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Oregon Legislative Briefing

**“Applying Innovation in Analytics
to Create Sound Health Policies and
Achieve System Efficiencies”**



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Experience

- ◆ Provide analytical support services, coordination and management strategies for states and health plans in identifying and targeting inefficient and uncoordinated care.
- ◆ Provided analytical, operational and policy consulting and program evaluation services to over 20 states in the areas of medical home models/pilots, care coordination models, utilization management programs, disease and drug management programs, and auditing services methods.

Identifying the Targets:

**Patients with Uncoordinated Care,
Lack of Appropriate Medication Use,
and Unmet Treatment Goals and
Avoidable Costs**

Examples: State Data Findings

- ◆ Lack of Treatment
 - ◆ Patients with no drug treatment yet incurred hundreds of millions in medical costs annually (for cholesterol, hypertension, mental health issues)
- ◆ Low Drug Adherence rates
 - ◆ 40-65% for major drug classes (asthma, diabetes, hypertension, mental disorders etc.)
- ◆ Clinical Goals Unmet
 - ◆ 50-80% of patients not at clinical goal (HAIC, BP)
- ◆ Uncoordinated Care-multiple providers/prescribers
- ◆ Avoidable ED and Hospital visits/Readmissions
- ◆ Substance Abuse- with related avoidable costs

State Findings

- ◆ Comprehensive analysis for Alabama, Ohio, Florida, New Jersey, Pennsylvania, and Virginia.
- ◆ **Alabama: \$360-390M savings**
 - ◆ Uncoordinated /duplicative services: \$166M
 - ◆ Reduce ER/Hospital visits chronic conditions: \$127M
 - ◆ Narcotic Abuse: \$34-40M
 - ◆ Pharmacy Efficiency: \$24-38M
 - ◆ Increase Medication Adherence: \$5M
- ◆ **New Jersey: \$143M savings**
 - ◆ Uncoordinated/duplicative services: \$87M
 - ◆ Reduce avoidable ER visits: \$31M
 - ◆ Reduce avoidable MH/SA visits: \$25M

State Findings (Cont.)

◆ Virginia: \$187M savings

- ◆ Uncoordinated/inappropriate services: \$80M
- ◆ Avoidable chronic/MH ER and hospital visits due to non-adherence: \$87M
- ◆ Inappropriate duplication of drugs: \$20M

◆ Ohio: \$655M savings

- ◆ Uncoordinated/inappropriate services: \$587M
- ◆ Duplicate paid claims: \$68M

◆ Florida: \$365M

- ◆ Uncoordinated/inappropriate services: \$350M
- ◆ Inappropriate duplication of drugs: \$15M

State Examples and Strategies

**Identify “Targets” and Create
Solutions to Improve Quality and
Reduce Unnecessary Costs**

Goals of Intelligent Claims Analysis Model

- ◆ Use clinically and statistically validated algorithms to identify subset of patients that exhibit utilization patterns consistent with uncoordinated and inappropriate care.
- ◆ Algorithms based on common indicators such as:
 - ◆ uncoordinated care from multiple prescribers/pharmacies,
 - ◆ accessing the ER for primary and chronic care,
 - ◆ avoidable ER & hospital visits for chronic conditions,
 - ◆ duplicative medical and drug services from various providers
 - ◆ random drug changes within therapeutic classes by different prescribers, “drug switching”
 - ◆ inconsistent drug usage, treatment gaps and non-adherence
 - ◆ lack of appropriate treatments/services based on guidelines

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
- ◆ Actual total one-year cost of \$44,000
- ◆ Potential Savings: \$39,000

SEC Published Study: Institute of Medicine *

National Cost Savings Estimates

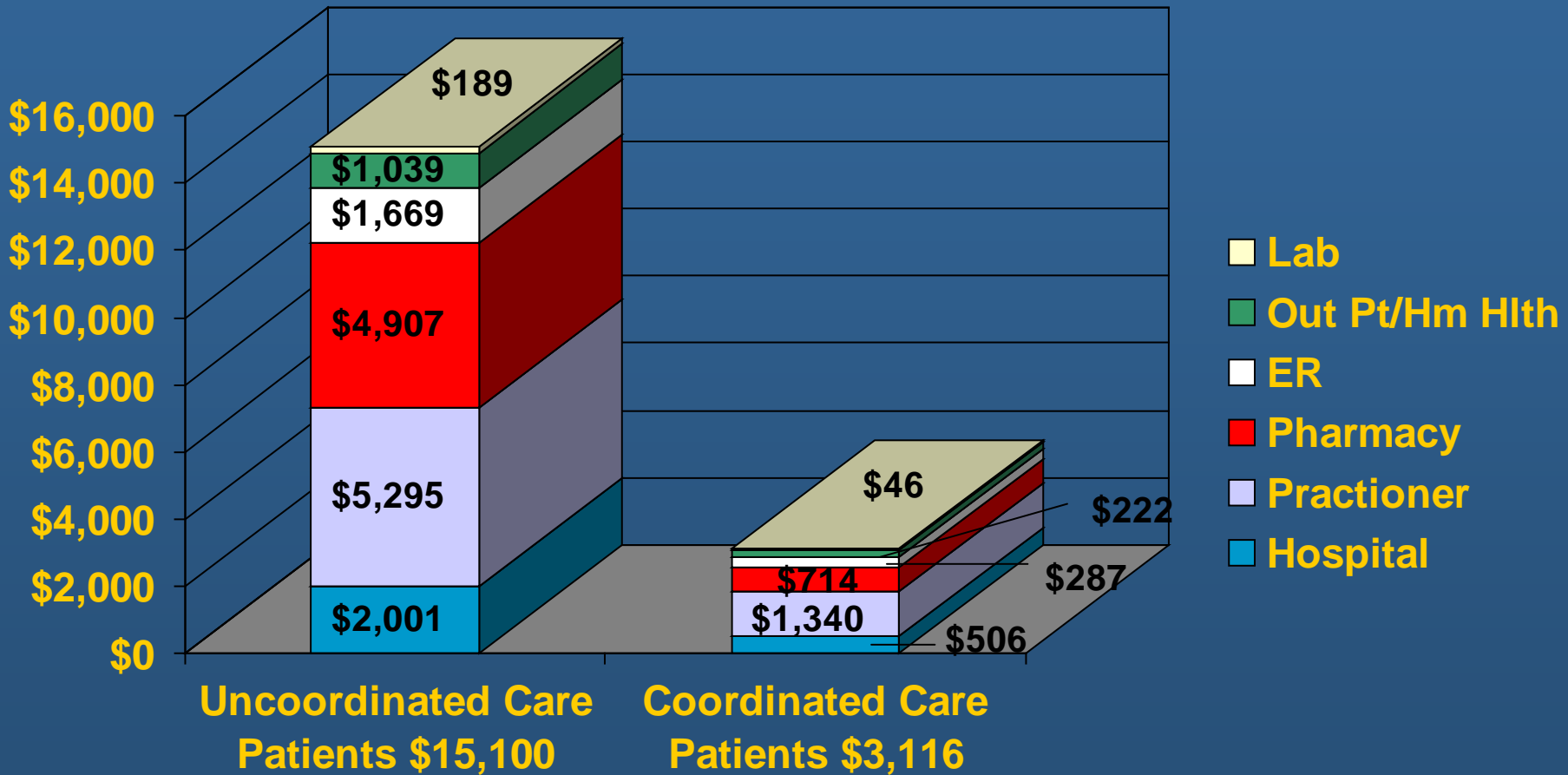
Per Year for Period 2010-2018

- ◆ 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

* Web Link: [The Healthcare Imperative: Lowering Costs and Improving Outcomes.](#)
The Institute of Medicine. 2010. Washington, DC: The National Academies Press.
Owens, MK. Chapter 3: Inefficiently Delivered Services, *Costs of Uncoordinated Care*,
pgs 131-138. http://books.nap.edu/openbook.php?record_id=12750&page=131

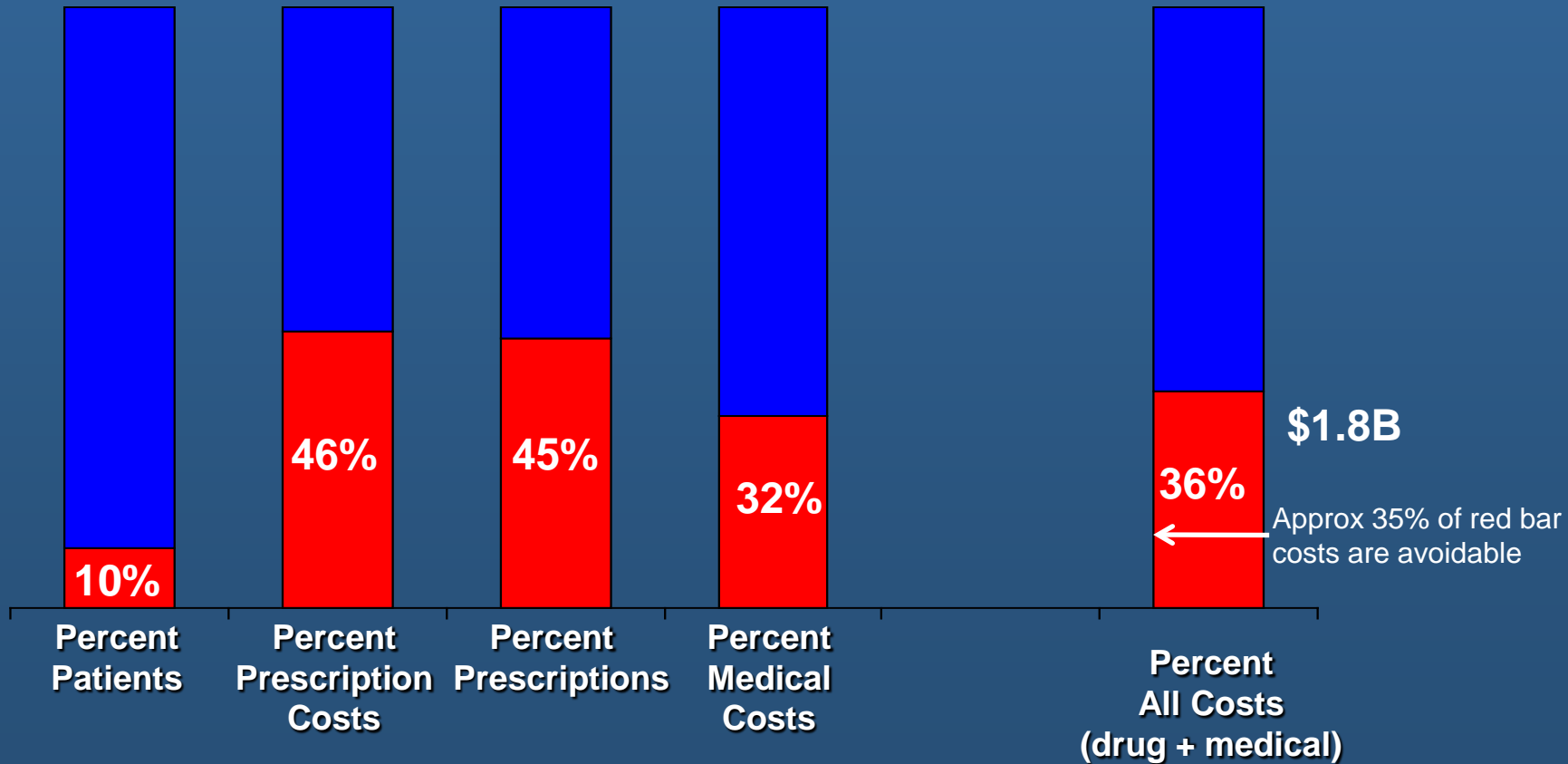
Coordinated Vs Uncoordinated Care Utilization and Cost Comparisons for Various States

State Medicaid Example: Average Contribution of Cost Components for Uncoordinated Care vs. Coordinated Care



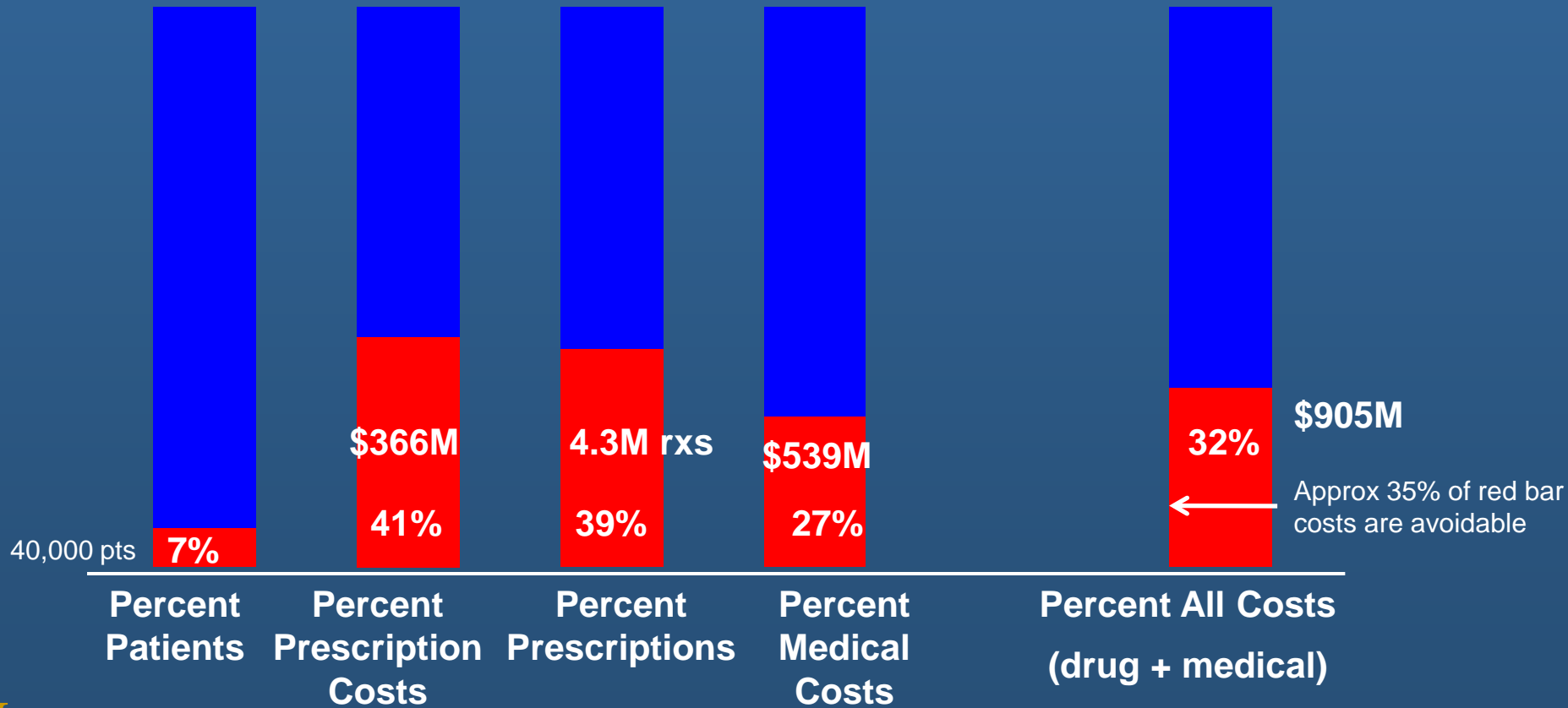
State Example: Utilization and Cost Summary for Uncoordinated Care Medicaid Patients

Uncoordinated Care Utilization and Cost Percentages



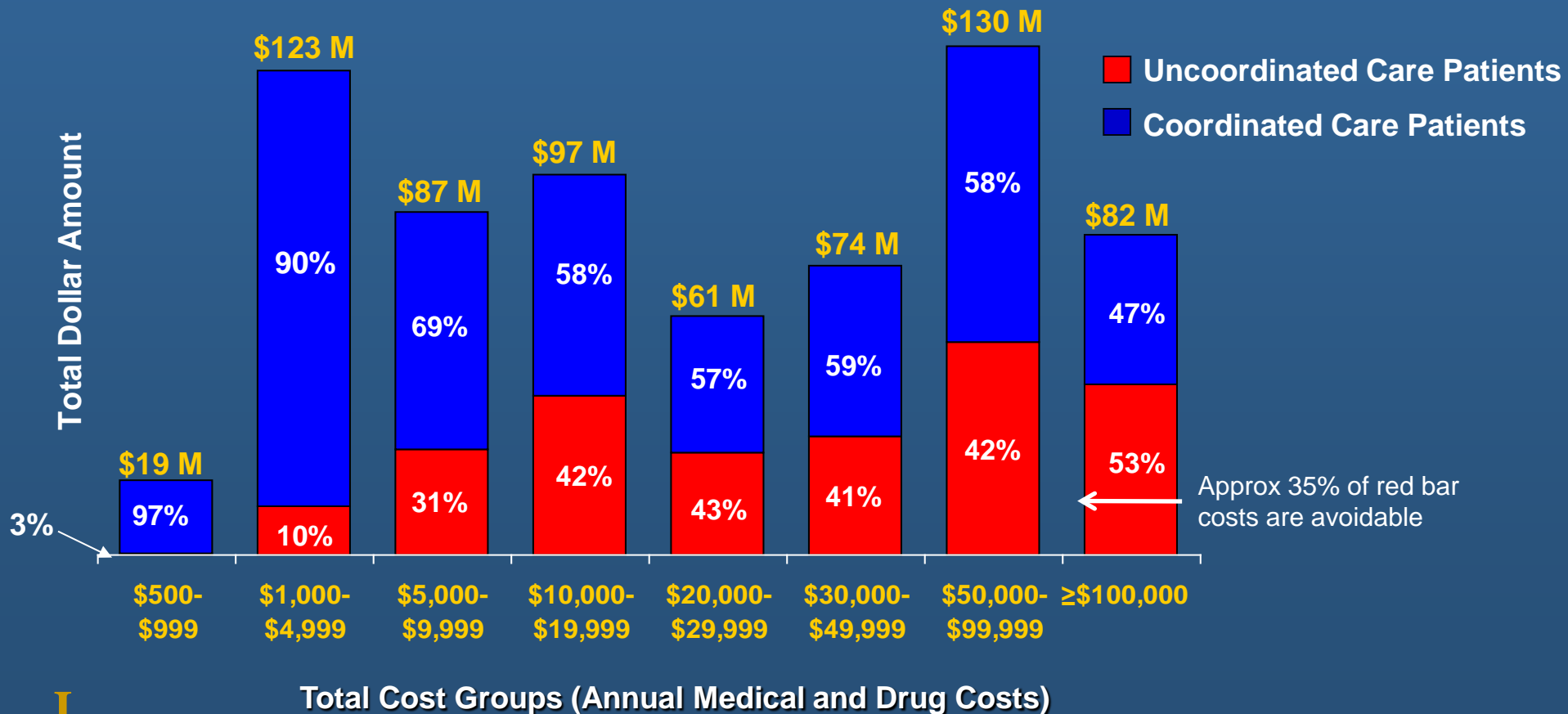
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Uncoordinated Care Utilization and Cost Percentages

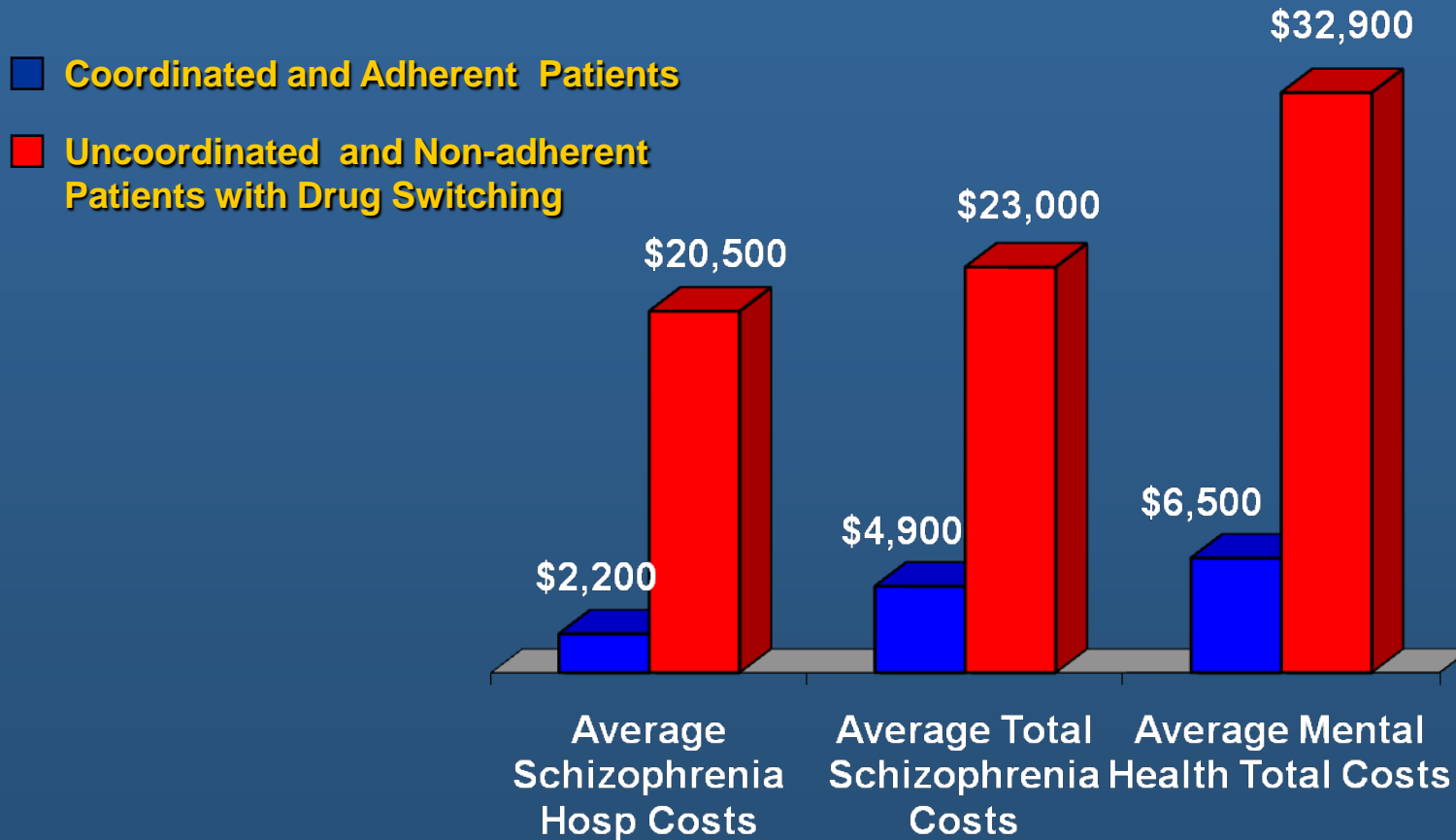


State Example: Medicaid Population Savings Across All Patient Cost Groups (Low to High)

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



State Example: Annual MH Cost Comparison of Schizophrenia Patients With Uncoordinated Care, Low Medication Adherence and Drug Switching



MEASURING AND IMPROVING OUTCOMES

Qualitative and Quantitative Measures

Utilization/Cost Measures

- ◆ Reductions in duplicative therapy within drug classes.
- ◆ Reductions in inappropriate narcotic use and other unnecessary drugs.
- ◆ Reductions in gaps in treatment/increases in clinical adherence rates.
- ◆ Reductions in drug switching within classes and among settings.
- ◆ Reductions in numbers of prescribers/pharmacies.
- ◆ Reductions in admission and readmission rates for avoidable visits.
- ◆ Reductions in total/PMPM costs for chronic disease and mental health patients.

Quality Measures

- ◆ Improved clinical end points for specific disease conditions (HA1c, BP, Lipids, etc.).
- ◆ Rates of appropriate labs ordered at appropriate time intervals.
- ◆ Medication consistency over time and reconciliation post discharge to outpatient setting.
- ◆ Improved mental and physical functional status.
- ◆ Reductions in inpatient, ER, outpatient avoidable visits.
- ◆ Improved compliance in HEDIS and NQF quality measures. (medication use/adherence, discharge FUP)

Innovative Analysis Utility

- ◆ Identify cost savings “targets” by analysis of baseline claims/encounter data and then quarterly monitoring. The population baseline should not include the uncoordinated care population.
- ◆ Determine patterns of care and avoidable costs for making data-driven decisions for each budget cycle.
- ◆ Use as ongoing tool to evaluate how quickly reforms are instituted, dollars saved and overall effect of policies on quality and cost effectiveness.
- ◆ Analysis allows ongoing design, monitoring and evaluation of program efficiency and new program approaches to care delivery i.e. medical homes, shared savings and other payment and care coordination models.
- ◆ Apply to state employee, Medicaid, Medicare Duals programs.

Creating the Path to Success: Utility of Innovative Analytical Approach in the Oregon Transformation Plan

Next Steps for Success in Oregon

1. Independent and ongoing evaluations of CCOs to identify uncoordinated care “targets”, create standard reporting, measure utilization changes, cost reductions, improved quality and other measures.
2. Manage utilization of the “targeted” patients in the CCO plans.
3. Utilize advanced analytics to evaluate and modify future budgets, create new performance measures, and compare CCOs efficiency and performance.
4. Support the new transformation models that create incentives for savings and better outcomes.
5. Engage in partnerships with common goals to provide technical assistance and other support.

State Partnership Opportunities to Better Manage Chronic Disease, and Create Value for the Health Care System

Stakeholders and Partners

- ◆ State Medicaid Agencies, Medicaid Health Plans/CCOS and Contractors
- ◆ Federal Agencies and Contractors (CMS, HRSA, SAMHSA, OPM, GAO, QIOs,)
- ◆ Medicare Advantage Plans and Part D Plans, Duals Demos
- ◆ State Employee Plans
- ◆ Health Care and Pharmaceutical Industry
- ◆ Hospitals and Long Term Care Organizations
- ◆ Providers, Physician and Health Care Networks
- ◆ State & National Pharmacy/Medical Professional Societies
- ◆ Patient Safety, Quality and Advocacy Groups (AIMM, NQF, AHRQ)
- ◆ State Legislators/Health Care Committees
- ◆ Executive Office of Governor, Health Authority

Contact Information

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