

*High-Cost Medi-Cal
FFS Beneficiaries:
Managing Their Care and Costs*



*Toby Douglas, Deputy Director
Department of Health Care Services*

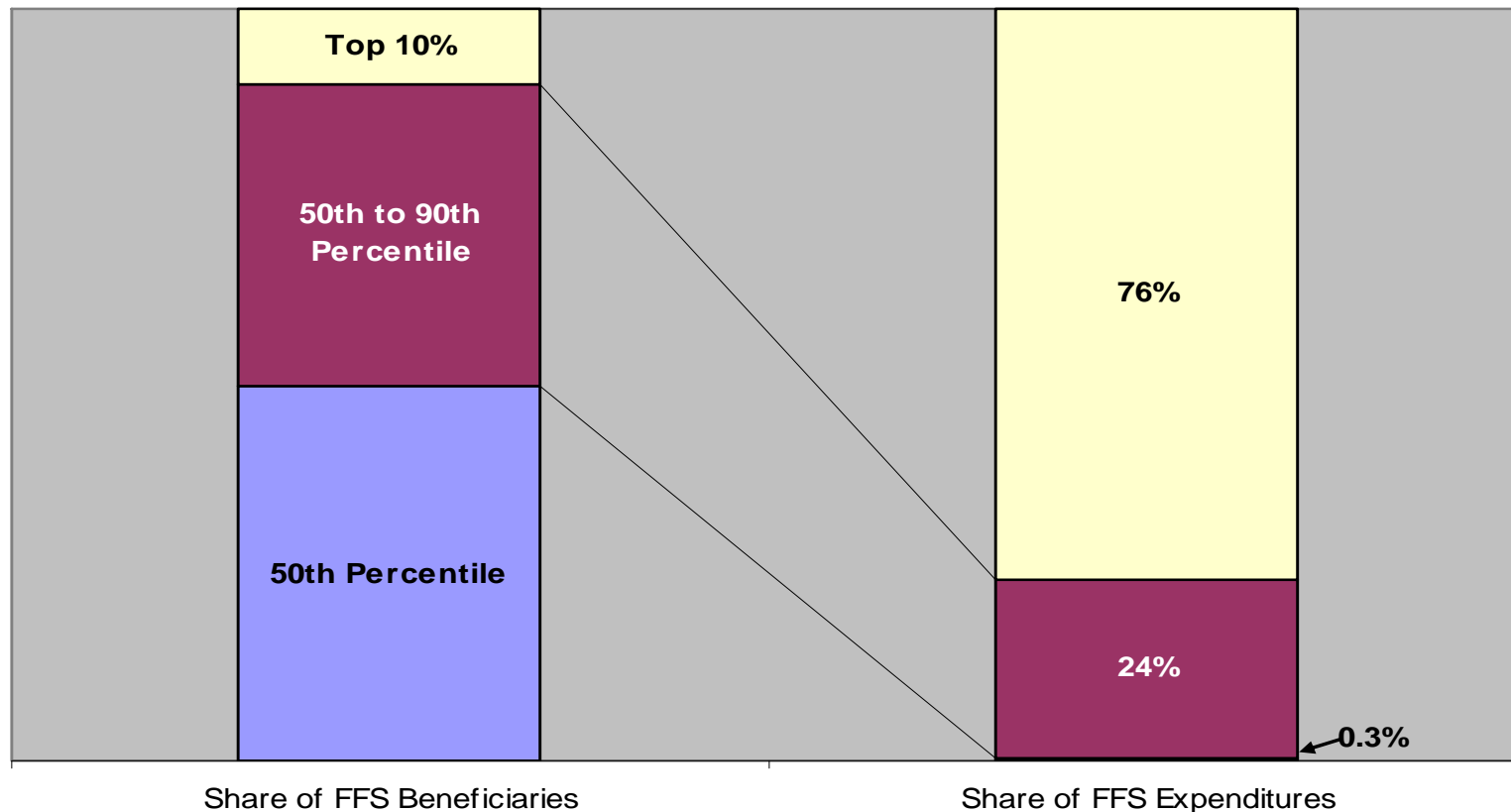
Part I

- The High-Cost, Fee-for-Service (FFS) population - the greatest opportunity:
 - Full-scope Medi-Cal
 - FFS
 - Non-dual eligible (non-Medicare)
 - Aged, Blind, and Disabled Aid Codes
 - About 360,000 beneficiaries

The Challenge

- ❑ Medi-Cal FFS, Seniors and Persons with Disabilities (SPD) enrollees:
 - Have the greatest health care needs of any eligibility group served by Medi-Cal, and
 - Account for the greatest per capita investment of Medi-Cal dollars
- ❑ National studies indicate that the traditional FFS delivery system does not adequately promote preventive and primary health care for those with complex chronic medical conditions.
- ❑ Medi-Cal's efforts to improve access and care coordination have been largely through capitated managed care arrangements that now serve over 3.5 million beneficiaries.

10% of FFS Beneficiaries consume 76% of the FFS dollars



SOURCE: Thomas MaCurdy et al., *Medi-Cal Expenditures: Historical Growth and Long Term Forecasts*, Public Policy Institute of California, June 2005.

The Right Care

- ❑ Preventable hospitalizations cost the U.S. health care system an estimated \$29 billion in 2004. [1]
- ❑ A study comparing preventable hospitalization rates between Medi-Cal FFS and managed care beneficiaries found that, among beneficiaries with disabilities, the average annual preventable hospitalization rate was about 1/4 lower in managed care than in FFS. [2]
- ❑ Studies, which include research from RAND Corporation, indicate that Americans receive appropriate care at the appropriate time just 55% of the time. [3]
- ❑ For persons with diabetes, the right care is provided only 45% of the time. The RAND data indicates that all socioeconomic groups are at risk for poor care.

[1] Agency for Healthcare Research and Quality, Department of Health and Human Services. National Healthcare Quality Report 2007. AHRQ Publication No. 08-0040, February 2008. Available at: <http://www.ahrq.gov/qual/nhqr07/nhqr07.pdf>

[2] Bindman AB, Chattopadhyay A, Osmond D et al. Preventing Unnecessary Hospitalization in Medi-Cal: Comparing Fee-for-Service with Managed Care. Prepared for the California HealthCare Foundation, February 2004. Available at: <http://www.chcf.org/documents/policy/PreventableHospitalizationsInMediCal.pdf>

[3] McGlynn, EA, Asch, SM, Adams, J et al. The Quality of Health Care Delivered to Adults in the United States. *New England Journal of Medicine* 2003; 348:2635-45. Available at: <http://content.nejm.org/cgi/content/full/348/26/2635>

Cost and Prevalence

- ❑ The average annual cost per user of services for Medi-Cal FFS, SPDs (about 360,000 persons) is \$8,200 per year.
- ❑ 16% have Diabetes – as compared to 7% for the United States population.
- ❑ 68% have more than one chronic condition.
- ❑ 29% have a diagnosis for a mental health condition.
- ❑ Approximately 20,300 individuals were identified as “**frequent users**,” with five or more annual Emergency Department (ED) visits.
- ❑ Care for these frequent users was **3.3 times** more expensive than care for other beneficiaries within this target population.

Part II – Current FFS Strategies

- Programs:
 - Medical Case Management (MCM)
 - Disease Management (DM) Pilots
 - Coordinated Care Management (CCM) Pilots

- Goal – emphasize prevention, primary care, and care management to reduce the prevalence and cost associated with chronic disease.

Medical Case Management (MCM)

- California State Registered Nurse case managers work with:
 - Hospitals;
 - Home health agencies; and
 - Physicians.
- Plan medical facility discharge and continuity of care, including follow-up.
- For beneficiaries with chronic and catastrophic illnesses that require intensive services, such as:
 - Repeated acute hospital admissions.
 - Complex chronic conditions.
 - Traumatic brain injury, diabetes, spinal cord injury, ulcer/wound care, etc.

MCM Services

- Expedite authorization of medically necessary services, such as:
 - Home health;
 - Durable medical equipment;
 - Medical supplies;
 - Non-emergency medical transportation;
 - Outpatient therapies; and
 - Prosthetics and orthotics.
- Link beneficiaries with other state, county and local resources.
- About 90 state nurses provide services for 2-12 months post-discharge.

DM Pilot Overview

Two three-year contracts to provide DM services:

□ McKesson Health Solutions

- 6 chronic conditions covered: atherosclerotic disease syndrome, CHF, diabetes, asthma, coronary artery disease, and COPD
- Alameda County and 122 select zip codes in Los Angeles County
- Approximately 18,000 enrolled members
- Operations began August 2007

□ AIDS Healthcare Foundation

- HIV/AIDS conditions covered
- Statewide
- Approximately 7,145 eligible members
- Operations are expected to begin early 2009

DM Pilot Evaluation

- UCLA Center for Health Policy Research will evaluate the following outcomes:
 - Financial: provision of services as a cost neutral or cost savings benefit
 - Beneficiaries: improved health outcomes
 - Organizational: provider satisfaction, effectiveness of community case workers, nurse triage line, outbound calling system
 - Clinical: vendor collects HgbA1c scores, HEDIS-equivalent measures, access to medications, etc.
- Control group comparison using non-pilot counties.
- First year results expected July 2009.

Coordinated Care Management

- ❑ Targets: (1) SPDs who have chronic conditions, or who may be seriously ill and near the end-of-life; and (2) persons with chronic health condition(s) and Serious Mental Illnesses (SMIs)
- ❑ Will be tested in up to five counties
- ❑ Chronic diseases covered: cancer, cerebrovascular disease, asthma, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, diabetes, hypertension, arthritis, obesity, and substance abuse
- ❑ SMI conditions covered: depression, bi-polar disorder, schizophrenia, dementia, non-organic psychoses, anxiety, dissociative, and somatoform disorders
- ❑ Operations expected to begin early 2009

DM and CCM Assessment

- Beneficiary holistic assessment
 - Based on paid claims data for low-risk groups, and
 - Telephonic RN discussion with member regarding needs for the high-risk group
- Stratify beneficiaries into risk groups
- Provide interventions based on risk group stratification
- Semi-annual beneficiary assessments - and more often as needed

Individualized Care Plan

- ❑ Patient-centered approach – i.e., based on patient specific assessment data
- ❑ Comprehensive
 - Medical
 - Pharmaceutical
 - Mental and social needs
- ❑ Explore self-care management strategies
- ❑ Identify interventions based on evidenced-based guidelines
- ❑ Linkages to community-based resources (transportation, support groups, clinics, etc.)
- ❑ Care plans are revised to adapt to beneficiary needs

Physician Support Services

- Medical Home concept is encouraged, but not mandated
- Physician education
 - Evidenced-based
 - Culturally competent
 - Utilizes community resources
- Use of Feedback loop from Department to Contractors - continuous program development and monitoring of:
 - Service utilization
 - Care plan progress
 - Gaps in care (Primary Care visits)
 - Provider issues elevated via contractor (e.g., access to specialty care, claims processing, etc.)

Part III - Strategies That Are Working in Other States

- Several states are using medical homes and targeted care management to successfully increase good health outcomes and reduce avoidable:
 - Emergency department visits
 - Inpatient hospital stays, and
 - Medication utilization

Lessons Learned from Other States

- California DM was introduced as a stand-alone intervention. States are finding that other strategies magnify the effect:
 - A reliable Medical Home as a coordination partner
 - Better integration of DM with the other providers and care systems through formalized working relationships
 - Interoperable data sharing between DM, primary care, specialists, and mental health providers

Community Oriented System

- Flexible system of care:
 - Promote regional strengths, and
 - Fill regional gaps
- Provide additional support and coordination to entities that are providing good chronic care.
- Stakeholder input.
- Community staff teams actively engage members through in-person interventions, such as community health workers, public health nurse, social workers, hospital and clinic case managers, and/or state staff to complement DM work.

Medical Home

- ❑ A participant is linked with a physician, non-physician medical practitioner, clinic, or other safety net provider who will serve as their medical home.
- ❑ The medical home providers:
 1. Assess the participant's health care needs
 2. Coordinate and plan the participant's care
 3. Provide quality primary care services and preventive screenings
 4. Authorize referrals to specialists, and
 5. Providing linkages to other care and equipment providers
- ❑ Evidence indicates that medical homes improves health outcomes and reduce access disparities. [\[1\]](#)
- ❑ Physician-based organizations support the medical home because it provides an on-going relationship with the patient that improves quality. [\[2\]](#)

[\[1\]](#) *Ibid*

[\[2\]](#) Joint Principles of the Patient-Centered Medical Home, March 2007; American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and the American Osteopathic Association.

Chronic Care Management

- Integrate care management services with a medical home provider, which is more effective than providing either service on its own.
- Stratify by disease complexity and integrate assessment, planning and facilitation of:
 - Primary care
 - Specialty care
 - Co-morbidities
 - Medication
 - Mental health
 - Drug dependency
 - Home and community based services
 - Other wrap-around services – “life skills”
- Utilize data on beneficiaries’ health status and outcomes, which can only come from the medical home.

Predictive Modeling

- ❑ One size does not fit all.
- ❑ Target current and future frequent users of health care.
- ❑ Use available data to match specific interventions to the population in anticipation of need.
- ❑ Risk stratification - different interventions for different risk levels, (i.e. need).
- ❑ Targets greatest resources to those with the most need.

Coordination Payment

- ❑ Provide additional compensation to providers for additional coordination work.
- ❑ Incentives should encourage providers to lower costs by improving outcomes through smarter, better health care.
- ❑ Incentives based on quality performance:
 - Participation with coordination, and
 - Reporting and achieving improvement in standardized chronic care measures.

Enrollee and Provider Supports

- ❑ Beneficiaries have access to a toll-free health advice line and participant self-management education materials.
- ❑ Providers have access to training and education for DM, CCM, evidence-based practices, and Quality Improvement data.

Data Systems

- ❑ Support quality measurement, reporting, and information sharing for coordination.
- ❑ Support quality comparison between providers.
- ❑ Must support a Pay-for-Performance (P4P) system that pays according to quality measures.

Quality Improvement System

- ❑ Standardized data collection and tracking over time.
- ❑ Data analysis to determine areas in need of improvement.
- ❑ Develop, prioritize, and implement improvement strategies according to program values, and
- ❑ Repeat as needed.

Measures of Success

Standardized quality measures can be compared and tracked over time:

- ❑ *Clinical Outcomes* – Changes in clinical process and outcome measures.
- ❑ *Humanistic Factors* – Patient quality of life and patient and provider satisfaction.
- ❑ *Operational Factors* - Monitoring contracted operational deliverables.
- ❑ *Financial Outcomes* – Return on Investment (ROI) and cost savings, including projections for future program savings.

Thank You