

Patient-Centered Primary Care Collaborative Webinar
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Focusing Care Coordination

Identifying and Quantifying the Cost of Uncoordinated Care to Achieve Cost Efficiency and Improved Quality

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SEC Services Overview

- ◆ Provide analytical support services, project design, coordination and management for partnerships between 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 and industry clients for medical home models/pilots, utilization management programs, disease management programs, audit methods, claims payments, system edits and other areas

Focusing Care Coordination Resources

- ◆ Identifying appropriate categories of patients and focusing care coordination means substantial cost savings and quality improvement.
- ◆ Evidence and experience supports new, more sophisticated approaches to risk stratification
- ◆ Supports and enhances innovative payment and care delivery models
- ◆ Important for health care reform efforts

Detailed Claims Analysis

- ◆ Florida, New Jersey, Ohio, Pennsylvania, and Virginia and others in process
- ◆ Over 9 million FFS lives and 330 million claims analyzed for uncoordinated care patterns, medical/drug utilization and cost drivers within all disease and demographic groups
- ◆ Separate analysis of Medicaid, Medicare duals and LTC pts in each state
- ◆ Excluded pts who died, hospice, major trauma and others with catastrophic illness
- ◆ Results have been replicated in the states

Study Identifying Uncoordinated Care

- ◆ Cohort of patients exhibiting patterns of extreme uncoordinated care
- ◆ Predictors included inappropriate use of various combinations and types of prescriptions, multiple numbers of different prescribing and treating physicians, multiple different pharmacies, frequently accessing the ER for non-emergent or preventable care, duplicative and inefficient use of all types of services.

Adherence and Persistency Data: How bad is it and how much does it cost us?

Cost of Non-Adherence

State Example: Antipsychotics for Adults

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

State Example: Disease Prevalence and Lack of Drug Treatment

◆ Cardiac Condition

- ◆ 35% of pts that were identified with cardiac diagnosis codes are not using any cardiac drugs for 12 months.

◆ Elevated Lipid Condition

- ◆ 72% of pts that were identified with lipid disorder diagnosis codes not using any lipid drugs for 12 months.

What does Uncoordinated Care Look Like?

Patient Examples

Patient Example # 1

46 YOF with Cardiac, COPD, and Depression

- ◆ **185 scripts totaling \$8,388 in drugs**
- ◆ **54 treating physicians, 34 different prescribers and 21 pharmacies**
 - ◆ **29 narcotic rxs (16 prescribers, 10 pharmacies)**
- ◆ **395 medical events for \$28,125**
 - ◆ **45 ER visits for total of \$10,012**
 - ◆ **147 outpatient claims totaling \$14,120**
 - ◆ **85 physician claims totaling \$2,237**
- ◆ **Total one-year costs of \$36,513**

Patient Example # 2

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
- ◆ Total one-year cost of \$44,000

How Much Does it Cost Us?

- ◆ Identified in multiple states that on average extreme uncoordinated care pts (<10%) account for approx. 30% of all medical costs, 45% of all drug costs and 32% of total plan costs and for older pts even more
- ◆ At least 35% of costs for the uncoordinated care groups represent potential savings
- ◆ Our regression analyses and matched comparison evaluations indicate that:
 - ◆ Approx. 10% of total direct care costs can be saved if the most extreme uncoordinated care patients are better coordinated via medical homes, health information exchange of data , targeted interventions and other combined strategies

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
- ◆ Used NHE data projections by category of spending, applied savings of 9% and assumed 3 year phase in.

Basic Steps for Focusing Care Coordination

Identify, quantify, and target patients with uncoordinated care

Incorporate targeting into care delivery models with actionable information

Direct provider/patient incentives with a patient-centered, shared accountability approach

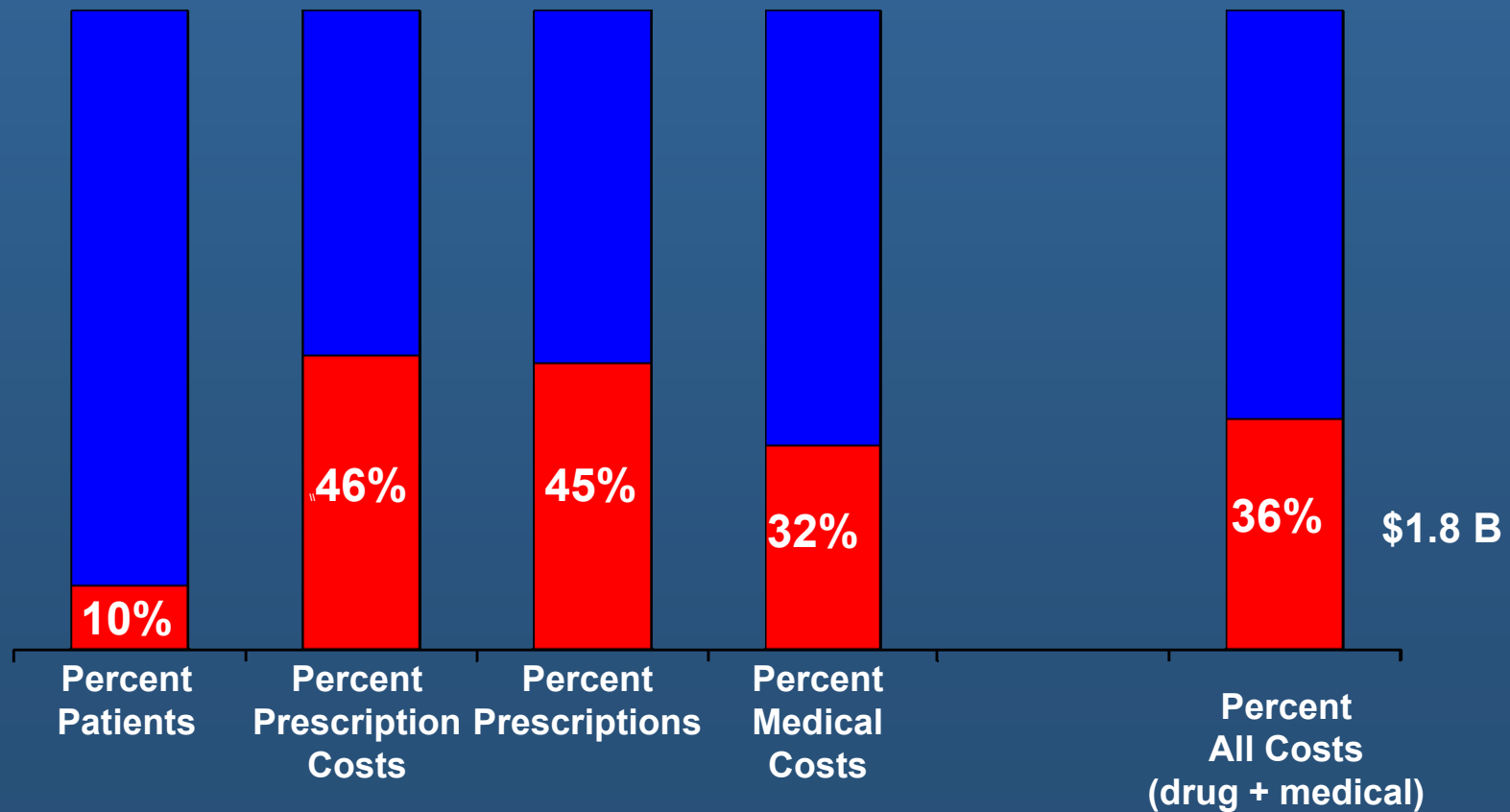
Use HIT, clinical integration, and decision support tools

Review and validate efforts

Coordinated Vs Uncoordinated Care Utilization and Cost Comparisons for Various States

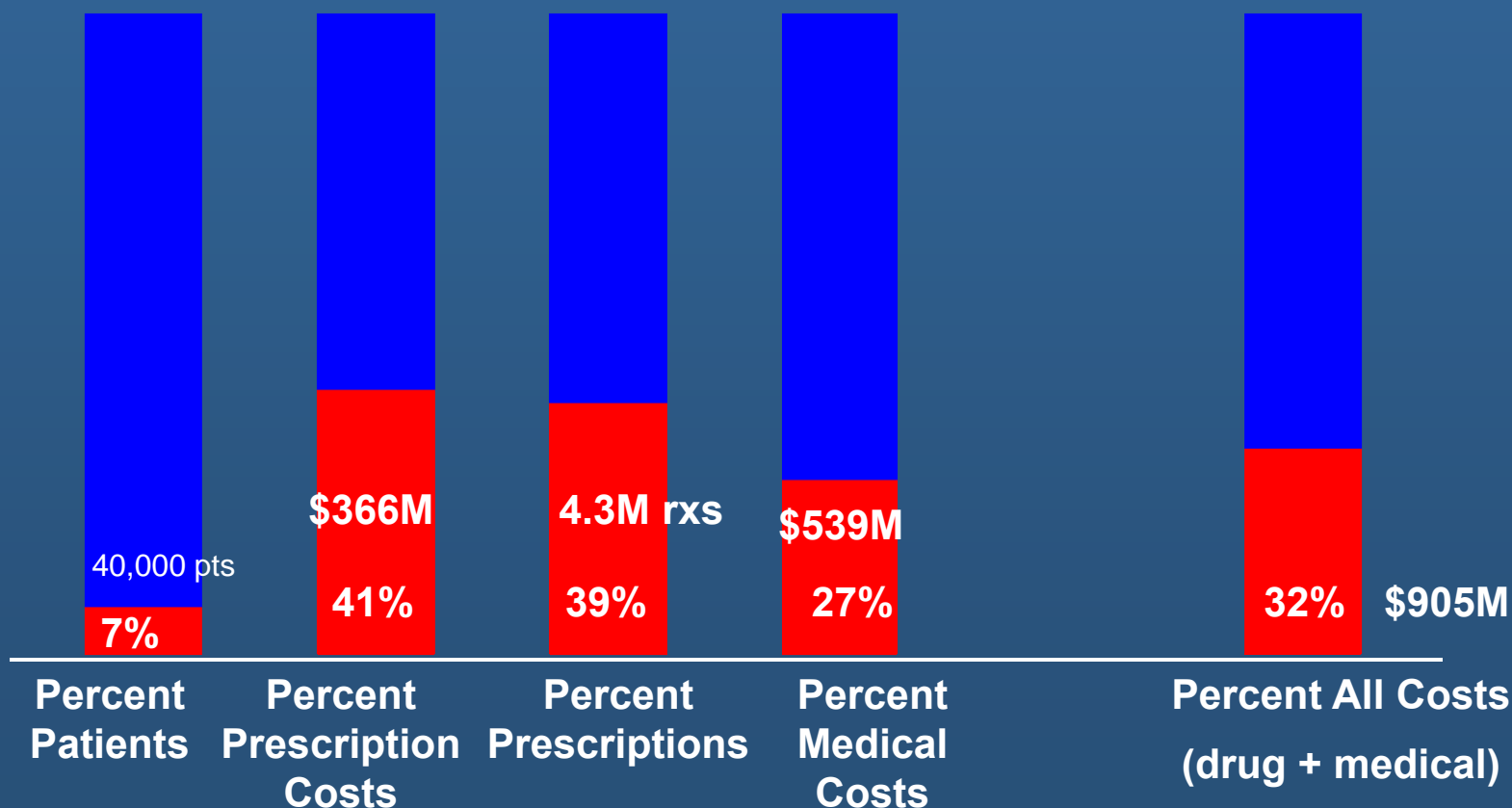
State Example A: Utilization and Cost Summary for Uncoordinated Care Patients

Uncoordinated Care Utilization and Cost Percentages



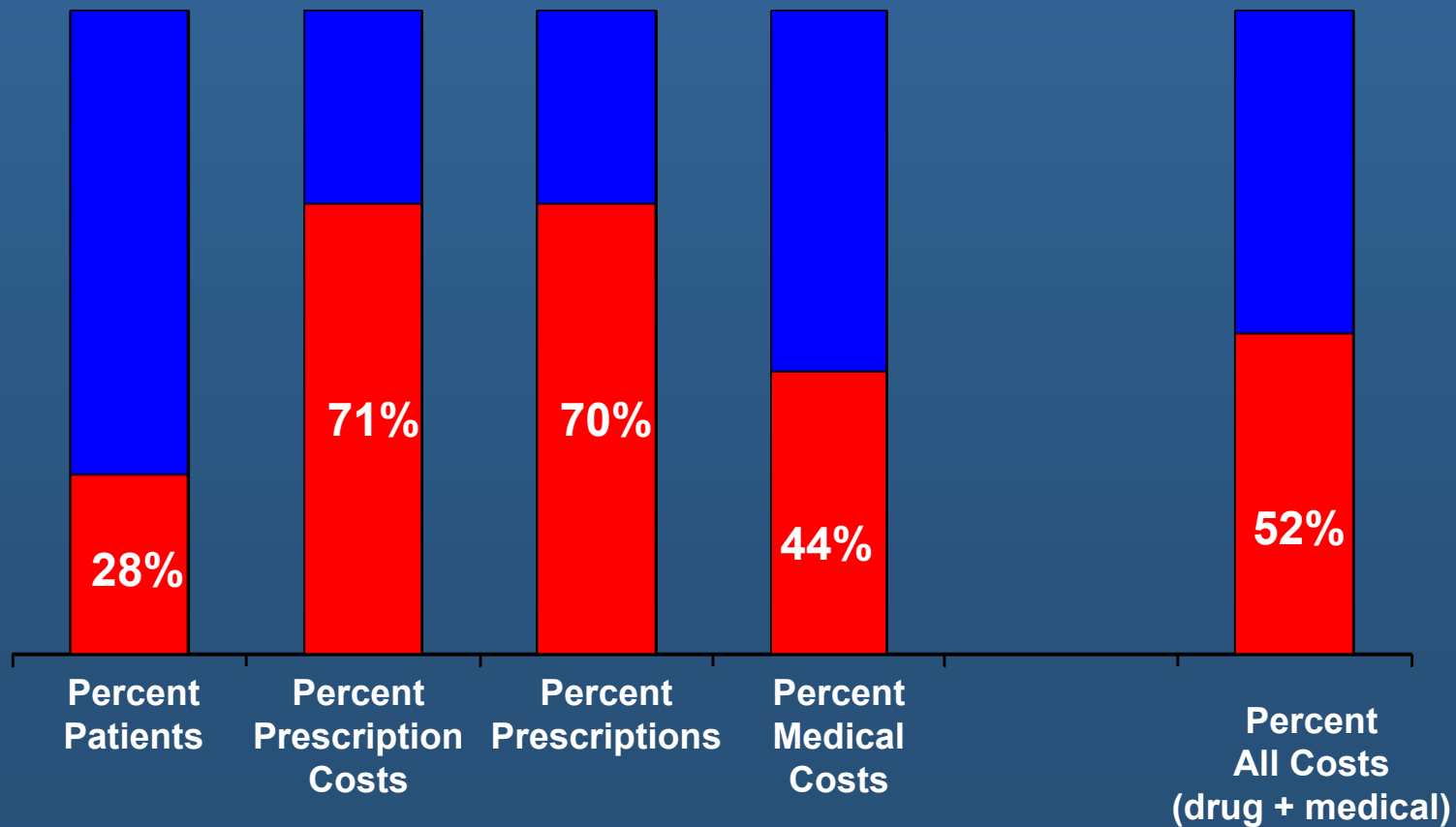
State Example B: Utilization and Cost Summary for Uncoordinated Care Patients

■ Coordinated Care Patients
 ■ Uncoordinated Care Patients



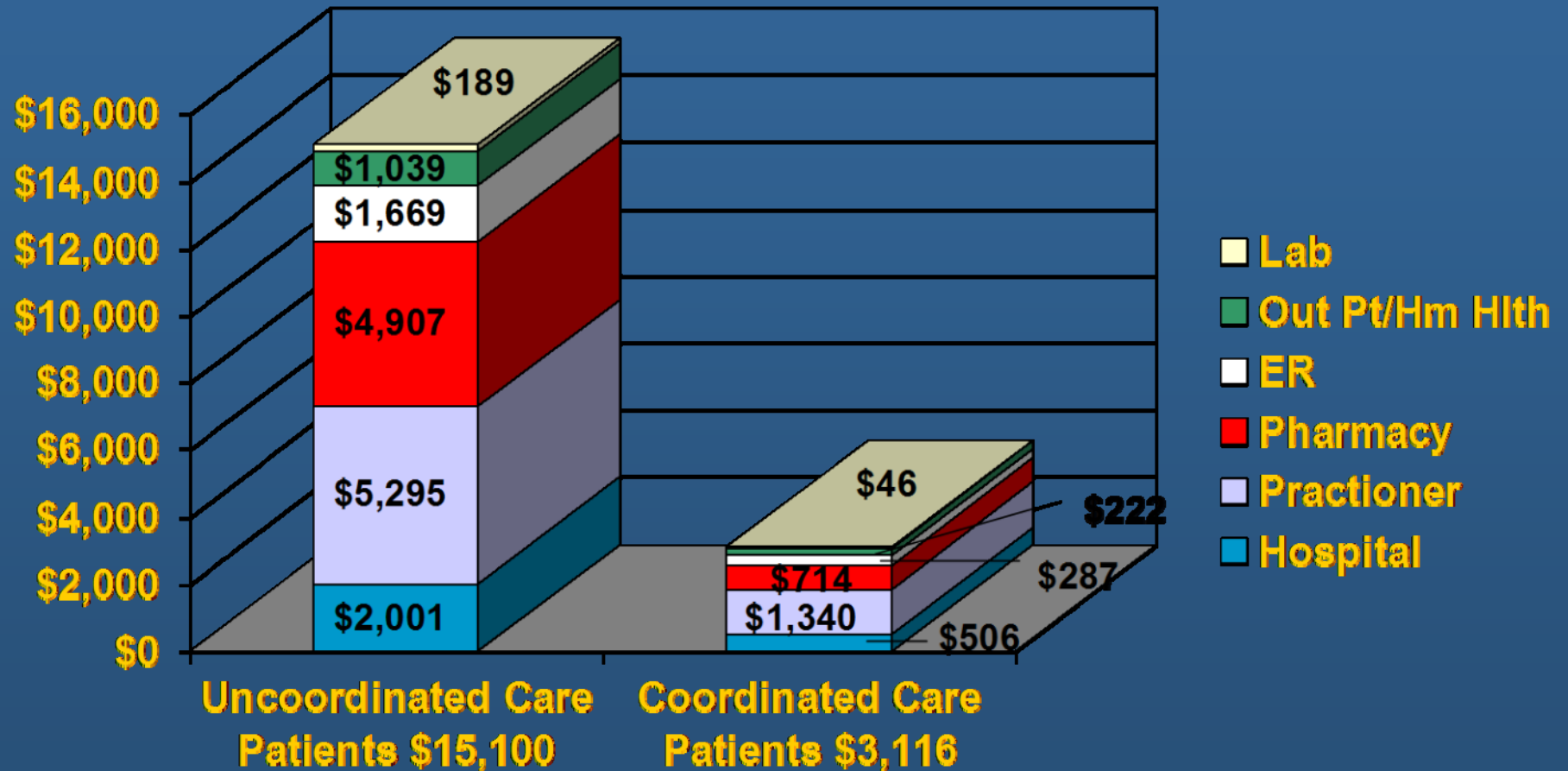
State Example: Pre-Medicare (Ages 55-64 pop. group)

Uncoordinated Care Utilization and Cost Percentages



State Example: Medicaid Only Group

Average Contribution of Cost Components for Uncoordinated Care vs. Coordinated Care Patients



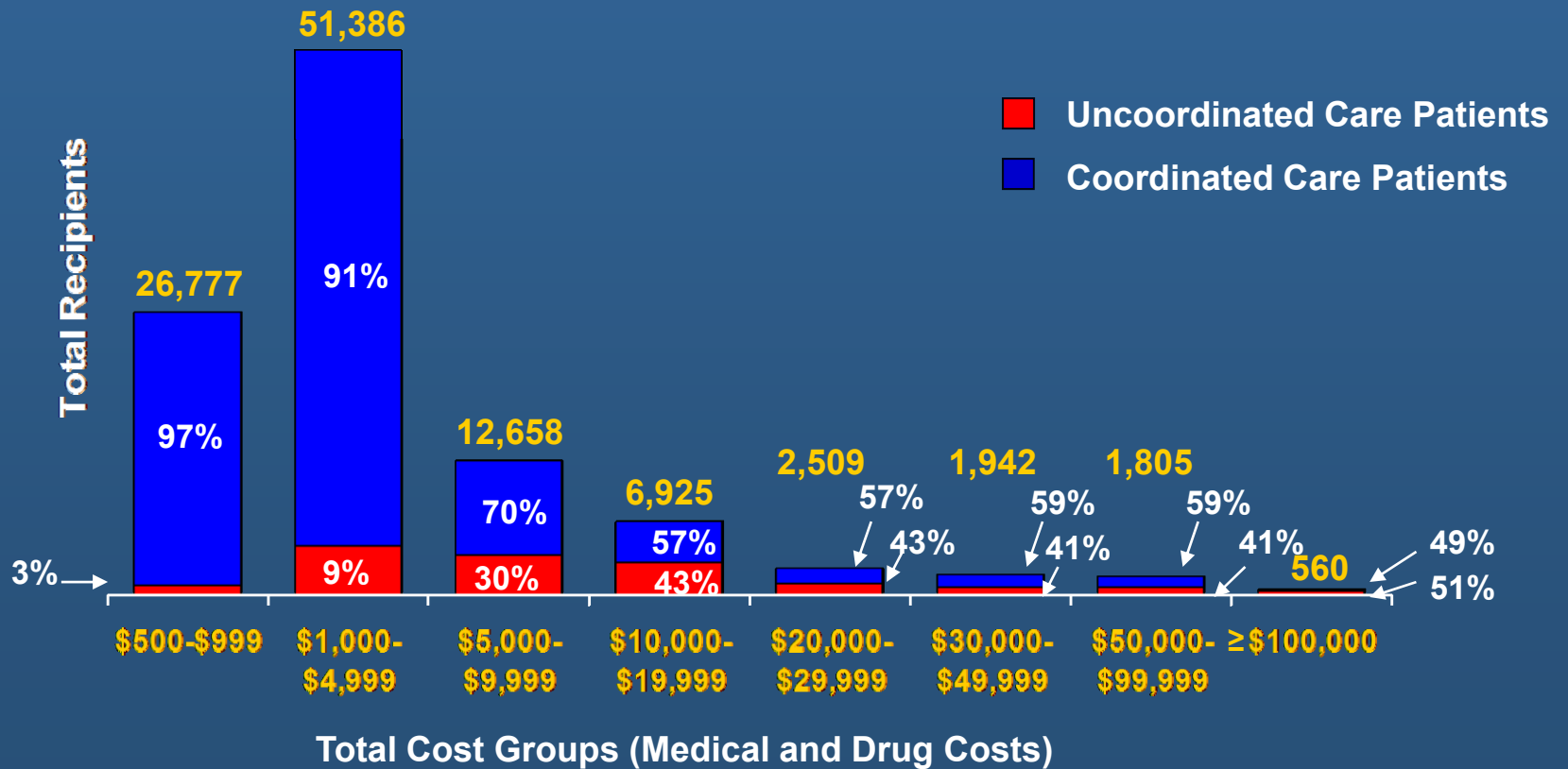
New Approach to Patient Management to Target Cost and Quality Impactable Patients With Uncoordinated Care

Traditional Disease/Utilization/Care Management Program Approaches

- ◆ Voluntary pt enrollment
- ◆ Target all pts with a major chronic disease-same interv.
- ◆ Assume all high cost and high utilizers are cost & quality impactable
- ◆ Focus resources on contacts with high cost and high utilizers
- ◆ Often rely on pt reported behavior instead of actual claims or medical chart data
- ◆ Assume chronic and/or complex disease drives majority of all cost

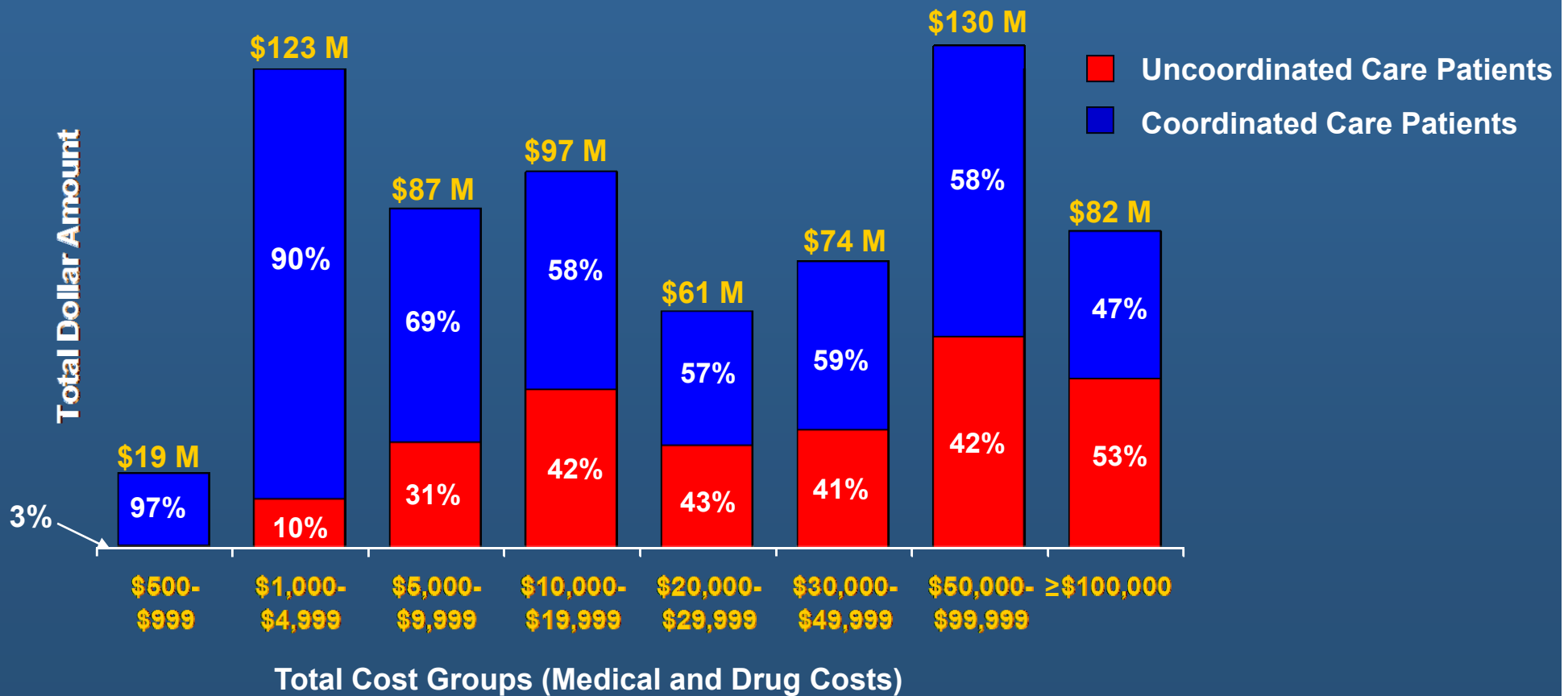
State Example: Percent Recipients By Cost Groups

Comparison of Uncoordinated Care vs. Coordinated Care Patients
by Total Cost Groups (Percentage and Number of Recipients)



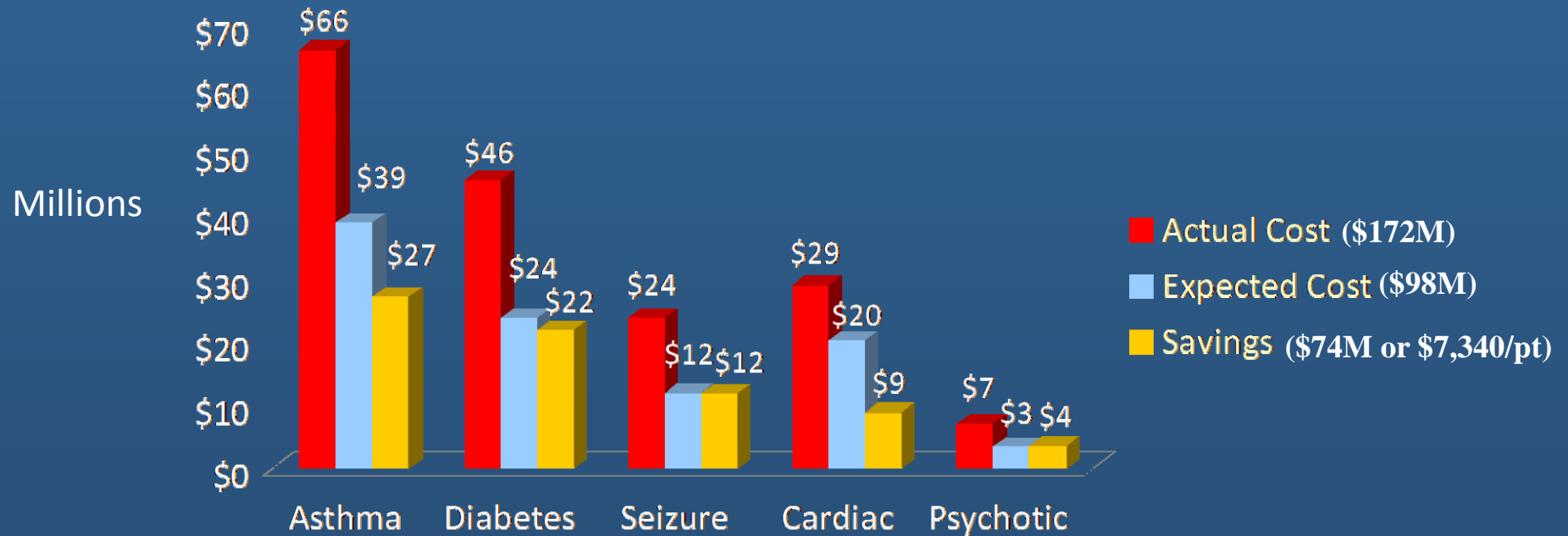
State Example: Percent Total Dollars By Cost Groups

Comparison of Uncoordinated Care vs. Coordinated Care Patients
by Cost Groups (Percentage and Amount of Total Costs)



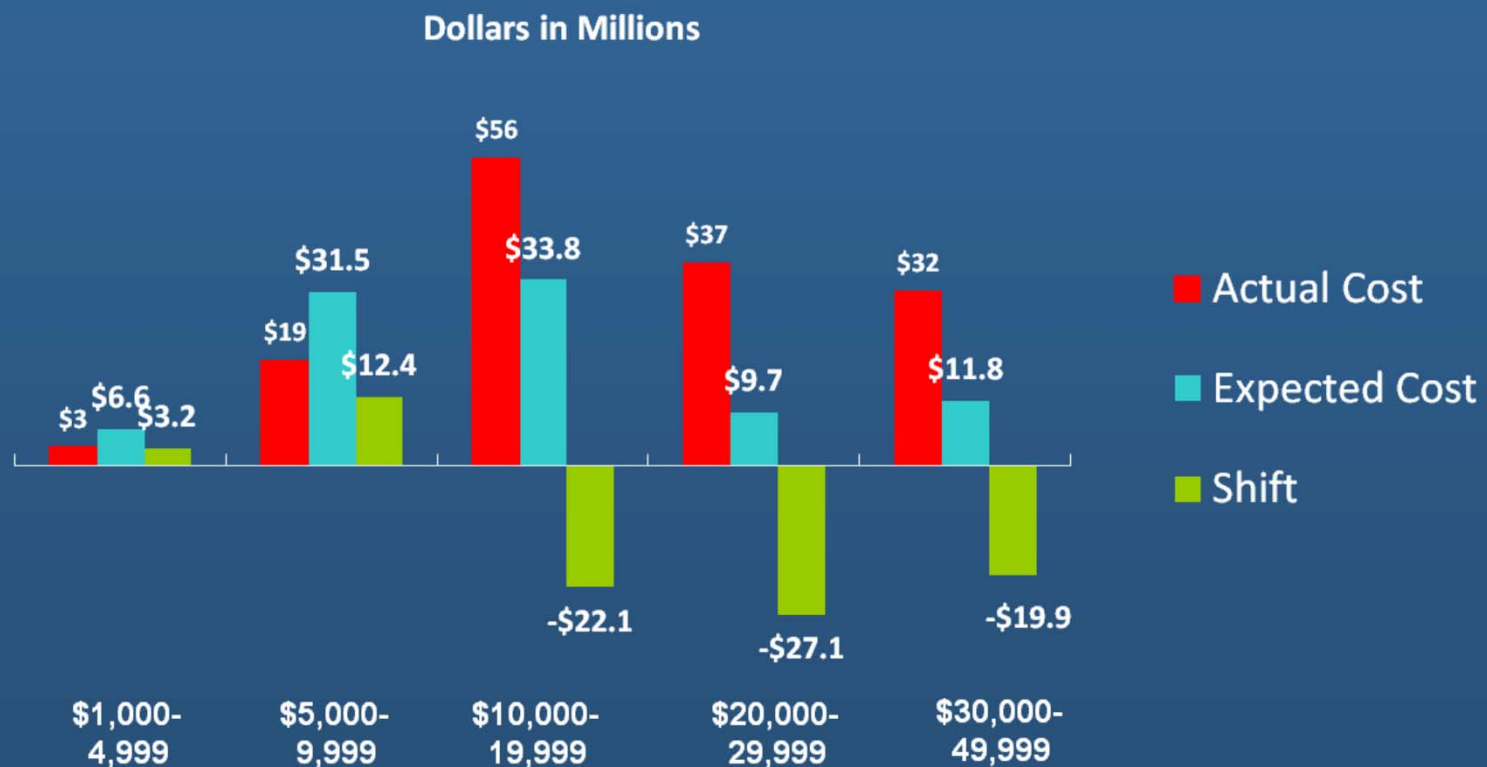
State Example: \$74M in Estimated Savings from 10,081 pts with Uncoordinated Care

Top 5 primary disease groups based on potential savings due to reducing actual cost down to the expected cost for like matched coordinated patients



Note: Comparison group of 10,081 Medicaid only uncoordinated care pts matched to 37,873 coordinated care pts by age, gender, primary disease, co morbid disease and severity score (CCI)

State Example: Actual Cost Vs Expected Cost Based on Matched Group of 9,747 Uncoordinated Care to 27, 881 Coordinated Care Patients



Note: Matched comparison of 9,752 uncoordinated adults matched to 27,881 coordinated adults on age group, gender, primary disease, secondary disease, co-morbid chronic conditions and CCI severity score

Utility and Implications of Analysis For Public and Private Plans

Analysis Utility

- ◆ Medicaid and Medicare MA/Part D plans
- ◆ Private plans and their PBMs
- ◆ State/local private and government employee plans
- ◆ Evaluation and Implementation of Medical Home, DM, and other Demo Programs
- ◆ Hospital and ER diversion and discharge programs
- ◆ Disease/care management/MTM programs
- ◆ Utilization review and QIO programs
- ◆ Actuarial and rate setting calculations

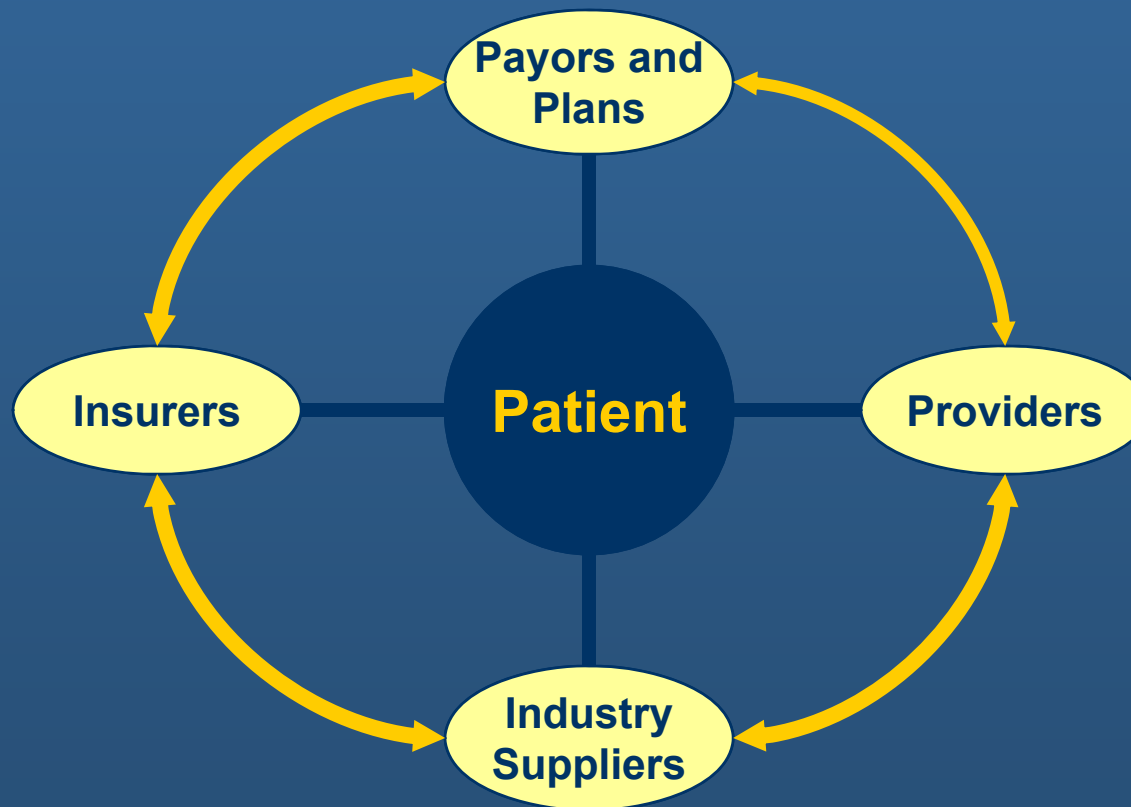
Analysis Implications

- ◆ Provides powerful evidence and cost data to support new payment models, organizational and clinical integration (HIT), and care delivery reform efforts in private and public plans
- ◆ Supports new, more sophisticated approaches to risk stratification for care and disease management
- ◆ Offers cost data that quantifies the magnitude of potential savings
- ◆ Constructs a framework of observed patterns of care for policy discussions on how to achieve value and improve quality

“Real” Healthcare Reform

**Creating Partnerships to
Reduce Uncoordinated Care and
Improve Quality and Value**

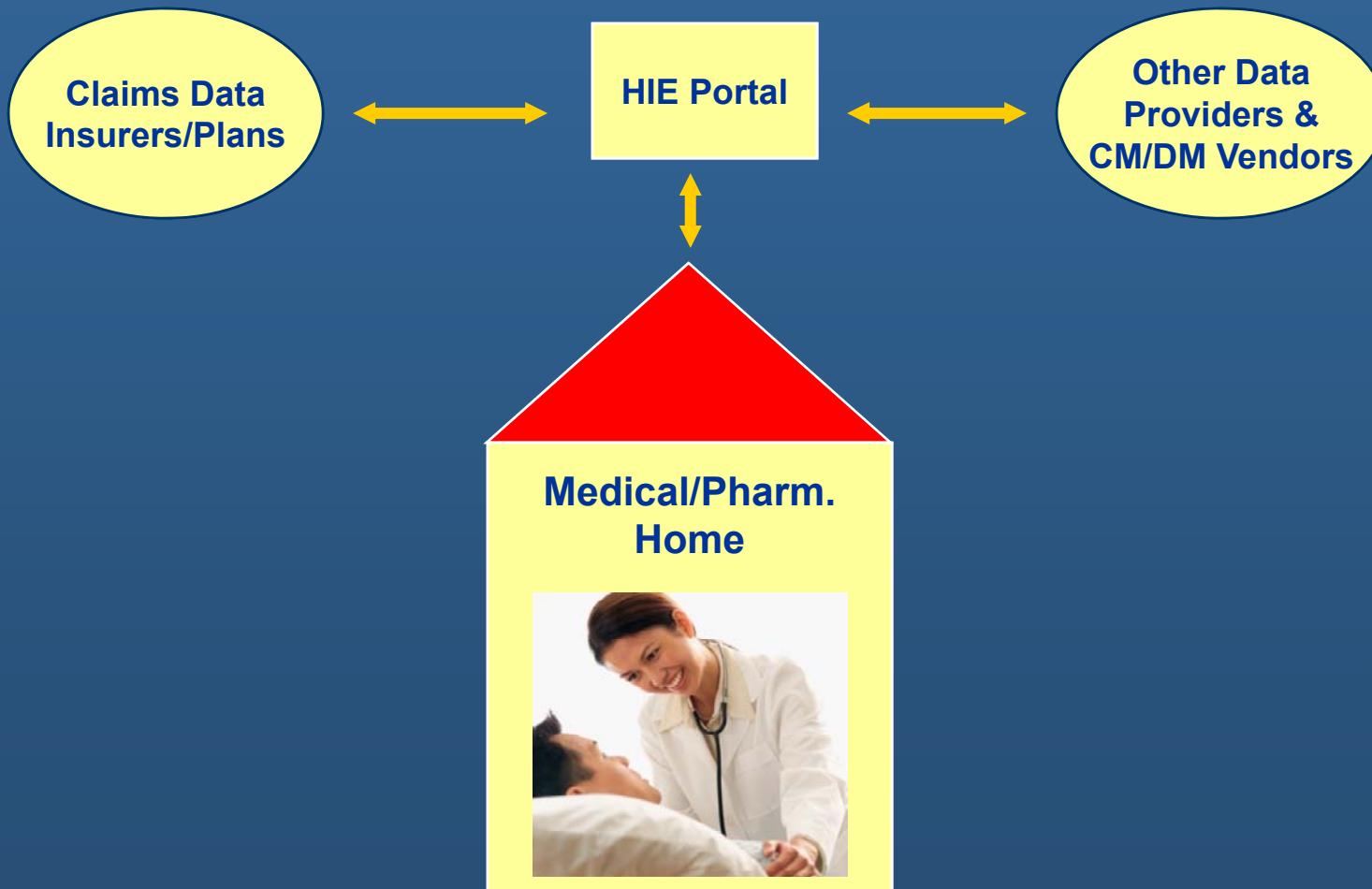
Patient Centered Care Model



Integrated Care Delivery Model

- ◆ **Clinical and organizational integration via HIE where providers manage and monitor the delivery of care with other providers**
 - ◆ Interoperative electronic systems with real time information and data exchange with decision support
 - ◆ two-way electronic communication system between “medical home” and other providers, patients, payers/plans, CM/DM vendors and others
 - ◆ real time or updated data feeds i.e. claims data
 - ◆ Coordination of interventions, care plans/management between “medical home”, other providers, or vendors

Integrated Medical Home Model



How do we achieve provider, plan and patient buy-in?



Provider Incentives

- ◆ Shared financial incentives and enhanced fees for improved coordination of care that result in net program savings and improved quality
- ◆ Access to information via technology i.e. HIE/EMR portals, e-prescribing, electronic two-way communication systems for improved practice efficiency
- ◆ Access to support services i.e. targeted CM programs to assist with utilization management, adherence, prevention, patient interventions and educational efforts

State/Plan Incentives

- ◆ Improved quality and cost efficiencies to meet budget and coverage goals
- ◆ Improved patient health, satisfaction and appropriate access to care
- ◆ Improved provider satisfaction and cooperation due to increased revenue and practice efficiency
- ◆ Redirect financial resources to wellness and prevention for long term savings
- ◆ Possibly reduce premiums and cost sharing burdens for drugs and other services

Patient Incentives

- ◆ Having an enforced “medical/pharmacy home” promotes patient satisfaction and enhanced accountability
- ◆ Improved focus on overall health goals rather than management of the immediate medical need
- ◆ Improved disease education and wellness
- ◆ Improved treatment plan and medication adherence
- ◆ Plans can offer rewards for improved behaviors such as benefit dollar credits, gift cards, coupons, reduced co pays etc.

Strategies to Achieve Reform Goals?

- ◆ Identify, quantify, and target uncoordinated care with direct provider/patient incentive and intervention strategies using HIT and other clinical integration and decision support tools
- ◆ Use analytics to create “roadmap” for selection of best approaches to payment reform, rate setting, organizational infrastructures and policies
- ◆ States/Plans can create partnerships with providers, industry, advocates, and others to enhance continuity and coordination of care to achieve “real” reform and value based care

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