



# **Illinois Disease Management/Medical Home Program**

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# Illinois Background

- **2.4 Million beneficiaries in HFS programs**
- **Primarily fee-for-service**
- **Voluntary managed care in Cook and seven other rural counties (170,000 members)**
- **Historic focus on eligibility determination and claims payment**
- **Increasing trend line medical costs**

# Overview

- Focus on access and quality while managing costs
- Primary Care Case Management – Medical Home
  - PCCM Administrator responsible for provider recruitment, client enrollment, quality and EPSDT compliance
  - Program designed to ensure Medical Home
  - 1.7 million beneficiaries eligible
- Disease Management population is a subset
  - Contract with DM vendor
  - 220,000 beneficiaries eligible
  - Targets disabled adults and children with asthma

# PCCM Program Status

- PCCM Network development began in Fall 2006
- Started member enrollment into Medical Home in February 2007 (Mandatory Enrollment)
- Current status PCCM
  - Statewide enrollment complete
  - 1.7 million members enrolled into medical home
  - 5,300 medical homes (physicians and clinics) with over 5 million member capacity

# PCCM Payment

- Pay vendor on PMPM basis (primarily)
- Minimal financial risk based on clinical only (withhold)
- PCP's are paid a PMPM for each member in panel for care management
  - \$2.00 per child
  - \$3.00 per parent
  - \$4.00 per disabled adult
- PCP continue to bill FFS for medical care
- Member mandatory enrollment

# Disease Management Program Status and Payment

- DM program administrator started July, 2006, and started contacting members August 2006 (Risk Based Contract)
- Pay vendor on PMPM basis
- Financial risk based contract (80% risk for meeting net savings target and 20% for clinical)
- Members may opt out

# Disease Management Eligibility

**Disabled Adults:** All eligible irrespective of disease or condition  
– 122,000

- includes 12,000 in LTC

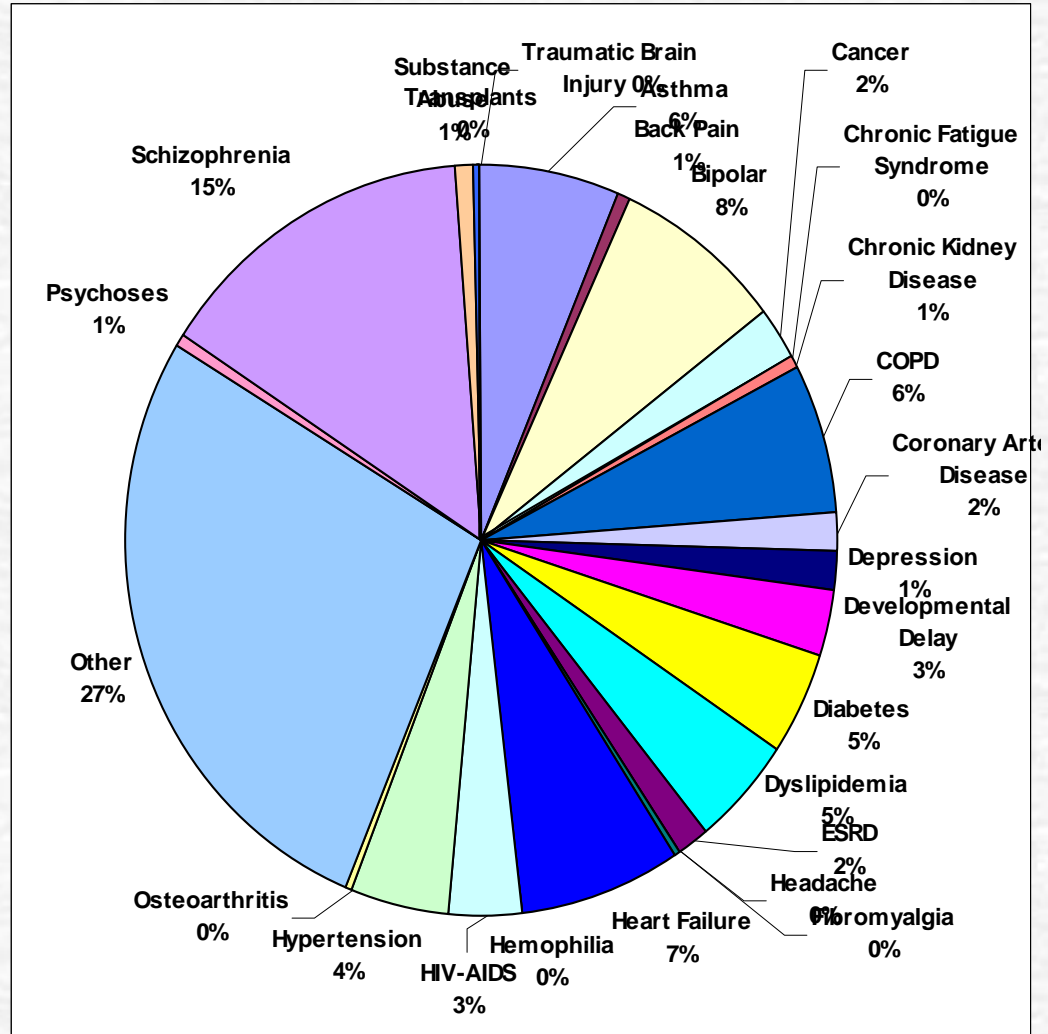
**Persistent Asthma:** Children and adults who have persistent asthma (utilizing the HEDIS definition) - 75,000

**Frequent ER Users:** Children and adults who are frequent emergency room users (defined as 6 or more visits a year) - 32,000

Participation in Your Healthcare Plus™ is voluntary, and statewide. Individuals can “opt out.”

# Disease State of DM Eligible Members (Disabled Adults - Community)

- Disease state shown by primary diagnosis:
  - Over 26% of members have a primary diagnosis within the core five conditions (Asthma, Diabetes, COPD, CAD, CHF)
  - Over 25% of members have a primary diagnosis of a behavioral health condition
  - A significant portion of members suffer from multiple co-morbidities



# DM Patient Involvement Strategy

- Community based teams – 170 local staff
- Teams are comprised of individuals who are indigenous to these communities, culturally diverse
- Staff is also placed in high volume sites (hospitals and clinics)
- Staff conduct DM both telephonically and face-to-face

# DM Program Model

- **Community Staff**
  - Nurse (routine and complex care)
  - Lay community educators
  - Social workers
  - Behavioral health workers
  - Hospital based case managers
  - Clinic based staff
- **Special Projects**
  - LTC initiatives
  - Pharmacy
  - Behavioral health
  - QIO

# PCP Support by DM Staff

- Support providers care plan by facilitating patient compliance.
- Patient education to help them better understand their disease, follow care plan and medication requirements.
- Intensive care management to most complex patients.
- Emphasize importance of making scheduled visits and reduce office no shows
- Support provider in post ER and hospitalization follow-up.
- Notify provider of any urgent medical problem or medication management/compliance issues.
- Physicians receive support in identifying patients with unusual drug utilization patterns

# PCP Support

- PCP access to secure web portal which contains PCP support materials
- Patient roster
  - Provides information on needed preventive services
- Provider profiles/registry
- Historical claims
  - 2 years Medicaid claims
- Pay for Performance

# Provider Profile



## Illinois Department of Healthcare and Family Services Your Healthcare Plus™ Disease Management Patient Summary

Provider ID: [REDACTED]  
 Name: [REDACTED]  
 Address: [REDACTED]  
 [REDACTED] 2

Total number of eligible patients with Diabetes: 38

### Performance Data Detail - Diabetes - Disabled Adult Population Paid Claims with Dates of Service from October 1, 2006 - September 30, 2007

Guideline Measures				
Indicator - Description	# of Eligible Patients (Denominator)	# of Eligible Events (Numerator)	Your Current Year Rate	Statewide Average
HbA1c testing at least every 12 months	38	26	74%	71%
Daily ASA / other antiplatelet	38	14	37%	41%
Annual microalbuminuria test	38	20	53%	59%
Annual retinal exam	38	4	11%	26%
Annual lipid panel	38	27	71%	68%
Annual influenza vaccination	38	5	13%	13%
Utilization Measures				
Indicator - Description	# of Eligible Patients (Denominator)	# of Eligible Events (Numerator)	Your Current Year Rate	Statewide Average
No Diabetes-related ED Visits within the last 12 months	38	37	97%	91%
No Diabetes-related IP Visits within the last 12 months	38	37	97%	96%

\*Please note that for providers who have only a small number of eligible patients (a small denominator) in the condition identified, the current year rate may not be a useful statistic. This data is included in order to facilitate comparison to state-wide averages and is provided for informational purposes only.

# Provider Profile



**Illinois Department of Healthcare and Family Services**  
*Your Healthcare Plus™ Disease Management Patient Summary*

Provider ID: [REDACTED]  
 Name: [REDACTED]  
 Address: [REDACTED]  
 [REDACTED]

Total number of eligible patients with Diabetes: 38

**Patient Guidelines Met - Diabetes - Disabled Adult Population**

ID	Member Name	DOB	Guideline Measures						Utilization Measures	
			HbA1c testing at least every 12 months	Daily ASA / other antiplatelet	Annual microalbuminuria test	Annual retinal exam	Annual lipid panel	Annual influenza vaccination	Diabetes ED Visits within the last 12 months	Diabetes IP Visits within the last 12 months
[REDACTED]	[REDACTED]	[REDACTED]		No		No		No		
[REDACTED]	[REDACTED]	[REDACTED]		No		No		No		
[REDACTED]	[REDACTED]	[REDACTED]			No	No	No	No		
[REDACTED]	[REDACTED]	[REDACTED]		No	No	No		No		Yes
[REDACTED]	[REDACTED]	[REDACTED]		No		No	No	No	No	
[REDACTED]	[REDACTED]	[REDACTED]		No		No	No	No	Yes	
[REDACTED]	[REDACTED]	[REDACTED]		No	No	No		No		
[REDACTED]	[REDACTED]	[REDACTED]		No	No	No		No		
[REDACTED]	[REDACTED]	[REDACTED]	No	No	No	No	No	No		
[REDACTED]	[REDACTED]	[REDACTED]		No	No	No		No		
[REDACTED]	[REDACTED]	[REDACTED]		No	No	No		No		
[REDACTED]	[REDACTED]	[REDACTED]		No	No	No		No		

# Behavior Health Intervention

- **Coordinate with Behavioral Health System**
  - Regional educational services
  - Share information regarding mental health, physical health management for high cost users
  - Co-manage high cost high risk group: outreach to local CMHC
- **Addressing Behavioral Health co-morbidities**
  - Many members have both medical and behavioral conditions
  - Focus on depression and impact on medical conditions
  - DM staff screen for depression as part of assessment
  - Behavioral Health conditions create “barriers” to care for medical conditions
- **Pharmacy issues are critical**

# Psychotropic Medication Management

- Provider mailing for psychotropics
- Targeted mailing based on specific claim indicators (~20 indicators: redundancy, contraindications)
- Alert sent to prescribers of record
- Encourage appropriate adherence to clinical guidelines
- Notify prescribers of refill patterns
- Will expand concept to organize reports around CMHC and LTC sites

# Selected Measures of DM Program Success

- Patient and provider satisfaction (survey)
- Reductions in avoidable hospitalization, ED visits
- Calculated cost avoidance relative to preprogram cost trends
- Improvements in state defined clinical indicators
  - Heart Failure: Percent of pts on ACE/ARB medication
  - Diabetes: Retinal exam, HgbA1c testing rates
  - CAD: Cholesterol testing rates
  - Asthma: Use of controller medications
  - COPD: Use of spirometry for dx

# Lessons Learned

- Need to focus on entire chronic disease population not just the five most common chronic diseases
- Difficult to find DM members – especially urban areas
- Be conservative regarding the number of targeted members who can be engaged in DM
- Mental Health is a significant problem both as a primary diagnosis and as co-morbidity
- Importance of interagency coordination, especially behavioral health
- Consider including waiver populations in DM
- Importance of physician and physician association “buy in” and need for their input (stakeholder advisory committee)

## Lessons Learned (2)

- Should launch PCCM and DM at the same time
- Need capacity to analyze claims data rapidly
- Data important in driving decisions during implementation
- LTC community very different and more difficult to engage and LTC residents have worse clinical metrics
- System-wide transformation takes time
- Need to provide decision support tools to PCP's and then provide training (CME)
- Consider tiered medical home requirements
- Need special focus on engagement PCP in DM process – pay for participation
- Avoid promising significant savings in year one
- Need precise contract language especially regarding financial reconciliation and how to deal with eligibility changes

# RESULTS: Year 1 (FY'07)

- \$34 million net savings
- Reduction in hospitalization costs (9%)
- Provider and patient satisfaction
  - 94% members satisfied or very satisfied
  - 65% providers report program useful and 70% would recommend their patients participate
- Modest improvement in clinical metrics
- Disease specific hospital admission rate decreases
  - CAD - 20%
  - CHF - 19%
  - Asthma - 19%