CareOregon

- Medicaid Non Profit “Managed Care” Plan serving 100,000 members
  - Membership includes adults and disabled populations
  - 50% seen in “safety net” clinics
  - New Medicare Advantage Plan – 5600 “duals”, 62% <65 yrs old

- State Capitation Package:
  - Mental Health carved out
  - Pharmacy and Chemical Dependency Included

- Staff: 230 employees
  - Largest Departments: Claims and Medical Management

- Usual Medicaid Challenges:
  - Poor State and Plan reimbursement
  - Medically and Socially complex population
  - Need to “add value” at plan level to maintain network and community engagement
  - Near bankruptcy in last recession.
Survival = Creating “Managed Care 2.0”

- Moving beyond Medical Benefit Management (MC 1.0):
  - Focus on “Covered Services,” “Least Costly Alternative,” Prior Authorization, Guidelines, Formularies, etc.
- Population Management as a core business strategy (MC 2.0):
  - Improving health improves lives and costs
  - Improving health is not just “medical:”
    - Poverty, mental health, housing, food, safety, lack of resources, substance abuse, etc
  - Improving Health means overcoming fragmentation of the health care system
    - Avoiding “stand alone” programs
    - Supporting population health models of primary care: medical homes, team care, enhanced access, behavioral health integration, patient driven care
“Typical” Utilization Pattern

April 1, 2002 - March 31, 2003
Includes Members with >4 months Enrollment Only

0% 5% 10% 15% 20% 25% 30% 35%
% of Members

% of Total Dollars
1% 2% 8% 30% 31% 29%

Non Users
Healthy Users
Low Mod High Very High

10% Savings
Has $12MM Annual Impact On CareOregon

<table>
<thead>
<tr>
<th></th>
<th>% of Members</th>
<th>% of Total Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non Users</td>
<td>23%</td>
<td>1%</td>
</tr>
<tr>
<td>Healthy Users</td>
<td>12%</td>
<td>2%</td>
</tr>
<tr>
<td>Low</td>
<td>24%</td>
<td>8%</td>
</tr>
<tr>
<td>Mod</td>
<td>29%</td>
<td>30%</td>
</tr>
<tr>
<td>High</td>
<td>9%</td>
<td>31%</td>
</tr>
<tr>
<td>Very High</td>
<td>3%</td>
<td>29%</td>
</tr>
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</table>
Population Management = “Complex Care” Strategy

- Starting in 2003: initiate population management “at the top” with focus on high risk/ high cost members.
- Identification of high risk members using predictive modeling: ACG PM
- Goal: improve the health outcomes and cost for the top 3% -- 3000 members - who use 30% of dollars; then impact the top 12% who use 60%.
- Goal: move from reactive, crisis management to proactive risk reduction starting with the highest risk, moving over time to lower risk and prevention.
- Goal: move from “care coordination” service focus to “case management” person/ bio psychosocial focus
CareSupport Inputs

CareSupport Case Management

- ACG PM
- HRA
- CHF Discharge
- Methadone Tx
- Psych Inpt Trigger
- Post-delivery
- Post-facility discharge
- Concurrent Rev.
- Provider/Caseworker
- Post-ED
Basic Conceptual Models

• **Medical Home Model**
  -- support for a productive on-going relationship between member and provider that is comprehensive and integrated

• **Chronic Care Model**
  – support for patient activation and self management; support for proactive clinic systems.
  – Modified to Complex Care Model to define Health Plan Case Management Role vs network provider role
  – Modified to Case Management Model to define domains of case management focus
Complex Care Model

Chronic Care Model

1. Community Resources and Policy

2. Health System Organization of Health Care

3. Self-Management Support
4. Delivery System Design
5. Decision Support
6. Clinical Information Systems

Informed, Activated Patient

Productive Interaction

Prepared Proactive Practice Team

Source: Ed Wagner, MD, et al Group Health Cooperative, Seattle
1. Morbidity

Self-Management Support
Delivery System Design
Decision Support
Clinical Information Systems

2. Practice Team: Medical Home
3. Medical Service Access
4. Patient: Self Management
5. Support System Resources

Community Resources and Policy
Health System Organization of Health Care
Program Structure:

- Multidisciplinary teams for comprehensive assessment and intervention
  - RN
  - Behavioral Health (BH)
  - Health Care Guide (HCG)
  - Registered Pharmacist (RPh)
- Teams assigned to a population of members: aligned to PCP clinics
- Building competency with behavior change: Motivational Interviewing
- Need for Process standardization and oversight
Creating Institutional Intelligence

• Protocols for complex case management
  – Standardized 360 clinical assessment tool to evaluate all potential enrollees; contains built in tools (eg PHQ 9), disease specific questions.
  – Standardized enrollment criteria (5 domains)
  – Standardized care plan template to identify problems, assets, solutions, and tasks

• Interdisciplinary rounds process to embed new logic
  – Intake rounds, Intervention rounds, BH rounds
  – Cross-pollination to encourage well functioning teams
Does this improve care? Baseline:

Above/ below 2 x Average Cost members **NOT** in case management:

<table>
<thead>
<tr>
<th>Risk/ Cost</th>
<th>No. Mmbrs</th>
<th>Year 1 Pmpm</th>
<th>Year 2 Pmpm</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hi Risk/ Hi Cost</td>
<td>97</td>
<td>$5871</td>
<td>$4932</td>
<td>-16%</td>
</tr>
<tr>
<td>Hi Risk/ Lo Cost</td>
<td>956</td>
<td>$859</td>
<td>$1029</td>
<td>+20%</td>
</tr>
<tr>
<td>Lo Risk/ Hi Cost</td>
<td>8624</td>
<td>$672</td>
<td>$426</td>
<td>-36%</td>
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<tr>
<td>Lo Risk/ Lo Cost</td>
<td>70796</td>
<td>$48</td>
<td>$85</td>
<td>+78%</td>
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“Regression to the Mean” significantly reduces cost in the high cost groups…. without our help….
Can we beat “regression to the mean”?

Members Case Managed
(Oct 1 2004-March 31 2005 and claims yr 1 and 2)

<table>
<thead>
<tr>
<th>Risk/ Cost</th>
<th>No. Mmbrs</th>
<th>Year 1 Pmpm</th>
<th>Year 2 Pmpm</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hi Risk/ Hi Cost</td>
<td>40</td>
<td>$8296</td>
<td>$3285</td>
<td>-60%</td>
</tr>
<tr>
<td>Hi Risk/ Lo Cost</td>
<td>77</td>
<td>$1179</td>
<td>$1337</td>
<td>+13%</td>
</tr>
<tr>
<td>Lo Risk/ Hi Cost</td>
<td>251</td>
<td>$1624</td>
<td>$847</td>
<td>-48%</td>
</tr>
<tr>
<td>Lo Risk/ Lo Cost</td>
<td>163</td>
<td>$105</td>
<td>$232</td>
<td>+120%</td>
</tr>
</tbody>
</table>

- Same direction, higher dollars, larger change; total paid change = $3.5 million
- 6 month results for 6 RNs: probably more than “regression to mean”
Care is cheaper, but is it better?

• Collaborative research pilot with CHR at Kaiser to determine whether our program improves HRQOL for our members

• Tool = HUI: Health Utility Index is a validated global measure of patient’s perception of functional health status across 9 domains:
  – 43 questions covering: vision, hearing speech, ambulation, dexterity, pain, emotion, cognition, self care
  – Assessed at entry into case management, then at one month and four months after baseline
  – All domains are also combined to give an overall health utility score with a range of -.36 (worst health state) to 0.0 (dead) to 1.00 (perfect health)
HUI Baseline Results

- Highly co morbid population: 33% non normal function in 5 domains; 46%, in three or more domains
- Evaluation of entire high risk target population (acgPM ≥0.5):
  - Mean baseline HUI3 score (N=160) was 0.19 compared with US population norm of 0.84.
  - The only comparable group were frail elders one week post hip replacement surgery
  - Significant burdens were identified in the areas of mobility, ambulation, pain, cognition, emotion, and self care.
    - 70% had most/ all activities limited by pain
    - 50% endorsed significant problems with memory and ability to think and solve problems
HUI Follow-up Results

• Four months after enrollment in the CCM program, there was clinically significant improvement identified:
  – Mean overall change score for HUI3 was -0.05 (negative score indicates improvement, and changes of ≥0.03 are viewed as clinically important)
  – At four month f/u, 25% of members enrolled had clinically significant improvement in pain and 30% had improvements in cognition, emotion, and ambulation.

• Conclusions:
  – It does not appear that the reductions in utilization associated with our program are at the expense of HRQOL.
  – For such a sick population, no change (stabilization) may be a huge success.
    • 88% of patients enrolled were stable or improved at 4 week f/u.
Current Challenges

• More focus on engagement and behavior change – moving away from a strictly “medical model”
• More defined structure of work to allow evaluation of “what works”
• Process improvement to increase efficiency
• Tighter integration with hospital concurrent review and other health plan programs
• Tighter integration with providers