California Health Care Foundation

# Estimating Number of SB 1004 Eligible Members Based on Current Plan Enrollment (using only claims/authorization/pharmaceutical data)

1. Identify members with qualifying diagnoses.
    a. Using ICD 9/10 codes or HCC codes, scan for claims with one of the four qualifying conditions as a primary diagnosis in prior 24 months.
        i. You will need data describing type of claim/setting (hospital, ED, ambulatory) and costs.
    b. Roll up findings to patient level.
        i. Some patients will have claims associated with multiple codes within a specific disease category (for example, the same patient had one admission coded as I50 and a second admission coded as I50.2).
        ii. Some patients (20%-30%) have claims associated with multiple qualifying conditions (cancer and liver disease, for example).
            1. As needed, assign patients to a primary disease group based on number of encounters or costs by disease.
                a. For example, if a patient had two clinic visits for heart failure but three hospitalizations and two ED visits for cancer, then the patient would be assigned to the cancer disease group.
2. Exclude from the population patients who did not have at least one ED visit or one hospitalization associated with one of the four qualifying conditions in the prior 12 months.

YOU COULD STOP HERE, THOUGH YOU WILL BE OVERESTIMATING THE NUMBER OF ELIGIBLE PATIENTS

3. For all remaining patients, as dictated by plan preference and data availability, add flags to indicate evidence of advanced disease (could be more than one flag per patient).
    a. General indicators (all diagnoses).
        i. Multiple ED visits or hospitalizations in prior 12 months.
        ii. Claim for hospice enrollment and disenrollment in prior 12 months.
        iii. Authorization or claim for home oxygen, hospital bed, or other DME indicative of functional decline (shower grab bars, bedside commode, etc.) in prior 12 months.
        iv. Multiple chronic progressive illnesses (defined per plan medical director, or any of the SB 1004 conditions plus other cardiac conditions / coronary artery disease, peripheral vascular disease, stroke, HIV/AIDS, renal failure, diabetes with end organ damage, dementia and other neurodegenerative diseases).
        v. For plans with access to risk stratification tools, scores indicative of high probability of hospitalization.
    b. CHF only.
        i. Presence of significant comorbidities as evidenced by secondary dx noted on claims where CHF was primary dx, or presence of ambulatory visits, ED visits, or hospitalizations for conditions other than CHF.

c. COPD only.

i. Claim or authorization for home oxygen (if this was not used as an indicator for all potential patients).

d. Advanced cancer only.

i. Medication claim/authorization for oral or infusion chemotherapy.

ii. ICD 9/10 procedure or dx codes for delivery of chemotherapy.

e. Liver disease only.

i. Presence of specified comorbid conditions as evidenced by primary or secondary dx noted on claims data.

4. Patients with additional indicators of advanced disease could be more reliably included in the eligible population.

a. You can note the number of individuals identified using increasingly restrictive criteria.

b. As a very loose rule of thumb, some plans report that between 0.75% and 1.5% of plan members will be eligible for PC, using criteria similar to those found in SB 1004.

| | | Number of member/patients | | | | |
|---|---|---|---|---|---|---|
| Population | Population Description | Cancer | CHF | COPD | ESLD | All |
| Pop 1 | # Patients with qualifying primary diagnoses | | | | | |
| Pop 2 | Of Pop 1, # with at least 1 ED visit or hospitalization in the prior 12 months for qualifying diagnosis | | | | | |
| Pop 3 | Of Pop 2, # with at least 1 additional indicator of advanced disease | | | | | |
| Pop 4 | Of Pop 2, # with at least 2 additional indicators of advanced disease | | | | | |