

A New Approach For Impacting Medicaid Populations

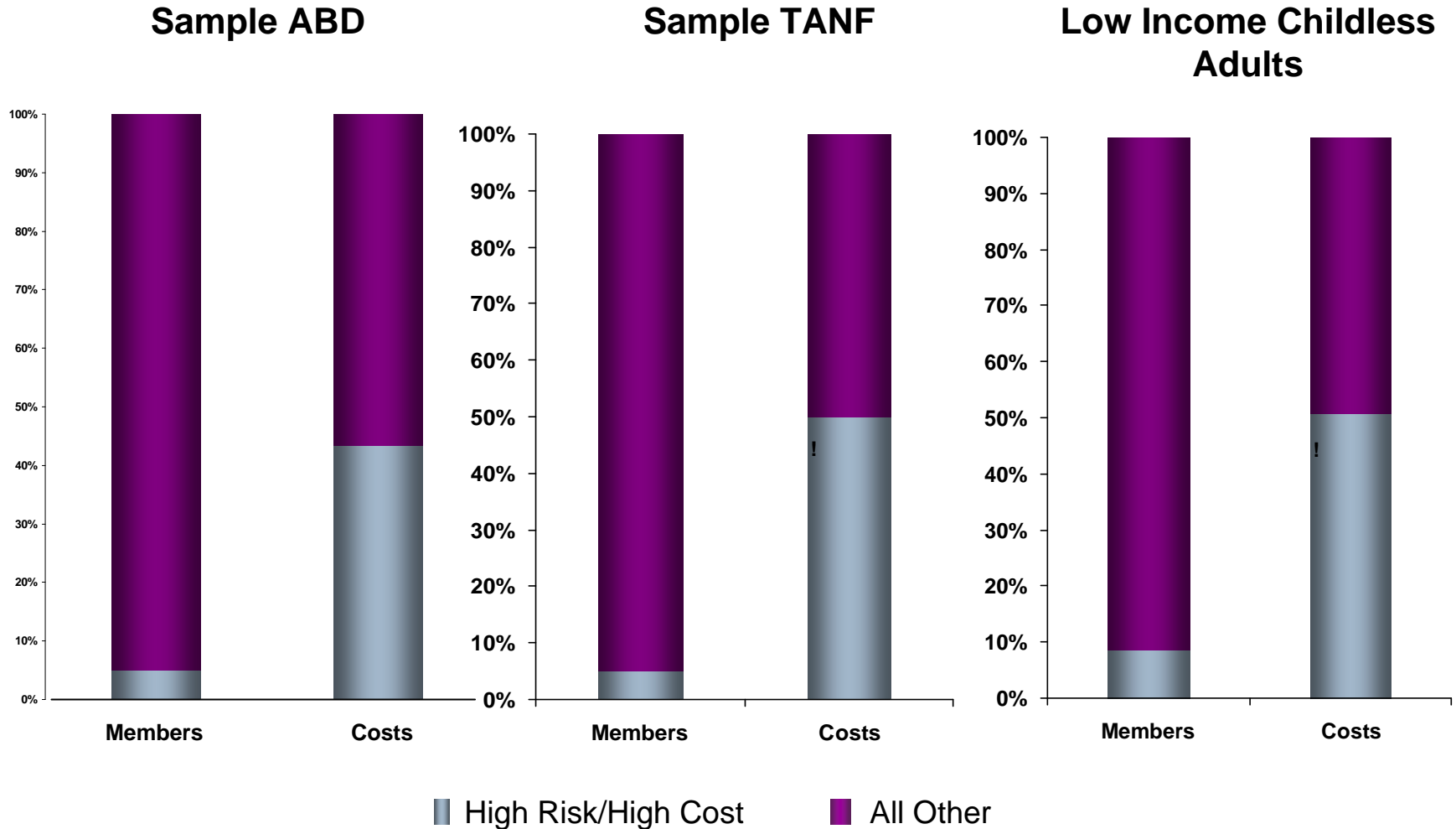
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AHIP Medicaid Conference
September 14, 2011

Agenda

- **Managed Medicaid – Population Review**
- **An Integrated Approach to Care**
- **A Focus on California**
- **Questions**

All Populations: Small Group → Poor Outcomes and Higher Costs



Complicated Members: The Top 5%

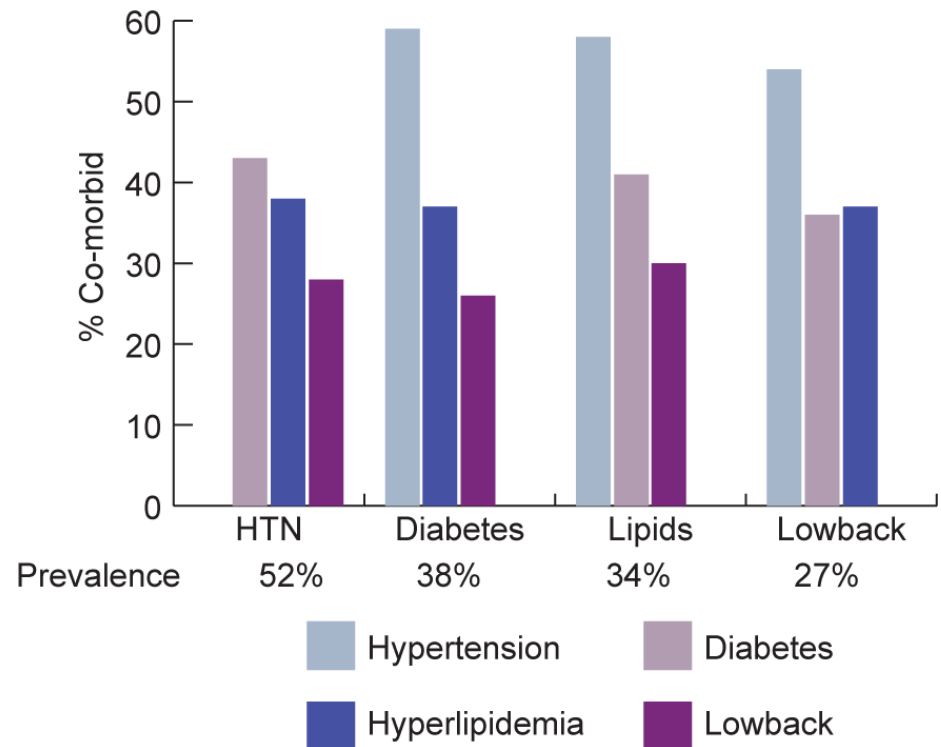
- **A small group of members drive a large portion of cost**
 - ~5% of members → ~50% of cost of care
- **Typical profiles**
 - Chronic diseases, multiple co-morbidities, co-morbid SMI/SA
- **Members not utilizing care efficiently**
 - Social Supports are often lacking - stable home, transportation
 - Multiple providers, settings, and levels of care
 - Healthcare is uncoordinated - health home not existent or not engaged
 - Unnecessary ER use, ACS hospitalizations/readmissions
 - Poly-pharmacy
 - Difficulty engaging in conventional DM
- ***Reducing uncoordinated care reduces costs, improves quality***

High Risk/High Cost Patients Are Complex & Drive Utilization

High Risk/High Cost Patients vs Remaining Patients:

- Average Monthly Spend:
 - 8 – 10 times higher
- Emergency Room Visits:
 - 3 – 5 times higher
- Inpatient Admissions:
 - >20 times higher
- Readmissions:
 - >80 times higher

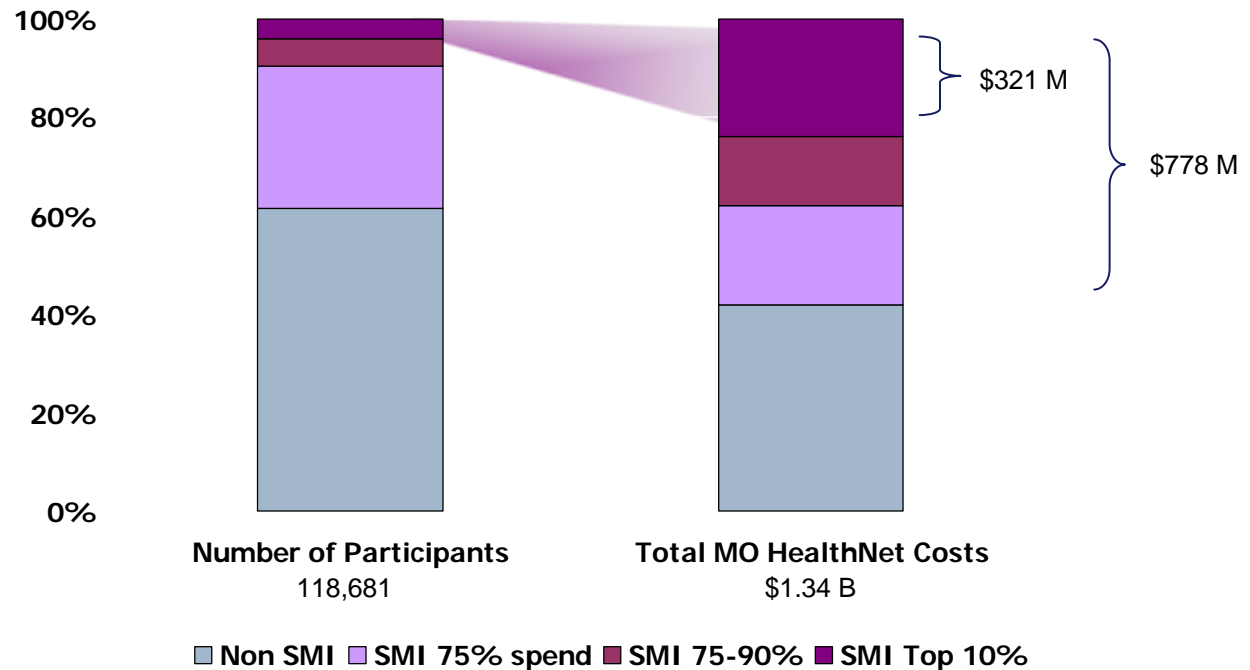
High Risk/High Cost Patients Have Significant Co-morbidities



ABD Members Have Additional Complexity

- **May have non clinical issues needing priority focus**
 - Housing; Transportation; Food
- **Have higher prevalence of SMI and SA**

Top 5% of SMI Population Account for ~25% of All Costs*



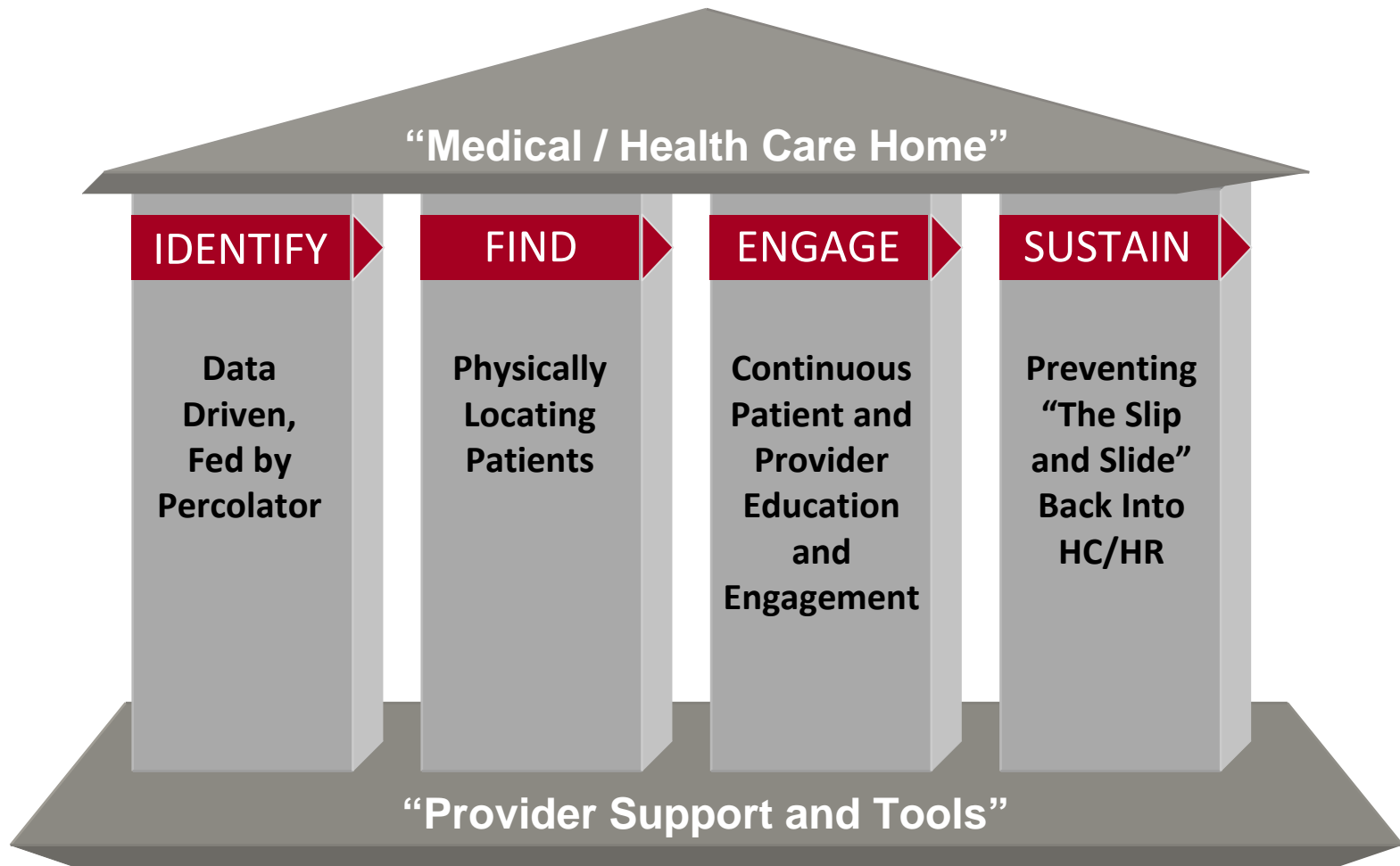
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Integrated Model: Differentiated, Effective

Conventional DM	Integrated Model
<ul style="list-style-type: none"> ▪ Medical/clinical education 	<ul style="list-style-type: none"> ▪ Access to care, public health approach
<ul style="list-style-type: none"> ▪ Gateway disease entry 	<ul style="list-style-type: none"> ▪ Data driven case identification
<ul style="list-style-type: none"> ▪ Stratify 	<ul style="list-style-type: none"> ▪ Stratify + “Percolate” (prioritize interventions and daily workflow)
<ul style="list-style-type: none"> ▪ High Risk / Cost by conditions 	<ul style="list-style-type: none"> ▪ High risk/ Cost + Impactable risk
<ul style="list-style-type: none"> ▪ Interventions = Education & Support 	<ul style="list-style-type: none"> ▪ Interventions = Case Finding, Coordination, Self-Management + establish and support effective health, home
<ul style="list-style-type: none"> ▪ Staffing & Delivery model: Nurse delivering remote telephonic disease education 	<ul style="list-style-type: none"> ▪ Staffing & Delivery model = Local multidisciplinary team (Nurse, SW, Care Coordinators...) for engagement, social support, linkage to health home
<ul style="list-style-type: none"> ▪ Multiple systems 	<ul style="list-style-type: none"> ▪ Single technology system that integrates data, drives workflow and delivers reports

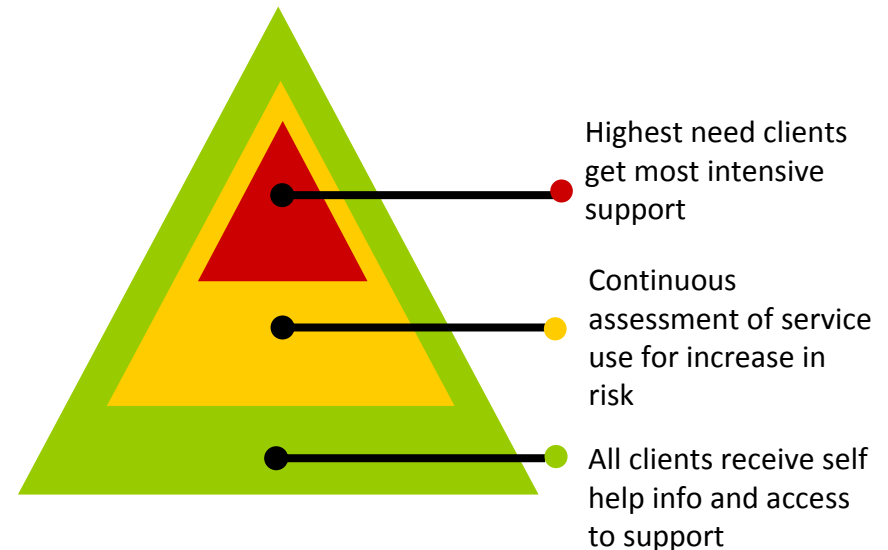
The Four-Pillar Strategic Approach



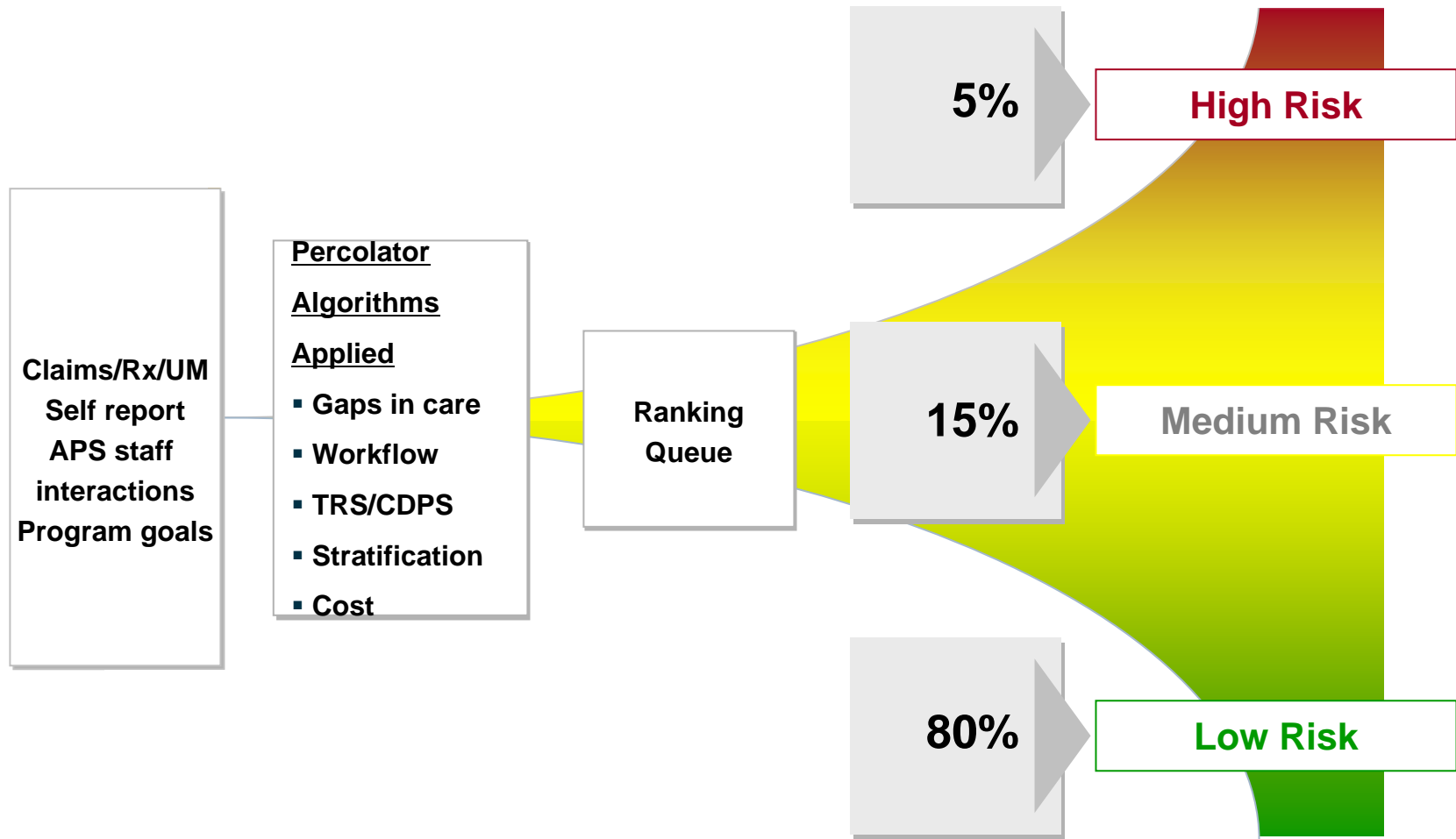
Effective Intervention Driven By Stratification

- **Program begins with a proprietary stratification process**
 - Stratification tools validated by population (i.e. CDPS for Medicaid)
 - Enhanced algorithms to identify the highest cost/highest risk clients with *impactable behaviors*
 - Analyses of multiple data sets identify highest priority clients:
 - Have multiple disorders
 - Use multiple providers
 - Have utilization patterns that drive uncoordinated care

Client interventions and engagement determined by need and ability to effect change



Stratifies Members Based on Need



Risk Stratification Differentiates Member Need

3 Sample Members Stratified by Need – High to Low Impact

	Member A	Member B	Member C
2 Yrs Data	PMPM Top 5% cost \$3,950 Intense Intervention	PMPM Top 20% cost \$2,100 Moderate Intervention	PMPM Top 5% cost \$3,990 Basic Intervention
Diagnoses	<ul style="list-style-type: none"> – Diabetes – Asthma – Depression 	<ul style="list-style-type: none"> – Diabetes – Depression 	<ul style="list-style-type: none"> – Diabetes – ESRD
PCP Visits/Year	1	3	4
ER Visits/Year	5	2	0
MPR	Diabetes 0.25; Asthma 0.10; Depression 0.50	Diabetes 0.80 Depression 0.80	Diabetes 0.80 ACEI/ARB 0.80
Keeps Medical Appointments	<50% of the time	<50% of the time	90% of the time
IP Admits	5	3	1
Social Services	Stable housing; no social support; no transportation support	Unstable housing; limited transportation	Stable housing; access to transportation

Risk-Based Member Interventions

Movement among tiers is dynamic and based on member risk and needs

High

- » Engage member: Face to face; telephonic; mail
- » Engage provider on behalf of member
- » Engage social services on behalf of member
- » Medication Coordination
- » Provider support and intervention

Moderate

- Assessment and assistance of immediate needs
- » Regular monitoring
- » Physician notification of potential risk
- » Medication Coordination

Low/All

- » Timely reminders for preventive measures
- » Encourage greater self-care skills
- » Increase health literacy
- » 24/7 access to nurse call line

Aggressive Goals Refocus Outreach Strategies

- **Initial outreach via telephone 30% success rate**
- **Apply successful strategies from other models of care to physically locate hard-to-reach members**
 - Field-based efforts to encourage referrals from providers
 - Partner with member advocates (community organizations, peer-supports)
 - Leverage social marketing, i.e. social networking sites, support groups
 - Ability to be flexible, nimble, proactive and reactive
 - Leverage analytics to identify best practices
 - Real time ability to assess what is working and where

Realign Definition to Support Long-term Goals

- **Engagement vs. “touch”- exceeds NCQA definition**
- **Better reflects long-term, meaningful participation of member in gaining appropriate access to good care and self-managing their health**
- **Engagement includes:**
 - Interactive contact = interactive field-based, face to face, mail-based communications, phone calls or phone contact using an interactive voice response system, or online contact using secure e-mail or interactive web-based modules or secure e-mails
 - Contact on behalf of member to another individual in the care management team, i.e. provider, pharmacy, community support that drives desired behaviors
 - Engagement includes addressing any member specific need at any point and time during their participation in the program

Supporting Member Within Health Care Environment

▪ **Goals to meet**

- Get to care (medical home, appointments)
- Adhere to care (medication, treatment protocols)
- Symptom self-manage in crisis (new, worsening sx)

▪ **Approach**

- Care coordination of complex social and medical needs based on member need, including field-based face to face and telephonic contact
- 24/7 Nurse Line advice line - provides member with direction in using appropriate health care entity for symptom management
- Provider engagement with access to real time member data

Integrated Care Team

- **Field-based**

- Activities:

- Find, assess and engage
 - Coordinate and support appropriate care utilization
 - Supports members and their families

- **Service center based**

- Activities

- Coordination of social, structural, convenience services, i.e. home delivered meals
 - Assures Integration of social component into medical model
 - Conduct additional assessments – role driven (medical assessments conducted by clinical team, social issues by non licensed team)

- **Staff**

- RN, Social Workers, Care Coordinators
 - Executive/Administrative Support
 - Leverage Core Functions (IT, Finance...)

Member Focused Medicaid Care Management

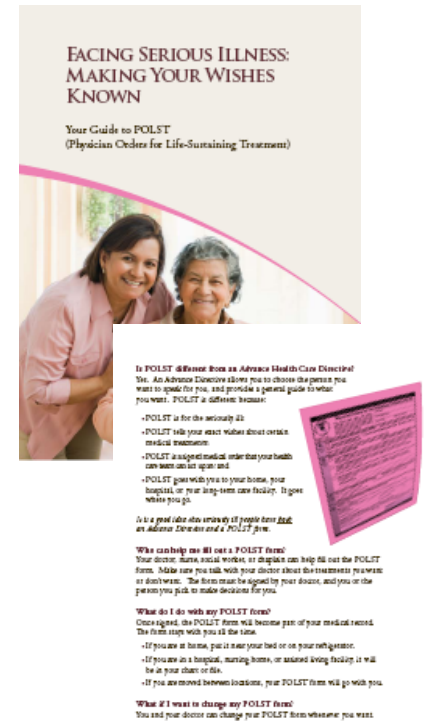
- **Healthcare is local**
 - Commitment to member and provider outreach
 - Meet members where they are
 - Home/Community
 - Medical Home
 - Hospital
- **Focus on members with most complex conditions**
 - High touch outreach → vital for complex population
 - Priority to those at greatest risk for poor clinical outcomes
- **Technology-enabled, clinical best practice care**
 - Dynamic “Percolator”™ stratification/prioritization methodology
 - Web based integrated plan of care
- **Provider partnership/collaboration**
 - Transitioning high cost/high risk members to appropriate use of the medical home model

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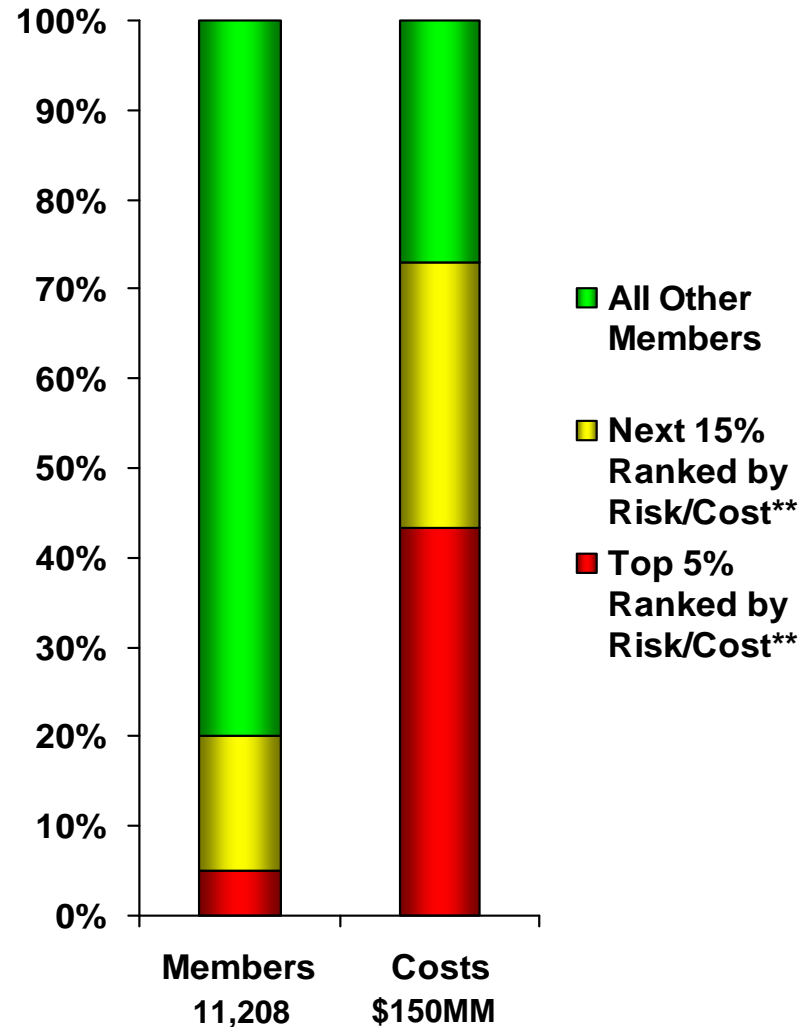
Medi-Cal Pilot Programs

- **Two pilots**
 - Seniors: chronically ill, multiple co-morbidities, complex needs
 - Chronically ill, multiple co-morbidities with a Severe Mental Illness
- **Medical Care Management Approach**
 - Focus on basic needs coordination: medical home, transportation, housing, advance care planning
 - Transition management between inpatient, nursing home, home
- **Provider coordination, outreach is vital to the program**
- **Community partnerships established to reinforce cultural competency, linkages to assure seamless transitions, leverage wealth of advocacy work**



ABD Members At Baseline

- **5% of all members account for 40.6% of costs and have**
 - CDPS risk scores 3.5 times that of total population
 - Higher rates of inappropriate use of services signaling poor coordination
 - Multiple medical and behavioral health co-morbidities



**2009-10 Baseline data*

***Score assigned using the Chronic Illness & Disability Payment System (CDPS) from UCSD*

Excludes dually eligible, pregnancy/neonatal, and LTC populations.

ABD Population Baseline Overview

Population n=11,208	Top 5% HR/HC	Next 15%	All Other 80%
% Of Total Costs	41%	32%	27%
Average Age	53	53	55
% Male	43%	39%	41%
PMPM	\$6,371	\$2,542	\$602
Months of Eligibility	12.0	12.0	11.9
Average Risk Score*	12.1	6.0	2.5
Number of Chronic Conditions	6.0	4.4	1.9
ER Visits / 1000	5,779	2,629	892
Inpatient Admits / 1000	2,714	835	158
Readmits / 1000	968	154	21

* Average Risk Score is based on CDPS
Excludes dually eligible, pregnancy/neonatal, and LTC populations.

2009 Baseline data

Preliminary Results: ABD Pilot Program

- Program Contract Focused on is a Sub-set of the Whole
- Savings Accrued for Entire Program, Driven by Targeted Group Savings
- Greater Savings Likely if Non-targeted Group Included

	Impact on Total Population	Impact on Targeted Top 5%	Impact on Next 15%	Impact on Lowest 80%
Total Spend	- 5%	- 19%	- 7%	+ 5%
PMPM	+ 3%	- 10%	-1%	+ 15%
Admits/1000	- 5%	- 10%	- 8%	+ 2%
Readmits/1000	- 6%	- 6%	- 5%	-7%
ER/1000	+ 4%	+5%	+4%	+3%

*Same ABD members measured in the same risk group from baseline to impact year

California Changes the Model

- **Aged, Blind and Disabled (ABD) X CA PC Modifier Factor = Seniors and Persons with Disabilities (SPD)**
- **Welfare and Institutions Code Section 14182 became law on October 18, 2010 – Permits mandatory enrollment of SPD**
- **CMS approved CA Section 1115 Medicaid Demonstration Waiver entitled “Bridge to Reform” which included mandatory SPD assignment to managed care**
- **June 1, 2011 begins mandatory enrollment phased on over 12 months based on birth month**

Requirements for MCO

- **Risk Stratification: At a minimum, stratified into high/low within 44 days of enrollment and assessments completed on high risk members within 45 days of enrollment**
 - Use of state claims from fee for service experience
- **Lower risk members to be assessed within 105 days of enrollment**
- **State mandated conditions for high risk designation at outset of stratification**
- **Application of proprietary risk stratification for further engagement, care planning and care management**
- **Provision for continuity of care**
- **Provision for stakeholder and consumer input**

California (Medi-Cal) Definition of Higher Risk

“Medi-Cal beneficiaries who are at increased risk of having an adverse health outcome or worsening of their health status If they do not have an individualized care management plan”

Conditions Included in High Risk Designation

- On oxygen past 90 days
- In an acute hospital setting
- Hospitalized within 90 days or 3 hospitalizations within 12 months
- 3 or more ED visits in combination with other evidence of high utilization
- Have a behavioral health diagnosis or developmental disability in addition to one or more chronic conditions or social circumstance of concern
- Have ESRD, AIDS, and/or recent organ transplant
- Have cancer, currently being treated
- Pregnancy
- Prescribed anti-psychotic medication within past 90 days
- Prescribed 15 or more prescriptions in the past 90 days
- Self-report of a deteriorating condition
- Other conditions as determined by the plan, based on local resources

Anthem CA SSB

- **Why we needed to do something different – the APS model for the SPD members - focus on community based outreach and care coordination**
- **Anthem chooses APS**
 - For SPD experience in CA
 - Community-based outreach model
 - Ability to implement a DHCS directed program quickly

Anthem: Why APS ?

- **Already credibly engaged with these populations elsewhere in CA**
- **Time demands of program creation and implementation**
- **Scalability of effort**
- **Willingness to join efforts**
- **Analytic capabilities**
- **Ongoing analysis and stratification of a dynamic population**

Oh, And By The Way . . . ADHC

- **CA announced with short notice that they will no longer pay for Adult Day Health Care services**
- **CA announced expectation that this population would be absorbed into SPD population under managed care**
- **Acute need to understand services being provided**
 - To determine actual needs
 - To develop care plans going forward
 - To enlist IHCC
 - To evaluate and enlist community based alternative services

APS Once Again Steps Forward

- **Existing credibility and active engagement with this population in CA**
- **APS will provide similar transitional services and planning for the fee for service population**
- **Actively working with us to anticipate needs and solutions for this new work**

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