CCIP ASO Outcome Overview

Drug Utilization Review Board
January 21, 2009

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Deputy Division Director, Clinical Services
MO HealthNet Division
Program History

- CCIP began enrolling participants in November 2006 (January 2007 patient management began)
- General ASO Enrollment began in June 2008
- As ASO contracting continues regionally, CCIP will merge into the ASO contracts
- MCO’s cover only the TANF population (largely mothers and children), therefore ASO or FFS programs will need to provide coordination care for Non-MCO patients in MCO regions
Hypothetical (Desired) Outcomes

- **Expected Impacts from CCIP/ ASO interventions:**
  - Healthcare outcomes
    - Improved adherence to objective monitoring
    - Improved medication adherence
    - Improvement of “in-range” monitoring parameters
  - Financial expenditures impact
    - Appropriate service access utilization
    - Appropriate trending of total cost of care
  - Integrated electronic record impact
    - Provider use of electronic tools
    - Provider participation/use of electronic tools
    - Actual use and support of key case management tools
  - Participant/Provider Feedback
    - Recognition/knowledge/acceptance of program
    - Impression of program activities
    - Critical analysis of program and components
Program Engagement Process

- Identify new eligibles from MOHealthNet Data
- Mail welcome letters to new eligibles
- Conduct telephone outreach campaigns to new eligibles
- Engage participants
- Conduct general and/or disease specific assessments
- Evaluate risk score and assessment findings to assign risk level
- Assign to High, Moderate, or Low Risk Level
- Schedule follow-ups consistent with the risk level, e.g. every 30 days for high risk (case management), every 90 days for moderate risk level (disease management), and every 90 day outreach for health and wellness mailings (low risk level and the case and disease management level).
- Services are provided on an ongoing basis as long as the participant remains eligible for MOHealthNet.
Direct Services Provided During Engagement Process

**Included But Not Limited To:**

- Identification of gaps in care, e.g. medications, tests for condition monitoring, preventive care services, and compliance.
- Assistance in locating resources to address social barriers affecting ability to seek appropriate medical / behavioral health care and close gaps in care, e.g. transportation, food, clothing, housing, etc.
- Addressing self-care issues with behavioral change coaching with the goal of increasing compliance with prescribed plans of care.
- Coordinating with the health care team (physicians, social workers, community support workers, etc.) to increase compliance with the plan of care.
- Services described may be provided telephonically or onsite in clinics or health centers.
Outcome Reports

- Medical Outcomes Metrics
- Financial Outcome Metrics
- HealthCare Home Metrics
- Provider Metrics
Metrics Outcomes Report
Through 2nd Qtr - 2008
Where CCIP Patients Reside
Overview of Population

- The total number of participants in the Chronic Care Improvement Program (CCIP) at the end of the reporting period was 103,308.
- The time period analyzed was July 1, 2007 - June 30, 2008.
- Of these, 24,700 had been continuously enrolled for at least 12 consecutive months.
The outcomes of the 24,700 continuously enrolled participants were compared to 97,665 MO HealthNet participants who have the same condition and submitted at least one claim for medical services to MOHealthNet during the analysis period, but are not enrolled in CCIP.

Non-enrolled MO HealthNet participants include those who:
- Reside in geographic areas that are ineligible for participation in CCIP
- Are eligible for CCIP but opted out of the program
Report Parameters

- Period definitions
  - Program Performance
- Conditions being managed
  - Asthma  Diabetes  Sickle Cell Anemia
  - CAD  COPD
  - CHF  GERD
- Eligible membership
  - Feb. 2007: 87,201 participants
  - March 2008: 141,420 participants
- Enrolled membership
  - Feb. 2007: 5,225 participants
  - March 2008: 97,790 participants
- Demographics
  - Average Age 51, (Male 47, Female 53)
  - Male 35% Female 65%
Deployment of Case Management/Disease Management Resources, Target Intensity of effort to Health Status

- Approximately 5%
- Approximately 15%

Health Status

Resource Utilization

- Intensive treatment and management
- Treatment and rehabilitation
- Early intervention
- Preventive care; Wellness education

- Advanced disorder, illness, or disease
- Established illness or disorder
- Early signs and symptoms of illness or disorder
- Healthy
A Typical Participant in This Overview

- A 47 year old male
- More than one major targeted disease
- Likely has a major cardiovascular diagnosis and diabetes
- Likely has experienced a major cardiac event
- A third have a major behavior health co-morbidity
- A generally motivated cohort

<table>
<thead>
<tr>
<th>Disease</th>
<th>Number of Individuals</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>9,817</td>
<td>39.7%</td>
</tr>
<tr>
<td>CAD</td>
<td>16,982</td>
<td>68.8%</td>
</tr>
<tr>
<td>CHF</td>
<td>5,746</td>
<td>23.3%</td>
</tr>
<tr>
<td>COPD</td>
<td>8,155</td>
<td>33.0%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>12,939</td>
<td>52.4%</td>
</tr>
<tr>
<td>GERD</td>
<td>12,592</td>
<td>51.0%</td>
</tr>
<tr>
<td>Sickle Cell</td>
<td>558</td>
<td>2.3%</td>
</tr>
<tr>
<td>Behavioral Disability</td>
<td>8,395</td>
<td>34.0%</td>
</tr>
</tbody>
</table>

*Includes co-morbid conditions

Continuous Enrolled 7/1/2007 - 6/30/2008

24,700
Missouri CCIP Diabetes Outcomes

HbA1c testing provides an estimation of average blood glucose values in people with diabetes. Enrollees in the CCIP program received substantially more HbA1c testing than those not enrolled.

Hemoglobin A1c Compliance

- **ENROLLED N=12,939**
- **NON-ENROLLED N=33,631**

Clinical Measure

<table>
<thead>
<tr>
<th>HbA1c - one or more tests</th>
<th>HbA1c - two or more tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>47%</td>
<td>25%</td>
</tr>
<tr>
<td>26%</td>
<td>12%</td>
</tr>
</tbody>
</table>
Lipid (cholesterol) testing is recommended for people with diabetes. CCIP enrollees received lipid testing at more than twice the rate of non-enrollees.
A Dilated Eye Exam and Microalbuminuria testing are two other recommended clinical assessments that should be performed annually on people with diabetes.
Nearly two-thirds of CCIP enrollees with COPD (emphysema) received treatment with bronchodilator medications, compared to 41% of non-enrollees.
Substantially more CCIP enrollees than non-enrollees with congestive heart failure (CHF) received treatment with recommended cardiac medications.
CCIP enrollees with asthma received recommended treatment with inhaled corticosteroids at a greater rate than non-enrollees.
CCIP enrollees with coronary artery disease (CAD) received recommended treatment with beta blocker medications at nearly twice the rate of non-enrollees.
CCIP enrollees with coronary artery disease (CAD) received recommended treatment with statin medications at a greater rate than non-enrollees.
Utilization of Services

- Use of major interventions
- Relative cost impact “off trend” of utilization changes
Enrollment in CCIP began in the I-70 corridor (Feb to July 2007) and then grew regionally with the addition of the Northeast (Aug), Southeast (Sept) and Southwest (Oct) regions. December increase due to updated eligibility determinations.
Average Total Monthly Costs for CCIP-enrolled participants were below projection. March 2008 demonstrates a $321 PMPM savings.
Trend Analysis of Emergency Room Utilization

ER Usage Rate per 1000

ER visits decreased more substantially than projected representing another key cost driver for savings.
CCIP enrollees had lower-than-projected ER costs and lower ER costs than MO HealthNet participants eligible for, but not enrolled in, CCIP.
Trend Analysis of Hospital Utilization

Hospitalization Rates per 1000 Jan 2006-June-2008

- Hospitalizations declined substantially more than projected helping to drive overall cost savings.
While average inpatient costs had increased during the baseline period, CCIP enrollees have had average inpatient costs below projection and below the inpatient costs of Mo HealthNet participants who are eligible for, but are not enrolled in CCIP.
Health and Wellness Total Program Parameters

- Includes all patients
- Dashboard metrics begin in April 2008
- Targeted at monitoring program vendor outputs
CCIP/Health & Wellness Program
Employees by County
### Health & Wellness Enrolled vs. Eligible

<table>
<thead>
<tr>
<th>Month</th>
<th>Enrolled</th>
<th>Eligible, But Not Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr 08</td>
<td>104,322</td>
<td>19,267</td>
</tr>
<tr>
<td>May 08</td>
<td>101,647</td>
<td>20,479</td>
</tr>
<tr>
<td>Jun 08</td>
<td>283,433</td>
<td>53,661</td>
</tr>
<tr>
<td>Jul 08</td>
<td>288,517</td>
<td>65,357</td>
</tr>
<tr>
<td>Aug 08</td>
<td>304,041</td>
<td>55,049</td>
</tr>
<tr>
<td>Sep 08</td>
<td>320,159</td>
<td>39,173</td>
</tr>
</tbody>
</table>
## Enrollees by Risk Level

<table>
<thead>
<tr>
<th>Period</th>
<th>High</th>
<th>Mod High</th>
<th>Mod</th>
<th>Low</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr 08</td>
<td>3,749</td>
<td>33,382</td>
<td>45,748</td>
<td>21,443</td>
<td>104,322</td>
</tr>
<tr>
<td>May 08</td>
<td>3,756</td>
<td>32,454</td>
<td>44,542</td>
<td>20,895</td>
<td>101,647</td>
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<tr>
<td>Jun 08</td>
<td>15,094</td>
<td>20,679</td>
<td>24,678</td>
<td>222,982</td>
<td>283,433</td>
</tr>
<tr>
<td>Jul 08</td>
<td>15,881</td>
<td>21,673</td>
<td>26,401</td>
<td>224,562</td>
<td>288,517</td>
</tr>
<tr>
<td>Aug 08</td>
<td>15,666</td>
<td>21,551</td>
<td>26,376</td>
<td>240,448</td>
<td>304,041</td>
</tr>
<tr>
<td>Sep 08</td>
<td>15,667</td>
<td>21,505</td>
<td>26,445</td>
<td>256,542</td>
<td>320,159</td>
</tr>
</tbody>
</table>

- **4.9%**
- **15% (6.7 & 8.3%)**
## Identified Healthcare Homes

<table>
<thead>
<tr>
<th>Period</th>
<th>Health Care Homes Identified</th>
<th>Identified by Participant Interview</th>
<th>% Identified by Participant Interview</th>
<th>Total Enrollment</th>
<th>% HCH Coverage</th>
<th>Projected HCHs Identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr 08</td>
<td>104,322</td>
<td>18,724</td>
<td>17.95%</td>
<td>104,322</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>May 08</td>
<td>101,647</td>
<td>19,028</td>
<td>18.72%</td>
<td>101,647</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Jun 08</td>
<td>99,620</td>
<td>19,938</td>
<td>20.01%</td>
<td>283,433</td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>Jul 08</td>
<td>205,633</td>
<td>26,896</td>
<td>13.08%</td>
<td>288,517</td>
<td>71%</td>
<td></td>
</tr>
<tr>
<td>Aug 08</td>
<td>225,903</td>
<td>28,716</td>
<td>12.71%</td>
<td>304,041</td>
<td>74%</td>
<td></td>
</tr>
<tr>
<td>Sep 08</td>
<td>234,951</td>
<td>21,561</td>
<td>9.18%</td>
<td>320,159</td>
<td>73%</td>
<td></td>
</tr>
<tr>
<td>Oct 08</td>
<td>245,575</td>
<td>45,066</td>
<td>18.35%</td>
<td>319,671</td>
<td>77%</td>
<td></td>
</tr>
<tr>
<td>Nov 08</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>244,952</td>
</tr>
<tr>
<td>Dec 08</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>255,773</td>
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</table>
## Primary Disease Identified

<table>
<thead>
<tr>
<th>Disease</th>
<th>Primary</th>
<th>Secondary</th>
<th>Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAD</td>
<td>38,393</td>
<td>25,354</td>
<td>63,747</td>
</tr>
<tr>
<td>Diabetes</td>
<td>26,909</td>
<td>10,463</td>
<td>37,372</td>
</tr>
<tr>
<td>Asthma</td>
<td>21,212</td>
<td>13,121</td>
<td>34,333</td>
</tr>
<tr>
<td>GERD</td>
<td>15,841</td>
<td>20,855</td>
<td>36,696</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>4,336</td>
<td>6,815</td>
<td>11,151</td>
</tr>
<tr>
<td>Maternity</td>
<td>3,972</td>
<td>6,230</td>
<td>10,202</td>
</tr>
<tr>
<td>COPD</td>
<td>3,846</td>
<td>16,346</td>
<td>20,192</td>
</tr>
<tr>
<td>Depression</td>
<td>3,477</td>
<td>15,409</td>
<td>18,886</td>
</tr>
<tr>
<td>Low Back Pain</td>
<td>1,692</td>
<td>11,345</td>
<td>13,037</td>
</tr>
<tr>
<td>Sickle Cell</td>
<td>892</td>
<td>0</td>
<td>892</td>
</tr>
<tr>
<td>Cancer - Breast</td>
<td>553</td>
<td>1,675</td>
<td>2,228</td>
</tr>
<tr>
<td>Cancer - Colon</td>
<td>161</td>
<td>670</td>
<td>831</td>
</tr>
<tr>
<td>Cancer - Prostate</td>
<td>113</td>
<td>561</td>
<td>674</td>
</tr>
<tr>
<td>Cancer - Lung</td>
<td>112</td>
<td>778</td>
<td>890</td>
</tr>
<tr>
<td>Hemophilia</td>
<td>90</td>
<td>198</td>
<td>288</td>
</tr>
</tbody>
</table>

|               | 121,599 | 129,820  | 251,419  |
# Health and Wellness Breakdown by Region

<table>
<thead>
<tr>
<th>Region</th>
<th>CCIP</th>
<th>ASO</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>I-70 Corridor</td>
<td>55,084</td>
<td>77,483</td>
<td>132,567</td>
</tr>
<tr>
<td>Northeastern</td>
<td>4,619</td>
<td>8,929</td>
<td>13,548</td>
</tr>
<tr>
<td>Northwestern</td>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Southeastern</td>
<td>29,645</td>
<td>72,419</td>
<td>102,064</td>
</tr>
<tr>
<td>Southwestern</td>
<td>17,686</td>
<td>54,235</td>
<td>71,960</td>
</tr>
<tr>
<td>Springfield Area</td>
<td>39</td>
<td>0</td>
<td>39</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>107,093</strong></td>
<td><strong>213,066</strong></td>
<td><strong>320,198</strong></td>
</tr>
</tbody>
</table>
Running Assessment Totals

Health & Wellness Assessments Running Total

Jan 08: 3,670
Feb 08: 7,225
Mar 08: 10,835
Apr 08: 14,493
May 08: 18,220
Jun 08: 22,334
Jul 08: 24,629
Aug 08: 26,157
Sep 08: 28,177
Oct 08: 33,360
Call Center Activity

Call Center Volumes

- Outbound
- Inbound

0 10,000 20,000 30,000 40,000 50,000 60,000 70,000

June 07 July 07 Aug 07 Sep 07 Oct 07 Nov 07 Dec 07 Jan 08 Feb 08 Mar 08 Apr 08 May 08 Jun 08 Jul 08 Aug 08 Sep 08 Oct 08

Outbound
Inbound
Approved Plans of Care (POC)

Approved Plans of Care/Reviews Monthly Breakdown

<table>
<thead>
<tr>
<th>Month</th>
<th>Initial POC</th>
<th>Monthly Reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct 07</td>
<td>5</td>
<td>398</td>
</tr>
<tr>
<td>Nov 07</td>
<td>64</td>
<td>520</td>
</tr>
<tr>
<td>Dec 07</td>
<td>62</td>
<td>490</td>
</tr>
<tr>
<td>Jan 08</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Feb 08</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Mar 08</td>
<td>23</td>
<td>56</td>
</tr>
<tr>
<td>Apr 08</td>
<td>44</td>
<td>190</td>
</tr>
<tr>
<td>May 08</td>
<td>58</td>
<td>226</td>
</tr>
<tr>
<td>Jun 08</td>
<td>96</td>
<td>325</td>
</tr>
<tr>
<td>Jul 08</td>
<td>190</td>
<td>398</td>
</tr>
<tr>
<td>Aug 08</td>
<td>339</td>
<td>444</td>
</tr>
<tr>
<td>Sep 08</td>
<td>380</td>
<td>597</td>
</tr>
<tr>
<td>Oct 08</td>
<td>597</td>
<td>4,741</td>
</tr>
</tbody>
</table>

Aggregate total, initial 6339
Update reviews 1578
"Did Not Keep Appointment" (DNKA) Averages…Mo HealthNet Health & Wellness Program vs. General Clinic Population Oct. ‘07 - July ‘08. (Columbia FQHC)

Participant Average = 7.48%
Overall Facility Average = 16.16%
Observations

- The frequency of recommended diagnostic testing and pharmacy utilization was consistently greater among program participants than non-enrollees.

- When compared to non-enrollees, program participants also experienced:
  - Decreased average monthly treatment costs
  - Decreased emergency room utilization
  - Decreased inpatient hospital admissions
  - Decreased no-show rates by > 50%
Issues and Concerns

- Changes in contractor leadership
- Slope of the ePOC approvals
- General provider relations
- Communication and coordination of resources
- IT coordination and relationships
- Confirming (cross validation) of report data
The Southern Tier of MO HealthNet

- Geo Mapping of Eligible Participants
  - MCO candidates
  - ASO candidates
  - All eligible participants

Includes Current Eligible (10/2008) Participants with No SCHIP Projections
MCO Eligibles Southern Tier

MO HealthNet MCO and ASO Regions
Managed Care Eligibles in Southern Counties by Zip Code

Legend - Eligibles in Southern Zip Codes
- Less than 500
- 500 - 2000
- 2000 - 4000
- More than 4000

Counts of Managed Care Eligibles
- In 5 Counties = 38,576
- In 21 Counties = 67,028
- In 37 Counties = 150,650
Non-MCO Eligibles Southern MO Tier

MO HealthNet MCO and ASO Regions
Non-Managed Care Eligibles in Southern Counties by Zip Code

Legend - Eligibles in Southern Zip Codes
- Less than 500
- 500 - 2000
- 2000 - 4000
- More than 4000

Counts of Non-Managed Care Eligibles
- In 5 Counties = 10,421
- In 21 Counties = 43,887
- In 37 Counties = 77,164

Cities Over 10,000:
- Cape Girardeau
- Carthage
- Jackson
- Joplin
- Kennett
- Nixa
- Papillion Bluff
- Sikeston
- Springfield
Tools for Clinical Use

- Smart PA
- Decision Support Tools
  - CyberFormance
  - Paid Claim Tool
- CyberAccess
- Care Connection
Tools for Patient/Participant Use

- Direct Inform (12/31/08)
- MORx Compare (current)
CyberAccess

Current Features
- Patient demographics
- Electronic Health Record
  - Record of all participant prescriptions
  - All procedures codes
  - All diagnosis codes
- E prescribing
- Preferred Drug List support
  - Access to preferred medication list
  - Precertification of medications via clinical algorithms
  - Implementation of step therapy
  - Prior authorization of medications
- Medication possession ratio
- DirectCare Pro
CyberAccess (current, con’t)

- **DirectCare Pro**
  - Notices pharmacy availability of intervention at POS entry
  - Clinical staff reaches out to patient
  - Targeted intervention bases on best practice and care and treatment guidelines
  - Intervention outcomes available to healthcare team
  - Direct billing
  - Outcomes monitoring
CyberAccess (current, con’t)

- General Medical Uses
  - Integrated call center support
  - Availability of laboratory values (and references)
  - Precertification of imaging
  - Precertification of durable medical equipment (DME)
Near Term Additions (First quarter 2009)

- Determination of level of care and precertification of home and community based services
- Electronic capture and storage of EPSDT forms
- Precertification of optical (as covered)
- Patient level editing
- Electronic medical record lite (EMR)
- Patient case management tools
  - Risk assessment
  - Stratification
  - Gaps in therapy
  - Episodes of care
  - Concurrent case management
- Eligibility determination reporting
- Incorporation of diabetic patient care management information
CyberAccess (con’t, 2nd quarter 2009 and beyond)

- Later term additions
  - Interoperability with other services (EMRs, hospital records)
  - Precertification of dental
  - “Plug-ins” for EMR
    - Scheduling
    - Billing
  - Integrated billing for service
  - Integration of discharge summary and medication reconciliation
  - Integration of home monitoring data/information
  - Integration of immunization registry
DirectInform

- Access to program provided benefits
  - Program integrity notification of services provides (EOB equivalent)
- Notification of wellness lapses
- Web portal participant health information
DirectInform Screen Shot 1 MHD
Future Addition Across User Interfaces

- Direct notification to participants and providers of gaps of care
- Integration of drill down to best practice lapse and gaps of care
- Integration of patient empowerment information such as asthma action plans, diabetic management plans of care
- Wellness initiatives such as anti-obesity programs
- Smoking cessation programs and general wellness empowerment tools
Discussion

Questions

Thank you

George.L.Oestreich@dss.mo.gov

573.751.6961