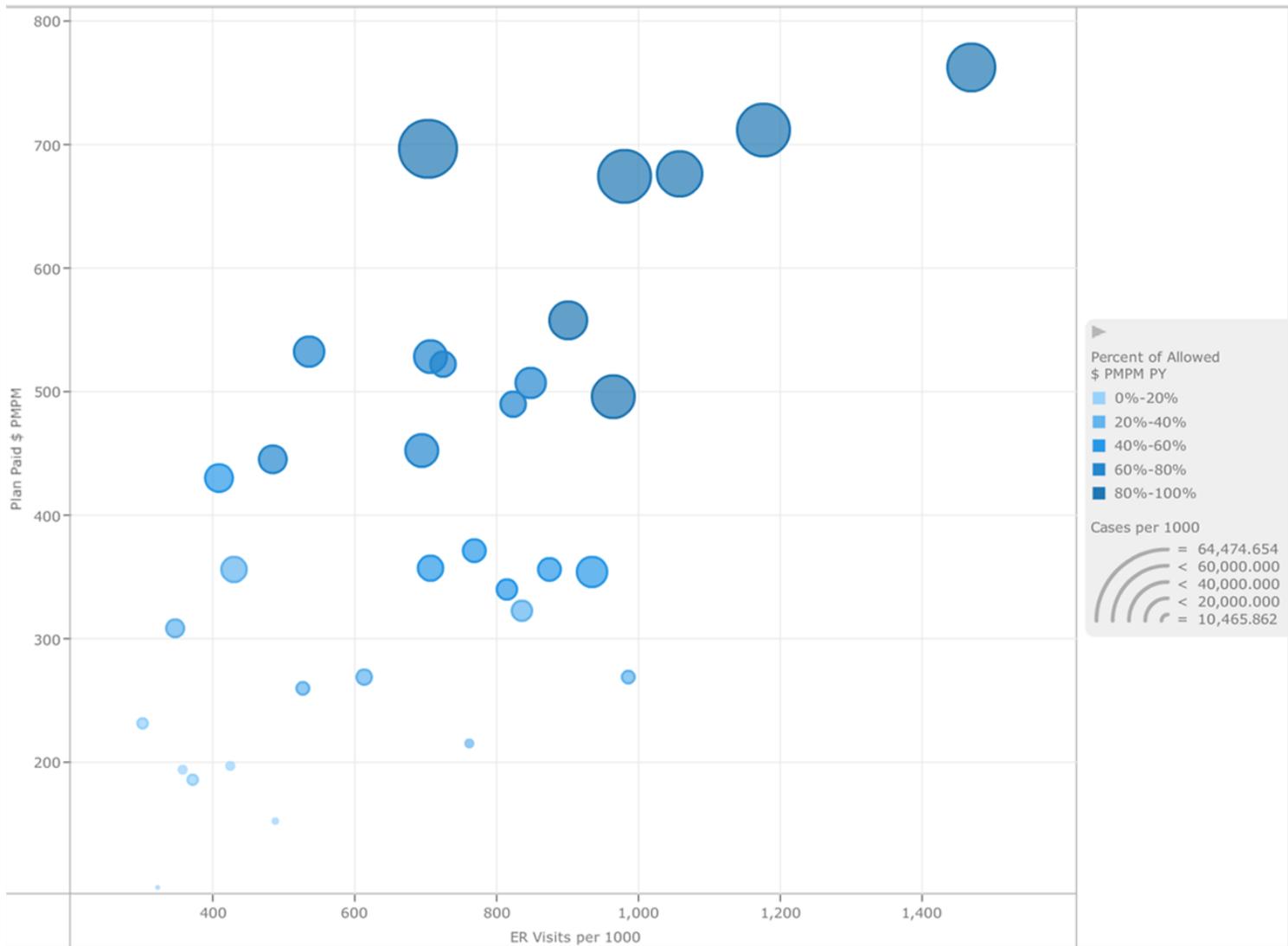
Inpatient readmission rates and ED utilization rates demonstrated a roughly linear correlation, suggesting a potentially similar root cause. 30 day follow-up was less associated with these measures than was 7 day follow-up. The results suggest that higher ER Use and Hospital Readmissions may be impacted by a targeted 7 day follow-up program.

ED Utilization Findings



Implications

Darker colors above are associated with a higher patient risk, according to the Milliman Advanced Risk Adjustment Score, while the size of the box is associated with actual ER usage rates. It is clear that ER usage is not directly associated with a patient's medical risk. This is particularly evident in a few clinics which could serve as excellent case studies to examine to determine possible causation. As a result, future projects may potentially use a ratio of ER usage and patient risk score as an intermediate marker for systematic problems within the practice (most traditionally associated with access).



Implications for Future Projects

While at first blush it appears logical, the evidence supports the concept that practices with higher ER utilization are associated with higher costs and greater utilization of other medical services. The implication of this is the ability to use any of these variables as a predictor for the others, ie- a high PMPM practice likely has higher ER utilization and the potential for over treatment- allowing interventions by practice coaches to be targeted to practices instead of universally applied.

FQHC vs Private Practices

	Plan Paid \$ PMPM (2013)	Plan Paid \$ PMPM (2012)	ER Visits per 1000 (2013)	ER Visits per 1000 (2012)	0-7 Day Follow Up % (2013)	0-7 Day Follow Up % (2012)	0-30 Day Follow Up % (2013)	0-30 Day Follow Up % (2012)	30d Readmission Rate (2013)	30d Readmission Rate (2012)
PRIVATE	\$427.02	\$472.20	677.67	578.83	1.55%	3.49%	3.12%	7.24%	11.04%	10.43%
FQHC	\$385.91	\$502.27	752.8	232	1.06%	7.34%	2.32%	18.30%	13.41%	5.63%

Implications for Future Projects

Despite a history of multiple projects in the past to promote efficiency within FQHC's, they were actually noted to have slightly higher PMPM costs at baseline in the project. However, they were able to demonstrate greater savings over the course of the project, but demonstrated concerning impacts on their follow-up and readmission rates. The relative proximity of the costs at both the beginning and end of the pilot project suggest that the total costs of care within private practice and FQHC are relatively similar. The concept of separate projects for FQHC's and private practices may be of limited utility in the future. While they use different means to achieve the output, both are currently achieving relatively similar output. As a result, future projects should aim to better define output targets and provide associated support, but should not attempt to define the manner in which these outcomes must be achieved.