Chronic Disease and Mental Health Treatment Patterns in Public Programs

Strategies for Identifying and Reducing the Costs of Uncoordinated Care

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State Medicaid Experience

- Provided analytical, operational and policy consulting and program evaluation services to over 20 states for medical home models/pilots, utilization management programs, disease management programs, drug utilization review procedures, audit methods, claims payments, system edits and other areas.

- States with comprehensive data analysis include Florida, Alabama, Ohio, Pennsylvania, New Jersey, Virginia.
Identifying the Targets:

Patients with Uncoordinated Care, Lack of Appropriate Medication Use, 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 chronic conditions and mental health issues)

- **Low Drug Adherence rates**
  - 40-65% for major drug classes (asthma, diabetes, hypertension, mental health 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 Examples and Strategies

Identify “Targets” and Create Solutions to Improve Quality and Reduce Unnecessary Costs
Methods 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
Chronic Disease Patient Example

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
Mental Health Patient Example

21 YOF with Psychosis/Schizophrenia

- 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 for atypical antipsychotic agents with random drug switching among agents
- Annual medical cost was $39,000 (multiple in-patient visits for MH conditions)
- Annual drug cost was $5,000
- Actual total one-year cost of $44,000
- Potential Savings: $39,000
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

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

Uncoordinated Care
Patients $15,100

Coordinated Care
Patients $3,116

- Lab
- Out Pt/Hm Hlth
- ER
- Pharmacy
- Practioner
- Hospital

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<th>Component</th>
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State Example A: Utilization and Cost Summary for Uncoordinated Care Medicaid Patients

Uncoordinated Care Utilization and Cost Percentages

- Percent Patients: 10%
- Percent Prescription Costs: 46%
- Percent Prescriptions: 45%
- Percent Medical Costs: 32%
- Percent All Costs (drug + medical): 36%

Approx 35% of red bar costs are avoidable

$1.8B
State Example B: Utilization and Cost Summary for Uncoordinated Care Medicaid Patients

Uncoordinated Care Utilization and Cost Percentages

- Percent Patients: 7%
- Percent Prescription Costs: 41%
- Percent Prescriptions: 39%
- Percent Medical Costs: 27%
- Percent All Costs (drug + medical): 32%

Approx 35% of red bar costs are avoidable.
Comparison of Uncoordinated Care vs. Coordinated Care Patients by Cost Groups (Percentage and Amount of Total Costs)

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

Total Dollar Amount

$500 - $999
$19 M
97%
3%

$1,000 - $4,999
$123 M
90%
10%

$5,000 - $9,999
$87 M
69%
31%

$10,000 - $19,999
$97 M
58%
42%

$20,000 - $29,999
$61 M
57%
43%

$30,000 - $49,999
$74 M
59%
41%

$50,000 - $99,999
$130 M
58%
42%

$100,000
$82 M
47%
53%

Total Cost Groups (Annual Medical and Drug Costs)

Uncoordinated Care Patients
Coordinated Care Patients

Approx 35% of red bar costs are avoidable

Total Costs: $74 M
Uncoordinated Care: 47%
Coordinated Care: 53%
Alabama Medicaid Analysis Data

- 300,000 patients incurring $200M in medical expenses and had no drugs for the year.
- 20,000 substance abuse patients incurring $193M in costs ($10,000/pt). Accounted for 40% of narcotics $ used by entire population. Savings =$35-40M/year.
- 22,000 patients had > 8 prescribers up to 50 prescribers.
- 500 patients with > 39 different drug classes used that incurred $26M ($52,000/pt).
- Emergency and hospital visits for MH conditions=$247M
- 18,000 uncoordinated care patients incurred $800M or six times the average costs per patient. Savings for improved care coordination =$166M/year.

Total savings estimated= $389M
Behavioral Health Prevalence, Cost of Care and Treatment Patterns
Prevalence and Co-morbidity Data

Prevalence

- State Medicaid programs have prevalence of 15-20% for all mental health disorders
- Serious Mental Illness (SMI) from 4-8%
- Schizophrenia averages about 5% (60% disabled)

Co-morbidities (Schizo, Bipolar, Depression)

- 22% Diabetes
- 43% Hypertension
- 17% Substance Abuse
- 20% Smoking
- 11% Obesity
Annual Cost of Care Data

- Schizophrenia: $17,000 - $20,000
- Bipolar: $14,000 - $17,000
- Major Depression: $12,000 - $14,000
- Multiple MH conditions: more than 2 X cost
Medication Treatment Data

Only 50-60% of patients with schizophrenia had even one script during the year.

Only 20-25% patients are 100% adherent.

Only 45-50% are 80% or more adherent (met HEDIS measure).

Those with less than 80% adherence had an average of 4 months of treatment gaps up to 10 months of gaps & drug switching.
$67M annually spent on schizophrenia population for MH coded services

- $48M annually spent on MH hospital inpatient services (70%)
- $19M annually spent on outpatient MH services (30%)
- Only 35% of patients accounted for the hospital stays and costs (4,800 pts)
- Potential cost savings is $48M ($10,000/pt)
Uncoordinated Care Cost Savings For Schizophrenia

- Approximately 30%-40% of treated patients have uncoordinated and inappropriate care.
- Account for over 50% of MH costs for the population.
- Average MH costs are 4 to 5 times higher.
- Potential cost savings is $20,000/pt or more.
State Example: Annual MH Cost Comparison of Schizophrenia Patients With Uncoordinated Care, Low Medication Adherence and Drug Switching

- **Coordinated and Adherent Patients**
- **Uncoordinated and Non-adherent Patients with Drug Switching**

- Average Schizophrenia Hosp Costs: $2,200
- Average Total Schizophrenia Costs: $20,500
- Average Mental Health Total Costs: $23,000
- Average Mental Health Total Costs: $6,500
- Total Costs: $32,900
Ensuring Continuity of Care, Access and Adherence to Treatment
Biomedical Innovations

- New drugs developed have lead to decreases in side effect profiles, easier dosing schedules, increased safety, and more advanced, genetically targeted technologies.

- Patients are unique, have complex, multiple conditions that require many different medication and treatment options be available to meet their specific needs.
Published Data on Effects Due to Discontinuing Drugs, Reduced Access and Gaps in Treatment

- California Medicaid schizophrenia patients with gaps in medication use: four times the increased risk of hospitalization.

- Wisconsin Medicaid MH patients with irregular medication use:
  - twice the rate of hospitalizations
  - four times longer stays in the hospital
  - four times the hospital costs ($4,000 vs. $1,000)

- Virginia Medicaid schizophrenia patients with low adherence (<65%):
  - 96% more ER visits
  - 116% more hospital visits
Factors that Reduce Adherence

- Drug switching due to uncoordinated care, formulary changes, lack of formulary continuity between inpatient and outpatient settings and across plans.
- Differential copay structures for drugs.
- Complicated dosing regimen (multiple times per day Vs once daily).
- Side effects and adverse events.
- Forgetfulness and lack of knowledge.
Factors that Improve Adherence

- Care coordination including access to wide variety of medications in each class with formulary continuity between inpatient/outpatient settings and plans.
- Uniform copay structure for drugs (brand/generic).
- Simplified dosing regimen.
- Medications with lower risk of side effects and other metabolic complications.
- Enhanced patient knowledge through counseling.
- Auto refills, refill reminders, dispense 90 day supply and/or home delivery options.
CREATING THE PATH TO SUCCESS: 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)
Next Steps for Success

1. Independent and ongoing claims based evaluations to determine current treatment baselines and create standard reporting measures.

2. Integrate physical and behavioral health care using new models i.e. medical homes, care networks etc.

3. Manage utilization of the targeted patients NOW.

4. Quarterly evaluations to measure utilization changes, cost reductions, and improved quality measures.

5. Support care models that create incentives for savings and compare outcomes among providers.

6. Engage in partnerships with common goals to provide technical assistance and other support. (NGA Grant and others)
Public Policy Actions

- Facilitate partnerships between providers, plans, private sector and others to identify “targets” and implement “real” solutions.
- Create and support policies that hold providers/plans accountable for care coordination improvements, enhanced access to services, improved treatment goals and quality.
- Support innovative payment, delivery and management programs in partnerships.
- Facilitate use of all types of providers in a team based care approach.
Partnership Opportunities to Better Manage Chronic Disease/Mental Health, 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, QIOs)
- Medicare Advantage Plans and Part D Plans, Duals Demos
- Employee and Commercial 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
- Office of Governor and State Health Officials
- National Support Organizations: NGA, NCSL, CSG
Contact Information

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