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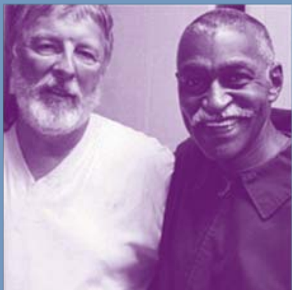

Washington State's Evolving Approach to Chronic Care Management

December 15, 2008

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Washington's Medicaid Program

- Total enrollment approximately 1 million
- Half in managed care; half in FFS (SSI, dual-eligible Medicare-Medicaid)
- Early experiment in managed care for clients on SSI was short-lived: one PCCM pilot, then attempt to launch mandatory statewide enrollment
- Recent integrated managed care pilot in one county for clients with disabilities: positive outcomes, but expansion not supported

Washington's Disease Management Program: Overview

- Operated 2002 through 2006
- Eligible population in Fee-for-Service Medicaid:
    - Aged, Blind or Disabled
    - TANF children only in Asthma (first year)
    - No dual eligible Medicare clients
- About 100,000 clients in population
- All clients eligible for 24/7 Nurse Advice Line
- Program was statewide

Washington's Disease Management Program: Overview

- Approximately 20,000 clients eligible for DM by having one or more targeted chronic conditions
- Clients identified through claims data, referrals from providers or self-referral
- Operated by two vendors:
  - McKesson for Asthma, Diabetes, Heart Failure, and COPD
  - Renaissance for End Stage Renal Disease, Chronic Kidney Disease
- Program included mix of telephonic and in-person; focus on self-management of disease

DM Cost-savings Analysis, Year 1

Condition	ESRD	Heart Failure	Diabetes	Asthma
Baseline Year Costs (Pmpm)	$9253	$1058	$742	$478
Program Year Costs (Pmpm)	$8623	$1041	$705	$468
Program Fees	$268,200	$1.25 M	$4.4 M	$2.1 M
Net Savings	$294,645	-$968,678	-$221,210	-$1.08 M

DM Cost-savings Analysis, Year 3

Condition	Heart Failure	Diabetes	Asthma	COPD
Baseline year costs (pmpm)	$1212	$811	$556	$919
Program year costs (pmpm)	$1143	$748	$507	$876
Program fees	$1.45 M	$3.76 M	$2.06 M	$1.04 M
Net Savings	-$213,456	$2,261,240	-$160,674	-$118,837

DM Program: Lessons Learned

- Evaluation showed mixed results
  - Self-reported data positive but may be inaccurate; loss to follow-up may bias results
  - Utilization data showed mixed results (only a few statistically significant outcomes)
  - Cost savings difficult to prove: contractual limits on methodology; comparison group for trend was dissimilar
- Program implementation lessons learned
  - Provider involvement was a challenge
  - Complex needs of clients do not fit a standard approach
  - All-in program design resulted in high costs for small effects
- Experience with DM provided solid foundation for next effort

Washington's Chronic Care Management Program: Overview

- Identify clients with complex conditions, at risk for high costs, using predictive modeling
- Support medical home development
- Improve health outcomes for program enrollees using evidence-based medicine
- Assist enrollees to prevent avoidable medical costs by improving access to care, self-management skills and health literacy
- Evaluate effectiveness of intervention using randomized assignment method

Washington's Chronic Care Management: Overview

- Adults on SSI (Aged, Blind, Disabled eligibility)
- Exclusions: dual eligible (Medicare-Medicaid), managed care and hospice clients
- 60,000 people potentially eligible
- Stratify the top 20% of risk (identified through Predictive Modeling)
- Voluntary enrollment; 6 month goal to graduate
- Payment for care management (enrollees only) and infrastructure (PM statewide, medical home at local level)

Care Management Contracts

- Statewide, Americhoice
- King County, King County Care Partners (solicited multiple bids for local model)
  - Telephonic or face-to-face assessment using standardized tools – PHQ-9, SF-12, etc
  - Assists client to identify health goals
  - Shares Plan of Care with client's primary care provider
  - Assists client in self-management of health conditions

Predictive Modeling

- Provided by AmeriChoice using **Impact Pro™**
- Uses historical claims data, demographics, etc. to identify clients at high risk/high cost
- Identifies:
  - Primary drivers of cost of care and risk factor
  - Care opportunities
  - Future Risk Score
  - Future Inpatient Risk
- Providers and care managers use for prioritization and intervention

Impact Pro© Care Opportunities

Impact Pro
- Welcome
- Members List
- Aggregate Reports
- Public Reports
- Group Reports
- My Reports
- Manage Reports
- Business Rules

Administration
- Configuration
- Users
- Roles
- Active Sessions

General
- IHCIS Home
- Support
- Preferences
- Logout

Search Members

Search

Print profile: Print tab: 35 of 50183 Page:

Member Information

Member ID: 0013540108 **Sex:** Male **Age:** 68

Months Enrolled: 12 **PCP:** 1

Risk Information

Future Risk, Costs: 31.69 **Future Costs:** $76,045 **Future Risk, Inpatient:** 22.02

Inpatient Stay Probability: 61.2 % **Prior Total Costs (Annualized):** $73,488 **Primary Risk Factor:** Neoplastic blood disease

Primary Risk Factor, Future Risk, Costs: 20.88

Care History | Risk Profile | Pro Active Profile

Clinical Indicators | Care Opportunities | Case Definitions | Care Alerts

Care Opportunities

Primary Condition	Name
CAD	CAD, no evidence of lipid testing
Diabetes	Diabetes with no evidence of flu vaccination
Diabetes	Diabetes, no evidence of lipid testing
Diabetes	Diabetes, no evidence of a visit to eye specialist
Diabetes	Diabetes, no evidence of HbA1C testing
Diabetes	Diabetes, no evidence of testing for microalbuminuria
Hyperlipidemia	Hyperlipidemia, no evidence of liver function testing while on antilipid treatment
Diabetes	Inadequate diabetes care follow-up (every 6 months)
Cerebrovascular Disease	No evidence of antithrombotic/antiplatelet therapy with evidence of stroke or TIA

First Year Results

- Low enrollment in both programs
- KCCP building provider support: first year lump sum released to clinics; willing to share pooled funds to hire FTEs
- Mixed evaluation findings (treatment vs. control)
  - Americhoice, no evidence of cost savings
  - KCCP, not significant but cost offset evident
  - Mortality rate significantly lower in treatment group (KCCP)

First year cost-effectiveness, KCCP

Measure	Treatment pre PMPM	Treatment post PMPM	Diff. PMPM	Control Pre PMPM	Control Post PMPM	Diff. PMPM	Level Diff-in-Diff PMPM
Outpt ER	$72.65	$80.05	$7.40	$75.86	$79.06	$3.20	$4.20
Inpt rel to ER	$331.74	$369.10	$37.36	$368.58	$347.85	-$20.73	$58.09
Inpt not rel to ER	$169.90	$143.39	-$26.51	$149.93	$177.81	$27.88	-$54.39
Total medical	$1299	$1368	$69.23	$1326	$1352	$26.18	$43.05

Opportunities

- Highest risk clients have multiple medical and social needs requiring intervention from multiple systems
- “Opt in” rate has potential for growth: need to increase outreach & engagement
- Building on early successes with referral and linkage to mental health, chemical dependency and services for people who are homeless
- Using tools such as Patient Activation Measure helps the nurse focus on the individual’s goals

Ingredients For Success In “Test As You Go” Programs

- Support at all levels of the state agency for innovation and robust evaluation
- Communicate up, down and sideways
  - Your team will help you learn from missteps
  - Good leadership will help you build on successes
  - Access to care requires close ties with gatekeepers; found funds that help clients access CD treatment
  - Don’t over-promise results
- Take advantage of opportunities
  - Executive order on chronic conditions; legislative interest in medical home