Treating the ABD Population in a Managed Care Environment: Organizational and Clinical Issues

Bradley P. Gilbert, MD
Chief Medical Officer
Inland Empire Health Plan

- Started September 1, 1996 with advent of Medi-Cal Managed Care Two Plan Model
- Covers Members in Riverside and San Bernardino Counties
- Is a non-profit, public entity formed as a Joint Powers Agency
- Serves 300,000 Members (Medi-Cal, Healthy Families, Healthy Kids and IHSS workers)
Current Medi-Cal Membership

- 232,951 Mandatory Members
- 17,899 Voluntary Members
  - 11,463 Aged, Blind and Disabled (ABD)
  - 5,550 Foster Care (special program with both counties)
Current Medi-Cal Membership

- Over 103 ABD Members choose IEHP every month
- The average enrollment period for ABD with IEHP is 30 months
IEHP Program for ABD Members

- Expanded site audit for PCPs for physical access
  - Ramps, Doors, Hallways, Bathrooms, etc.
  - Exam Tables
  - Results *published* in Provider Directory

- Closest bus stops published in Provider Directory for all PCP offices
IEHP Program for ABD Members

- Persons with Disabilities Workgroup
  - Structured Feedback

- Member materials in alternative formats
  - Web site
  - Printed materials – Braille, large print
IEHP Program for ABD Members

- Linkage with Community Agencies
  - Independent Living Centers
  - Lighthouse for the Blind

- Excellent Working Relationship with Outside Agencies
  - Inland Regional Center – hiring a nurse to be placed at IRC
  - County Mental Health – joint CMEs last month
  - County Hospitals
Medical Care Issues

- Specialty Network – IEHP has three times the number of specialists compared to Medi-Cal FFS
- Pharmacy – Mail order and delivery capacity
- Care Management – RNs and coordinators
- Wheelchair Seating Clinic
  - Specialized assessment for non-powered/ powered wheelchairs to determine what equipment needed
  - Limited equipment vendors to ensure quality
Medical Care Issues

- Health Management – asthma, diabetes, high risk pregnancy
- Standing Referrals/Extended Access to specialists
- Wellness Program – Living with a Disability
Preparing for 2007 Mandatory ABD

- IEHP estimates 40,000 new ABD enrollees
- ‘New’ enrollees may be slightly different population
  - Developmentally delayed – current caseload overlap with IRC is 1,000, with 9,000+ IRC Medi-Cal FFS Members
  - Seriously Mentally Ill – probably under-represented in current IEHP Membership
- Medical diagnoses not expected to be significantly different
Physician/Provider Network Preparation

- Primary Care Physicians
  - Increase number of Internal Medicine PCPs

- Specialists
  - Increase number of key specialists – neurology, rheumatology, pain management

- Physical Therapy/Occupational Therapists
  - Increase # of PT/OT sites
Care Management

- ABD population requires more and potentially different care management services

- Increased use of Medical Social Workers (MSW)
  - Knowledge of community resources
  - Psycho-social issues

- Increased use of specialty physicians as ‘PCPs’
Conclusion

- IEHP is already serving 11,463 ABD Members with the number choosing us growing monthly
  - These members voluntarily choose and stay with IEHP

- IEHP has already identified key areas to bolster with increased ABD Membership

- DHS should develop readiness standards with input from consumers, advocates, health plans, etc.
  - Physician Network Adequacy
  - Care Management Planning
  - Ancillary Provider Network Adequacy
Health-Based Payment: Lessons from other states

Rick Kronick, Ph.D.
Professor and Chief
Division of Health Care Sciences
Department of Family and Preventive Medicine
University of California, San Diego
Rkronick@ucsd.edu
Overview of Presentation

- Goals of Health-Based Payment (HBP)
- Status of Medicaid Implementation Efforts
- Implementation issues
- Lessons learned
- Summary
Problems of Unadjusted Rates

- Market dysfunction
  - Responsive plans face large losses
  - High needs patients and their providers put at risk
Distribution of Expenditures By Deciles for Colorado Medicaid Beneficiaries on AFDC and with Disability

% of expenditures

- on AFDC
- w/disability

Decile

1-4 5 6 7 8 9 10

(least costly tenths to most costly tenth)
### Medicaid Health-Based Payment Activities

<table>
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<th>State</th>
<th>Population Covered</th>
<th>Date Implemented</th>
<th>Classification System</th>
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<td>SSI + TANF</td>
<td>May-97</td>
<td>ACGs</td>
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<td>Virginia</td>
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<td>2003</td>
<td>CDPS</td>
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| **Planned**    |                    |                  |                       |
| CalOptima      | SSI                | 2005             | CDPS                  |
| Oregon Mental Health | SSI & TANF | 2005 | CDPS-MH |

¹No longer contracting on a risk basis with MCOs
The ABCs of Risk-Adjusted Payment

- Estimate the relative cost of beneficiaries with specified diagnoses
- Using data supplied by managed care organizations, measure the prevalence of diagnoses in each plan
- Adjust payments upwards to plans with disproportionately large numbers of beneficiaries with chronic illnesses; downwards to others
- Health-based payment is typically implemented in a budget-neutral environment
  - HBP isn’t a printing press; if there isn’t ‘enough’ money in FFS, HBP doesn’t fix that
Key Ingredients for Successful HBP

equitable data

equitable data

equitable data

equitable data
Persistence of Diagnoses from Year 1 to Year 2

- Schizophrenia: 79.6%
- Diabetes: 67.5%
- Multiple Sclerosis: 58.0%
- Quadriplegia: 57.0%
- Ischemic Heart Disease: 43.0%
- Cystic Fibrosis: 34.0%

Figures are the percent of Medicaid recipients with disabilities with the specified diagnosis in year 1 who have the diagnosis appear on at least one claim in year 2.
Results of HBP (micro)

• In CO, for PWDs, a University and Children’s Hospital has a case-mix of 1.35
• In OR, a plan that uses Oregon Health Sciences University has a case-mix of 1.13
• In MD, implementation errors created major problems; state has corrected them; working on moving forward
• Every state that has implemented HBP has maintained it over time
Results of HBP (macro)

- HBP appears to get more money to plans that serve sicker people
- Equitable data is key technical challenge
- Only limited evidence that plans or providers respond by developing systems of care to attract sicker people (but HBP isn’t used enough yet to expect this), and there are some reports of positive developments
Summary

• HBP is necessary to encourage plans to compete for the chronically ill
• HBP is not sufficient to encourage this competition
  – other efforts are needed: e.g.,
    • Performance standards in contracts that are appropriate for persons with disabilities
    • Collection and publication of information on quality, access, satisfaction, and outcomes, particularly for the chronically ill
    • Monitoring of: quality assurance and quality improvement activities; of enrollment and disenrollment patterns; and of marketing activities
• Equitable data is a key technical challenge in implementing HBP
• Medicaid programs likely to continue implementation efforts, but scope and pace will depend on whether HBP achieves policy and political goals, and on the extent to which persons with disability are in managed care
• ‘Side’ benefits of HBP:
  • Greatly increased attention to the accuracy of encounter data, allowing these data to be used for rate setting and program management
  • Facilitating and catalyzing plan efforts at profiling and disease management
Estimates of Preventable Hospitalizations in the SSI Population

Andrew B. Bindman, MD
Professor Medicine, Health Policy, Epidemiology & Biostatistics
University of California San Francisco

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Medi-Cal Managed Care

- Goals to improve access and control costs
- Expanded during mid to late 1990s on county by county basis
- Targeted urban counties and TANF (CalWORKs)
- Three models
  - County organized health system (COHS)
  - Geographic
  - 2-Plan
- Mandatory replaced voluntary managed care programs in many counties
Managed Care Strategy

- Managed care requires beneficiaries to have a regular primary care provider.
- A regular source of care may improve access to care and coordination of services.
- Opportunities for population-based care management to improve quality.
- Could reduce access and quality through resource constraints.
Percentage of Medi-Cal Beneficiaries < 65 Years in Managed Care: 1996-2001
SSI Medi-Cal Managed Care Beneficiaries, 1994-1999

- Of the ~20% in managed care about half voluntary and half mandatory

- Mandatory beneficiaries from counties that implemented COHS model of managed care
Previously Demonstrated

- Preventable hospitalization rates in Medi-Cal substantially higher than in privately insured.
- Medi-Cal managed care associated with a 25% reduction in preventable hospitalizations for CalWORKs beneficiaries.
- ~7,000 fewer preventable hospitalizations among CalWORKs beneficiaries per year (~$66million/yr).
What is a Preventable Hospitalization?

A Hospitalization for an Ambulatory Care Sensitive (ACS) Condition

1. Condition avoidable through primary prevention (e.g. immunizable dz)
2. Condition with acute course and window for intervention (e.g. Dehydration)
3. Condition with chronic course amenable to self-management (e.g. asthma)

Sample ACS Conditions (ICD-9)

Acute Conditions:
- Dehydration
- Ruptured Appendicitis
- Cellulitis
- Bacterial Pneumonia

Chronic Conditions:
- Asthma
- Hypertension
- COPD
- Diabetes Mellitus

IOM, 1993
Annual Preventable Hospitalization Rates for CalWORKs/SSI Beneficiaries (<65yrs)

- CalWORKs: 9.4 Admits/1000/Year
- SSI: 79.9 Admits/1000/Year
Research Questions

1. Do Medi-Cal SSI beneficiaries in managed care have lower rates of preventable hospitalizations than those in fee-for-service?

2. What are the preventable hospitalization cost savings associated with Medi-Cal managed care for SSI beneficiaries?
Average Annual Preventable Hospitalization Rate* Among SSI-Eligible Medi-Cal Beneficiaries <65 Yrs in Fee-For-Service and Managed Care

*Age, sex, race/ethnicity, county, month & year of admission

Observed & Expected Average Annual Preventable Hospitalization Rates* Among SSI-Eligible Medi-Cal Beneficiaries <65 Years

*Adjusted for age, sex, race/ethnicity, county & month of admission

Source: Office of Statewide Health Planning & Development/Department of Health Services
SSI Preventable Hospitalizations*:
Length of Stay, 1994-1999

*Adjusted for age, sex, race/ethnicity, county, month & year of admission

Source: Office of Statewide Health Planning & Development/Department of Health Services
SSI Preventable Hospitalizations*: Mean Charges, 1994-1999

*Adjusted for age, sex, race/ethnicity, county, month & year of admission

Source: Office of Statewide Health Planning & Development/Department of Health Services
How Much Did Managed Care Lower Preventable Hospitalization Charges for SSI Beneficiaries in 1999?

- Had all Medi-Cal SSI beneficiaries been in fee for service preventable hospitalization charges would have been $586.4 million/yr

- $42 million (7%) in preventable hospitalization charges was saved from 19% in managed care

- Had all SSI beneficiaries been in managed care projected hospital savings would have been $221 million (38% savings)
Limitations in Assessing Costs

- Keeping patients out of the hospital cannot be done for free - administrative and ambulatory care costs.

- Separate economic analysis by Duggan suggests Medi-Cal managed care for CalWORKs associated with 17% overall increase in spending.

- No comparable data for SSI beneficiaries.
Other Risks and Limitations

• Improvements in service for Medi-Cal managed care beneficiaries might compete with and undermine care for uninsured

• Reduction in hospital days could threaten DSH payments and safety net stability

• Findings may not be pertinent to all subgroups of the aged, blind, and disabled

• SSI managed care limited to relatively few counties and findings may not be generalizable throughout the state
Policy Implications

• Managed care offers an opportunity for reduced morbidity and substantial savings in preventable hospitalization spending

• Not yet demonstrated what the cost is for achieving these (and potentially other) health benefits and their associated hospital savings

• Expansion of managed care to SSI/ABD population should be done in a way that won’t undermine access to Medi-Cal providers and in conjunction with on-going evaluation of its costs and benefits
“Is there a doctor who accepts Medicaid in the house?”