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# Healthcare Delivery Innovations: Patient Care Coordination

## New Strategies and Opportunities for Partnerships

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# Services Overview

- Provide analytical support services, project design, coordination and management for partnerships between plans, states, industry and DM/UM vendors for identifying gaps in treatment and inefficient and uncoordinated care
- Provided analytical, operational and policy consulting and program evaluation services to over 20 states for medical home models/pilots, utilization management programs, chronic disease coordination of care programs, HIT expansion, drug utilization review, and other areas


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# Topics

- Current State Activities
- Managing and Treating Chronic Disease
  - Use analytics to identify targeted patients with coordination of care and medication problems, develop intervention strategies and incentive programs with states/plans
- Partnership Opportunities
  - Identify uncoordinated care, improve and reward appropriate Rx use, implement best practices within various models, support state program initiatives and demos utilizing technical assistance and resources


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# Current Environment


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# Current State Activities

- Implementation of federal reform efforts – expansion of covered lives, health exchanges
- Expansion of Medicaid managed care and new provider delivery and payment rates/models
- Implementation of various demos/programs i.e. Medical Homes, Medicaid/Medicare duals integration, Accountable Care Organizations, Care Coordination, Health Information Exchanges, National Clinical Pharmacy Services Expansion (PSPC model)


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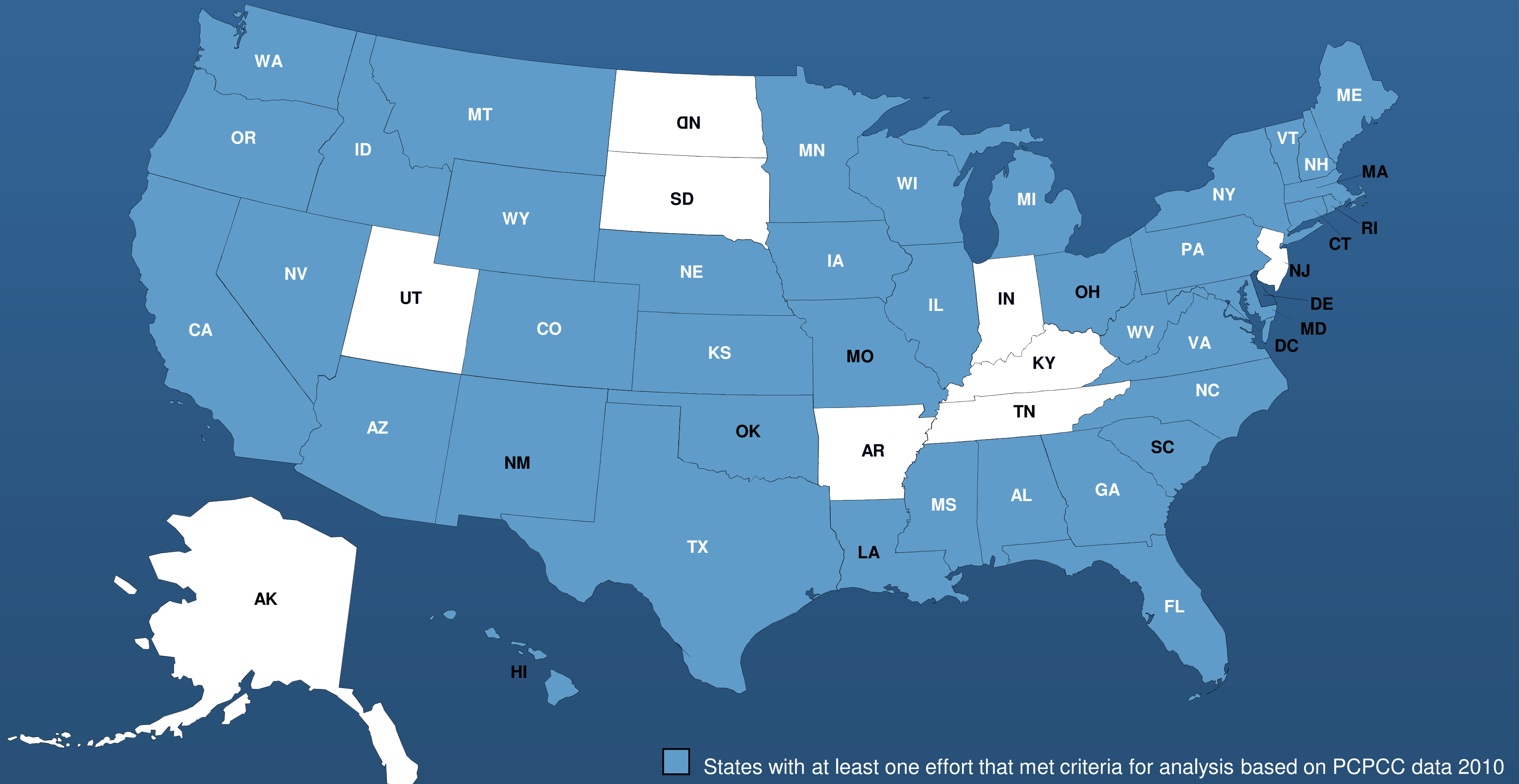
# Partnerships in 40 States to Advance Medical Homes for Medicaid or CHIP Programs

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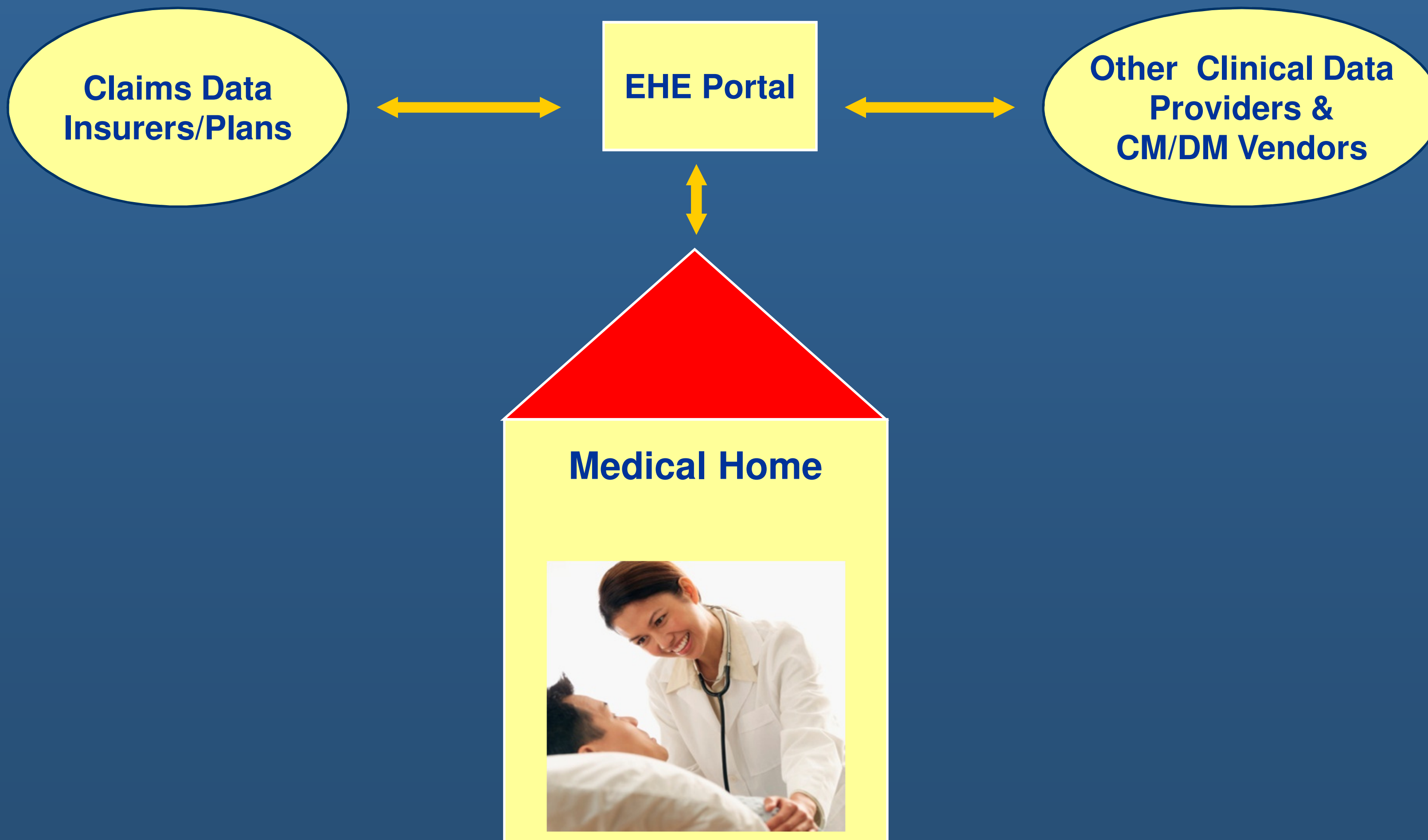
# Medical/Health Home Information and Communication Model

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# Accountable Care Organizations (ACO)

**ACOs are defined as a group of providers that have the legal structure to receive and distribute incentive payments to participating providers.**

Source: Premier Healthcare Alliance


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# Coordination of Care State Demos

- 15 State Medicaid-Medicare Duals Care Integration Demos (Spring 2012 implementation)
- 23 other states have applied

| California | Colorado | Connecticut |
|---|---|---|
| Massachusetts | Michigan | Minnesota |
| New York | North Carolina | Oklahoma |
| Oregon | South Carolina | Tennessee |
| Vermont | Washington | Wisconsin |

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# Provider Challenges

- Coverage expansion creates additional access barriers in a strained system
- Increasing patient loads per provider/facility
- Decreasing reimbursement rates
- Increasing requirements for improved quality, performance, and access
- Increasing administrative barriers for obtaining service authorizations, payments
- Access to clinical and utilization data


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# Defining the Problems:

## Uncoordinated Care, Lack of Appropriate Medication Use, Unmet Treatment Goals for Chronic Conditions


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# Real State Data Examples in Chronic Disease Treatment

- Lack of Treatment
  - 277,000 pts with no drug treatment and incurred $247M in medical costs for year (cholesterol, hypertension, MH)
- Low Drug Adherence rates
  - 40-65% for major drug classes (bronchodilators, inhaled steroids, diabetes, HTN, antipsychotics, antidepressants etc.)
- Clinical Goals Unmet
  - 50-80% of patients are not at clinical goal for chronic conditions


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# Cost of Non-Adherence

State Medicaid Example:
Use of antipsychotics for adults

- Only 15% adults adherence rate 90% or >
- Lower adherence pts (65% or less) had:
  - 96% more ER visits (74% more cost/visit)
  - 116% more hospital visits ($1,160 more/visit)

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# Adverse Drug Events

- Adverse drug events (ADEs) cost a health care system $8700 per event.
- Approximately 30% of the chronic disease population needs clinical pharmacy services
- Comprehensive medication management (CMM) can avoid 5.4 million ADEs per year and save $47B
- Average ROI is 12:1

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# What are the solutions?

- Conduct baseline and periodic analysis of claims data to identify the right subset of patients to target that have high risk and uncoordinated care
- Comprehensive medication management by clinical pharmacists that achieve appropriate use and adherence to medications
- Coordinate care across all settings and transitions in care using integrated HIT systems and models of care (PCMH)
- Payment models that create incentives for savings and better outcomes
- Partnerships with common goals


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# Strategies for Partnering

## Identify Uncoordinated Care and Create Solutions to Improve Quality and Reduce Unnecessary Costs

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# Goals of Intelligent Claims Analysis Model

- Use clinically and statistically validated algorithms to identify subset of patients that exhibit utilization patterns consistent with uncoordinated and inappropriate care.

- Algorithms based on common indicators such as:
  - uncoordinated care from multiple prescribers/pharmacies,
  - accessing the ER for primary care,
  - avoidable ER and hospitalization visits,
  - duplicative medical and drug services from various providers
  - random drug changes within therapeutic classes by different prescribers, “drug switching”
  - inconsistent drug usage, treatment gaps and non-adherence
  - lack of appropriate treatments/services based on guidelines

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# How Much Does it Cost Us?

Costs:

- Identified in multiple states that the most extreme uncoordinated care pts make up 10% percent of adult population yet account for approx. 30% of medical costs, 45% of drug costs and 32% of total plan costs annually

Savings:

- At least 35% of total (medical plus drug) costs for the uncoordinated care population represent potential savings

- Overall savings of at least 10% of total direct care annual costs if the most extreme uncoordinated care patients are better coordinated

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## SEC Published Study: Institute of Medicine *

### National Cost Savings Estimates
### Per Year for Period 2010-2018

- Public Programs (Medicaid and Medicare)
  - Avg. of $133.5 billion per year
- Private Programs
  - Avg. of $106.6 billion per year
- Total Public and Private
  - Avg. of $240.1 billion per year

*Web Link: **The Healthcare Imperative: Lowering Costs and Improving Outcomes. The Institute of Medicine. 2010. Washington, DC: The National Academies Press.** Owens, MK. Chapter 3: Inefficiently Delivered Services, *Costs of Uncoordinated Care,* pgs 131-138. http://books.nap.edu/openbook.php?record_id=12750&page=131

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# Patient Example

21 YOF with Psychosis

- Received 12 atypical antipsychotic scripts for 4 different atypical antipsychotic drugs over 1 yr period with total cost of $3,220
- Had 6 different prescribers and avg of 3 different prescribers per atypical drug with random drug switching among similar drug products
- Annual medical cost was $39,000 (multiple in- pt visits for psychosis)
- Annual drug cost was $5,000
- Actual total one-year cost of $44,000
- Potential Savings: $39,000


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# State Example: Utilization and Cost Summary for Uncoordinated Care Medicaid Patients

| | Percent Patients | Percent Prescription Costs | Percent Prescriptions | Percent Medical Costs | Percent All Costs (drug + medical) |
|---|---|---|---|---|---|
| Uncoordinated Care | 10% | 46% | 45% | 32% | 36% |

$1.8B

Approx 35% of red bar costs are avoidable

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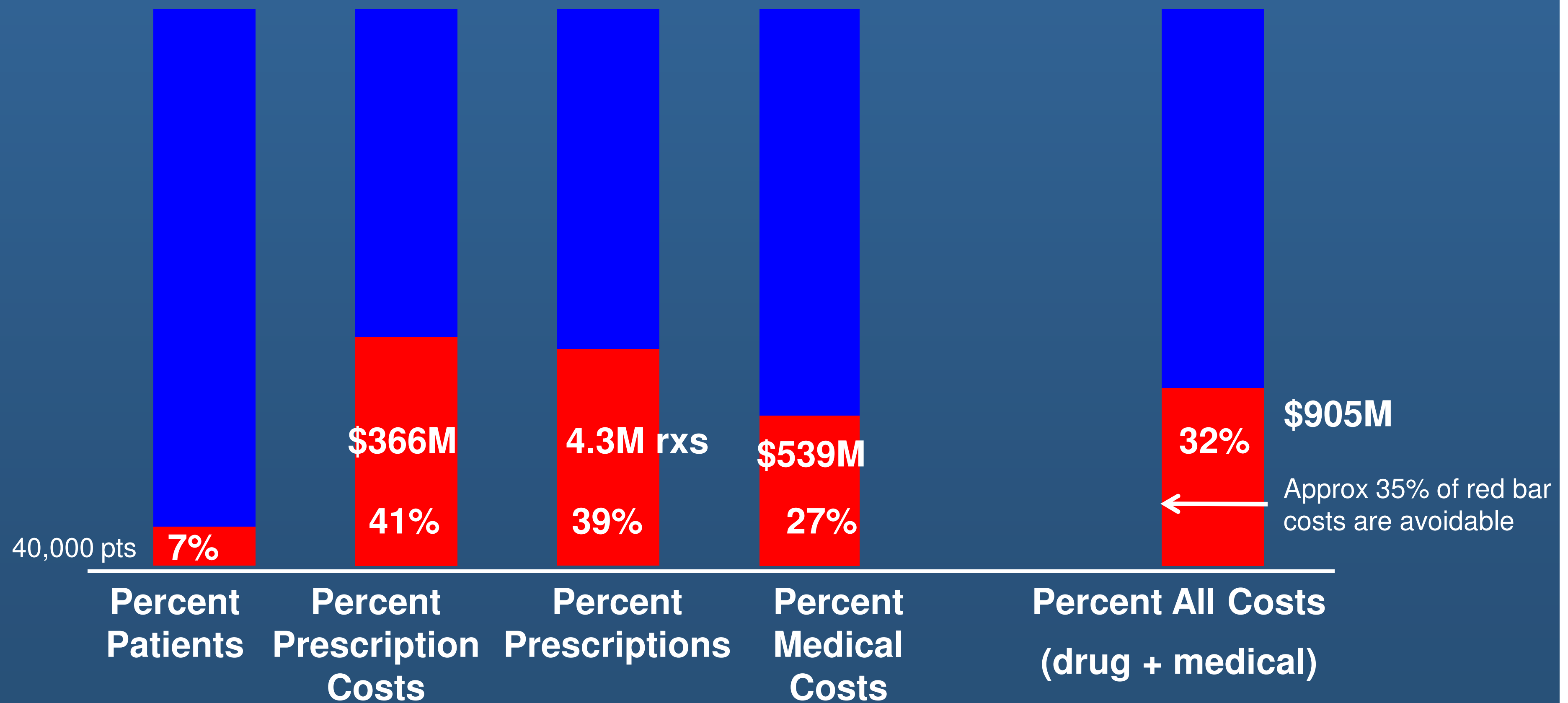
# State Example B: Utilization and Cost Summary for Uncoordinated Care Patients

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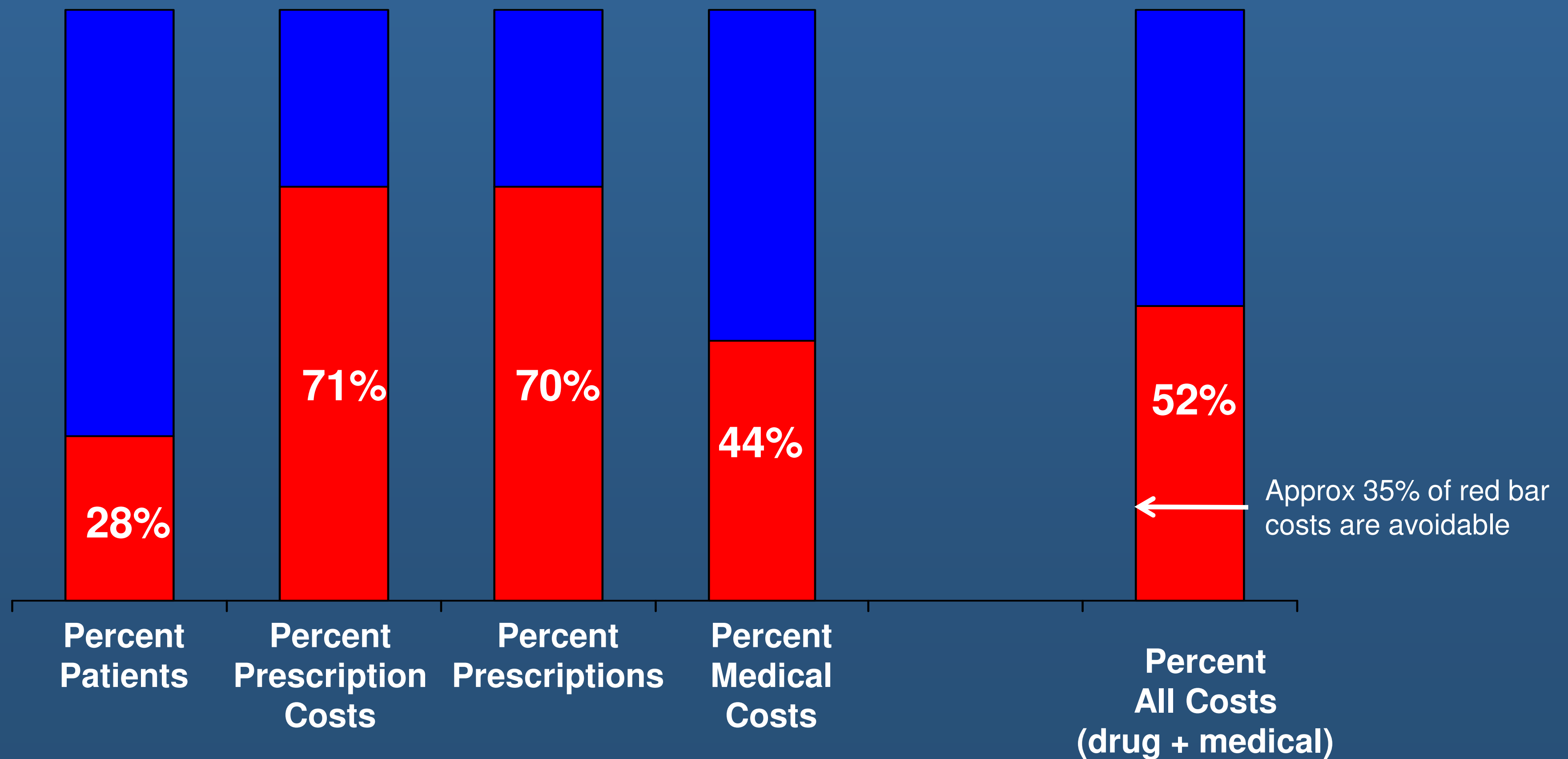
# State Example C: Pre-Medicare Part D
## (Ages 55-64 pop. group)

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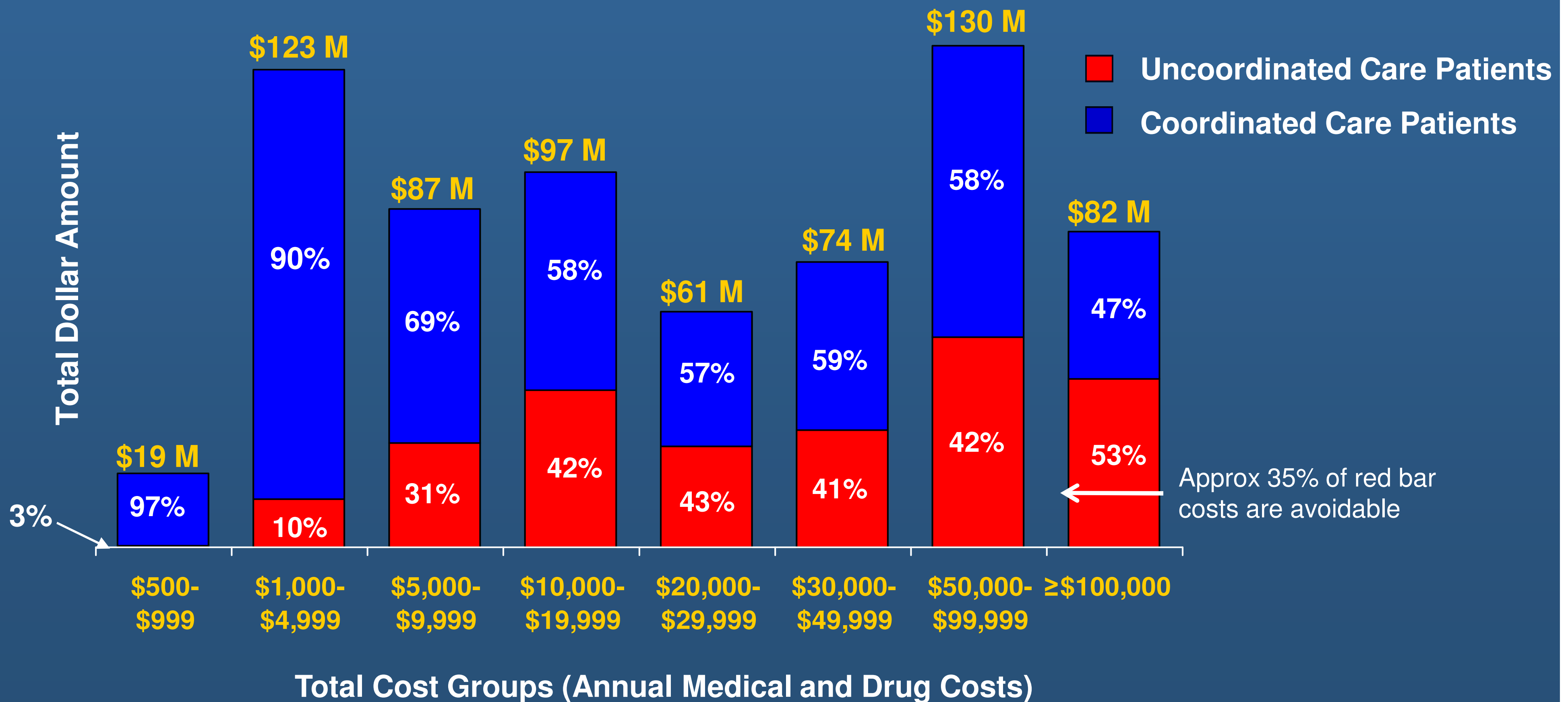
State Example:

# Savings Across All Patient Cost Groups (Low to High)

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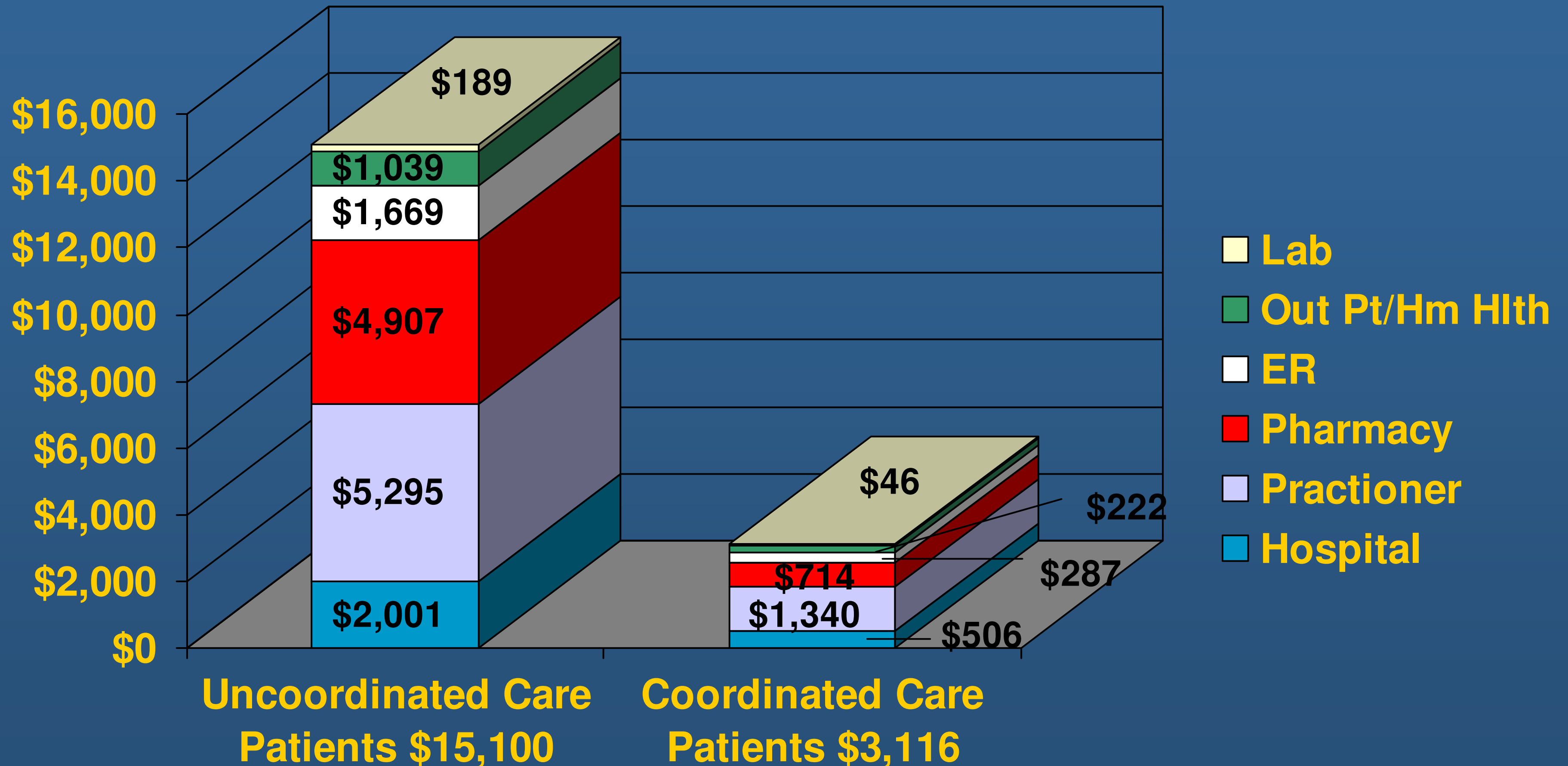
# State Example:
# Average Contribution of Cost Components for Uncoordinated Care vs. Coordinated Care Patients



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# Analysis Utility

- Medicaid FFS and MCO plans
- Commercial MC and PPO plans
- State government employee plans
- Evaluation and Implementation of Medical Home, ACO, and other demos
- Care transition monitoring programs
- Utilization review, program integrity and QI
- Development/evaluation of care coordination measures for comparative analysis between plans and among providers
- Auditing of vendors system edits (PBM)
- MCO plan cap rate calculation adjustment s


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# Partnership Opportunities to Improve Appropriate Medication Use, Manage Chronic Disease, and Create Value for the Health Care System

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# Specific Partnership Goals

- Facilitate resources that provide technical/analytical support to identify and manage uncoordinated care patients with avoidable costs
- Increase appropriate drug use/adherence and continuity of care
- Promote provider/patient based intervention programs and accountable models of care
- Demonstrate and measure the value of using  services and medications appropriately


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# Public Policy Implications/Actions

- Focus efforts on state Medicaid and employee programs which can benefit from this model and achieve huge savings
- Facilitate partnerships between providers, plans, private sector and others to identify and implement “real” solutions
- Support legislation that holds providers/plans accountable for care coordination improvements, support innovative programs, and use of providers in new roles


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# Moving Forward

- Let's stop throwing money at the problem, better understand the data, and become partners in creating value based solutions!

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# Contact Information


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