Innovations in Preventing and Managing Chronic Conditions: What’s Working in the Real World

Engaging Providers to Achieve Chronic Care Improvement for Medicaid Populations

April 8, 2009

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APS Healthcare is a leading *behavior change* organization, delivering *innovative solutions* that enable consumers, practitioners and payers to act in ways that *enhance health, well-being and productivity*

- **National Presence**
- 56 public sector programs
- 43 Medicaid programs
- 26 states and Puerto Rico

**Medicaid Health Management Programs**
- Wyoming Healthy Together Total Population Management Program
- Georgia Enhanced Care Program
- Georgia Medicaid Management Program
- Vermont Chronic Care Management Program
- Missouri Chronic Care Improvement Program
- Oregon Disease and Medical Care Management Program
- California Coordinated Care Management Program for Seniors and Persons with Disabilities
Our Approach to Helping States Find Solutions

• Focus on changing patient & provider behaviors

• Support Provider practices to improve chronic care management
  – Identification of gaps in care, e.g. medications, tests for condition monitoring, preventive care services, and compliance
  – Assistance in locating resources to address social barriers affecting ability to seek appropriate medical / behavioral health care and close gaps in care, e.g. transportation, food, clothing, housing, etc.
  – Addressing self-care issues with behavioral change coaching with the goal of increasing compliance with prescribed plans of care
  – Coordinating with the health care team (physicians, social workers, community support workers, etc.) to increase compliance with the plan of care
  – Innovative technology – APS CareConnection® – facilitates coordination among providers through integrated individualized Plan of Care

• Healthcare is local
  – Decentralized, community-based operations
  – Co-location of APS staff
  – Services described may be provided telephonically or onsite in clinics, hospitals or health centers

• Focus on Specific Population Issues
Serious Mental Illness (SMI) Prevalent in Medicaid

**SMI & Physical Illness in Medicaid Program**

- 39% of THM Population Has a SMI
- SMI Participants Account for 58% of Total Costs

- Non-SMI: 61%
- SMI: 39%

- Non-SMI: 42%
- SMI: 58%

Top 5% of SMI Population Account for ~25% of All Costs
Overuse of ER High in Medicaid

Avoidable ER Use in Medicaid Program

ER Visits = 151,690

- 151,690 (87%)
- 33,709 (13%)

24,078

- Not Preventable
- Primary Care Treatable
- Preventable/Avoidable
- Non-emergent

Note: Emergency room visits classified according to the likelihood that the visit could have been avoided, treated in a primary care setting, or a truly emergent, unavoidable visit, using an algorithm developed at New York University (NYU ED Classification Algorithm). For further information please see: [http://wagner.nyu.edu/chpsr/](http://wagner.nyu.edu/chpsr/)
State of Wyoming Case Study - Summary

- Began in 2005 – 54,000 members
- Eligible Members
  - Age, Blind and Disabled (ABD)
  - Low-Income (TANF) Children and Adults
- Covered Conditions –
  - Total Population Approach
  - All conditions and co-morbidities managed
- Program Components
  - Health & Wellness: all members
  - Disease Management: 8,500 members
  - Care Management: 520 members
- High Risk Pregnancy
- Mental Health
- Medical Home Facilitation
- Pay for Participation
Wyoming Case Study - Program Benefits

Participant Benefits

- Link to “Healthcare Home” with their own Primary Care Provider
- Case support coordinating health care services
- Health coaching and self-management education
- Prevention initiatives
  - Smoking cessation
  - Weight management
- Printed and web-based educational materials
- Toll-free 24 hour Health Advice line

Provider Benefits

- Provides telephonic health management services
- Identify and fill gaps in care
- Utilizes clinical guidelines and best practices
- Provides practice with resources, information and education
- Supports physician treatment plan
- Supports appropriate utilization of services
- Free support to Medicaid members
- Member access to a 24/7 toll-free line for after-hours calls
Wyoming Pay-for-Participation (P4P) Program

- Payment to providers through 8 codes ranging from $11.60 to $74.96 for immediate reward
- Provider outreach and training, with marking and program materials to support initiative

Enhanced Reimbursement of Procedures

Pay for Participation Screening and Education Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>S0315</td>
<td>Disease Management Program; Initial assessment and initiation of the program (by physician, PA or NP). Must refer client to Healthy Together program within or established illness.</td>
<td>$50.00</td>
</tr>
<tr>
<td>S0316</td>
<td>Disease Management Program; follow-up assessment (by physician, PA or NP). Reinforce Healthy Together program for established illness.</td>
<td>$25.00</td>
</tr>
</tbody>
</table>

Screening and Education Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0182</td>
<td>Prostate cancer screening; digital rectal examination.</td>
<td>$24.99</td>
</tr>
<tr>
<td>G0245</td>
<td>Foot exam initial; initial physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensations, which must include diagnois LOPS, body history, physical exam, etc.</td>
<td>$74.96</td>
</tr>
<tr>
<td>G0246</td>
<td>Foot exam follow-up; follow-up physician evaluation and management of diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation to include at least body history, physical exam, exam feet, etc.</td>
<td>$44.28</td>
</tr>
<tr>
<td>99406</td>
<td>Smoking and tobacco cessation counseling visit: Intermediate, greater than 3 minutes up to 10 minutes which may include prescription.</td>
<td>$11.90</td>
</tr>
<tr>
<td>99407</td>
<td>Smoking and tobacco cessation counseling visit: Intensive, greater than 10 minutes.</td>
<td>$22.15</td>
</tr>
<tr>
<td>D1206</td>
<td>Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.</td>
<td>$35.00</td>
</tr>
</tbody>
</table>

*Most bill usual and customary rate. These fees are subject to change.*
Wyoming Case Study – Clinical Outcomes

- Members with Influenza Vaccination - Diabetes
- % Members with reported Reduction in BMI - Diabetes
- Members with Influenza Vaccination - COPD
- % Members who Quit Smoking - COPD
- % Members reporting improved Exercise Tolerance - COPD
- Members with prescription for Beta Blocker - CHF
- Members with prescription for ACE or ARB - CHF
- Members with Pneumococcal Vaccination - CHF
- Members with Influenza Vaccination - CHF
- % Members who Quit Smoking - CHF
- % Members who Quit Smoking - CAD
- Percent of Members with Daily Aspirin usage - CAD
- Members with Influenza Vaccination - CAD
- Members with prescription for a Rescue Medication and preventive Medication - Asthma
- Members with prescription for a Rescue Medication - Asthma
- % Members using Peak Flow Meter as recommended by MD - Asthma
- % Members with completed Asthma Action Plan - Asthma

% Improvement
### Wyoming Case Study – Utilization Impacts

#### Key Metrics

<table>
<thead>
<tr>
<th></th>
<th>% Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members with ER Encounters</td>
<td>-17.4%</td>
</tr>
<tr>
<td>Total ER Encounters</td>
<td>-11.7%</td>
</tr>
<tr>
<td>Members with Inpatient Admissions</td>
<td>-42.7%</td>
</tr>
<tr>
<td>Members with Readmission</td>
<td>-40.6%</td>
</tr>
<tr>
<td>Total Inpatient Admissions</td>
<td>-40.5%</td>
</tr>
<tr>
<td>Average Inpatient LOS</td>
<td>-18.8%</td>
</tr>
</tbody>
</table>

**Third-Party Validated Savings of Nearly $30 Million over First Two Years**
State of Missouri Case Study - Summary

- Began in 2007; 280,000 members

- Eligible Members
  - Age, Blind and Disabled (ABD) not enrolled with Managed Care Organization
  - Low-Income (TANF) Children and Adults

- Covered Conditions - Co-morbidities are managed in conjunction with the targeted disease
  - Asthma - GERD
  - CAD - Hyperlipidemia
  - CHF - Hypertension
  - COPD - Sickle Cell
  - Diabetes

- Program Components
  - Health & Wellness: all members
  - Disease Management: 118,000 members
  - Case Management: 9,000 members

- Mental Health

- Medical Home Facilitation

- Pay for Participation/Pay for Performance
Missouri Case Study - Program Benefits

**Participant Benefits**
- Link to “Healthcare Home” with their own Primary Care Provider
- Individual Plan of Care for chronic care improvement
- Improved health and overall quality of life
- Risk assessment and stratification through predictive modeling
- Holistic and disease specific assessment
- Extensive participant outreach and self management education
  - A 24/7 nurse line
  - Printed and web-based material
- Coordination with care providers, community resources and social services
- Improved health and overall quality of life

**Provider Benefits**
- Collaboration with CCIP Health Coach via secure internet based portal
- Physician assisted health risk surveillance
- Reduced administrative burden in managing CCIP participants
- Incentive payments for participation and positive outcomes (P4P)
- Collaboration/support of provider’s treatment plan and goals using evidence-based guidelines
- Coordination with community agencies
- Vigilant monitoring of the participant’s progress and outcomes by APS Health Coaches
- Source of new patients
- Healthier and more adherent patients
Missouri Pay-for-Performance (P4P) Program

- Per encounter payments for office visits and program participation
- Annual lump sum payment based on achieving satisfactory outcomes measurements within target patient population

### Incentive Payment for Quality Metrics

<table>
<thead>
<tr>
<th>Disease</th>
<th>Effectiveness Measure</th>
<th>Target Goal</th>
<th>P4P Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>Use of Inhaled Corticosteroid</td>
<td>&gt;70%</td>
<td>5%</td>
</tr>
<tr>
<td>Asthma/COPD</td>
<td>Use of Inhaled Bronchodilators</td>
<td>&gt;70%</td>
<td>5%</td>
</tr>
<tr>
<td>Asthma/COPD</td>
<td>Providing Influenza Immunizations</td>
<td>&gt;70%</td>
<td>5%</td>
</tr>
<tr>
<td>Asthma/COPD</td>
<td>Providing Pneumococcal Immunizations</td>
<td>&gt;70%</td>
<td>5%</td>
</tr>
<tr>
<td>GERD</td>
<td>Attempt to Step-down H2A or PPI Therapy</td>
<td>&gt;50%</td>
<td>8%</td>
</tr>
<tr>
<td>CHF</td>
<td>Use of ARB or ACE Inhibitor</td>
<td>&gt;70%</td>
<td>7%</td>
</tr>
<tr>
<td>CHF</td>
<td>Use of Beta Blockers</td>
<td>&gt;70%</td>
<td>7%</td>
</tr>
<tr>
<td>CAD</td>
<td>Measurement of Lipid Profile Performed</td>
<td>&gt;70%</td>
<td>7%</td>
</tr>
<tr>
<td>CAD</td>
<td>Treatment with Statin Medication</td>
<td>&gt;70%</td>
<td>7%</td>
</tr>
<tr>
<td>All Cardio</td>
<td>Providing Influenza Immunizations</td>
<td>&gt;70%</td>
<td>5%</td>
</tr>
<tr>
<td>All Cardio</td>
<td>Providing Pneumococcal Immunizations</td>
<td>&gt;70%</td>
<td>5%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Measurement of A1c Performed</td>
<td>&gt;70%</td>
<td>6%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Measurement of Lipid Profile Performed</td>
<td>&gt;70%</td>
<td>6%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Performance of Dilated Retinal Exams</td>
<td>&gt;70%</td>
<td>6%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Urinary Microalbumin or Glomerular Filtration Rate Measurement</td>
<td>&gt;70%</td>
<td>6%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Providing Influenza Immunizations</td>
<td>&gt;70%</td>
<td>5%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Providing Pneumococcal Immunizations</td>
<td>&gt;70%</td>
<td>5%</td>
</tr>
</tbody>
</table>
Missouri Case Study – Clinical Outcomes

![Bar chart showing clinical outcomes for different conditions and treatments.](chart.png)

- One or more HbA1c Test - Diabetes
- Two or more HbA1c Tests - Diabetes
- One or more Lipid Panel - Diabetes
- Two or more Lipid Panel - Diabetes
- Dilated Eye Exam - Diabetes
- Microalbuminuria Screening - Diabetes
- Bronchodilator Medication - COPD
- ACE/ABR Medication - CHF
- Beta Blocker Medication - CHF
- Diuretic Medication - CHF
- Inhaled Corticosteroid Medication - Asthma
- One or more Lipid Panel - CAD
- Two or more Lipid Panel - CAD
- Beta Blocker Medication post MI - CAD
- Statin Therapy Medication - CAD

Legend:
- Enrolled
- Non-enrolled
Missouri Case Study – Utilization Impacts

• October 07 – September 08 utilization below trend projection resulting in:

• ER Utilization Reductions
  – Average reduction of 106 visits per 1,000
  – 58% reduction in ER utilization rate compared to projected

• Inpatient Utilization Reductions
  – Average reduction of 73 admissions per 1,000
  – 44% reduction in inpatient admission rate compared to projected
Missouri Case Study – Fiscal Impact

Oct 07 – Sept 08 total costs below projection resulting in:
- $128 average PMPM reduction for enrolled participants
- $155 million annual reduction (7.8% reduction in total costs)
Statewide centralized health management infrastructure efficiently facilitates enhanced clinical outcomes and cost avoidance.

Effectiveness achieved through supporting providers by coordination and linking of the services available in the healthcare system.

- Medical home linkage enhances continuity of care
- Analytic tools at providers’ disposal to support better decision-making
- APS CareConnection@ facilitates coordination among providers through integrated individualized Plan of Care
- Health Coach services address gaps in care
- Development and administration of incentives aligned with best practices