APS HEALTHCARE
Healthy Together

Innovations in Preventing and Managing Chronic Conditions: What's Working in the Real World

Engaging Providers to Achieve Chronic Care Improvement for Medicaid Populations

April 8, 2009

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Company Overview

APS Healthcare is a leading *behavior change* organization, delivering *innovative solutions* that enable consumers, practitioners and payers to act in ways that *enhance health, well-being and productivity*

- *National Presence*
- *56 public sector programs*
- *43 Medicaid programs*
- *26 states and Puerto Rico*

Medicaid Health Management Programs

- *Wyoming Healthy Together Total Population Management Program*
- *Georgia Enhanced Care Program*
- *Georgia Medicaid Management Program*
- *Vermont Chronic Care Management Program*
- *Missouri Chronic Care Improvement Program*
- *Oregon Disease and Medical Care Management Program*
- *California Coordinated Care Management Program for Seniors and Persons with Disabilities*

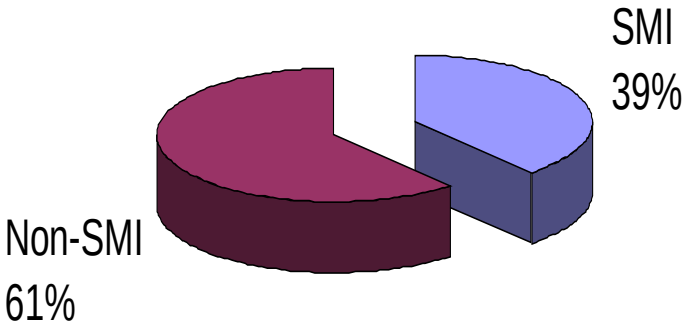
Our Approach to Helping States Find Solutions

- Focus on changing patient & provider behaviors
- Support Provider practices to improve chronic care management
  - 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
  - Innovative technology – APS CareConnection® – facilitates coordination among providers through integrated individualized Plan of Care
- Healthcare is local
  - Decentralized, community-based operations
  - Co-location of APS staff
  - Services described may be provided telephonically or onsite in clinics, hospitals or health centers
- Focus on Specific Population Issues

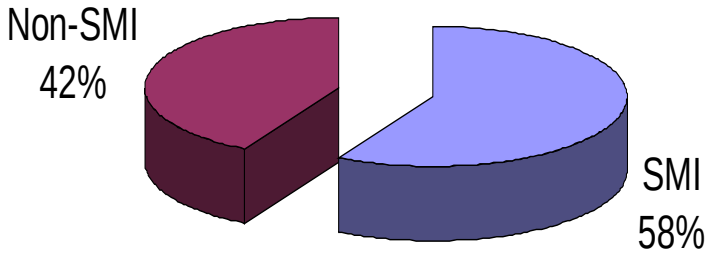
Serious Mental Illness (SMI) Prevalent in Medicaid

SMI & Physical Illness in Medicaid Program

39% of THM Population Has a SMI



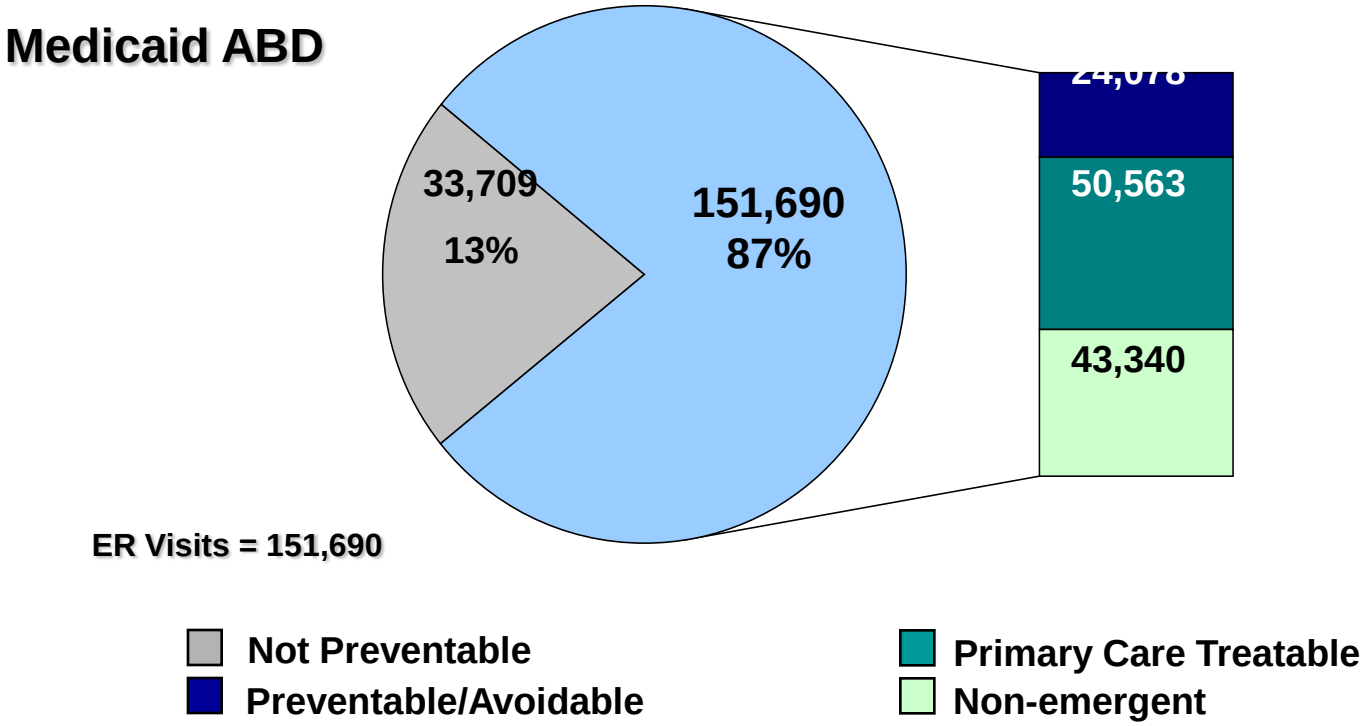
SMI Participants Account for 58% of Total Costs



Top 5% of SMI Population Account for ~25% of All Costs

Overuse of ER High in Medicaid

Avoidable ER Use in Medicaid Program



Note: Emergency room visits classified according to the likelihood that the visit could have been avoided, treated in a primary care setting, or a truly emergent, unavoidable visit, using an algorithm developed at New York University (NYU ED Classification Algorithm). For further information please see: http://wagner.nyu.edu/chpsr/

State of Wyoming Case Study - Summary

- Began in 2005 – 54,000 members
- Eligible Members
  - Age, Blind and Disabled (ABD)
  - Low-Income (TANF) Children and Adults
- Covered Conditions –
  - Total Population Approach
  - All conditions and co-morbidities managed
- Program Components
  - Health &Wellness: all members
  - Disease Management: 8,500 members
  - Care Management: 520 members
- High Risk Pregnancy
- Mental Health
- Medical Home Facilitation
- Pay for Participation

Wyoming Case Study - Program Benefits

Participant Benefits

- Link to “Healthcare Home” with their own Primary Care Provider
- Case support coordinating health care services
- Health coaching and self-management education
- Prevention initiatives
  - Smoking cessation
  - Weight management
- Printed and web-based educational materials
- Toll-free 24 hour Health Advice line

Provider Benefits

- Provides telephonic health management services
- Identify and fill gaps in care
- Utilizes clinical guidelines and best practices
- Provides practice with resources, information and education
- Supports physician treatment plan
- Supports appropriate utilization of services
- Free support to Medicaid members
- Member access to a 24/7 toll-free line for after-hours calls

Wyoming Pay-for-Participation (P4P) Program

- Payment to providers through 8 codes ranging from $11.60 to $74.96 for immediate reward
- Provider outreach and training, with marking and program materials to support initiative

Enhanced Reimbursement of Procedures

Pay for Participation Screening and Education Codes

Total Health Record/Pay for Participation Program for Wyoming EqualityCare (Medicaid)

Code	Description	Fee
	Disease Management Codes	
S0315	Disease Management Program; initial assessment and initiation of the program (by physician, PA or NP). Must refer client to ***Healthy Together!*** program with new or established illness.	$50.00
S0316	Disease Management Program; follow-up/assessment (by physician, PA or NP). Reinforce ***Healthy Together!*** program for established illness.	$25.00
	Screening and Education Codes	
G0102	Prostate cancer screening; digital rectal examination.	$24.99
G0245	Foot Exam Initial: Initial physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensations, which must include diagnosis LOPS, patient history, physical exam, etc.	$74.96
G0246	Foot exam follow-up: Follow-up physician evaluation and management of diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation to include at least pt history, physical exam, exam feet, etc.	$44.28
99406	Smoking and tobacco cessation counseling visit: Intermediate, greater than 3 minutes up to 10 minutes which may include prescription.	$11.60
99407	Smoking and tobacco cessation counseling visit: Intensive, greater than 10 minutes.	$22.15
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	$35.00

Must bill usual and customary rate. These fees are subject to change.

Diabetes

Total Health Record/Pay for Participation Program

Provider Guidelines for Assessment and Education of Adult Diabetic EqualityCare Clients

This is not a billing form. You must still submit a claim form to be reimbursed for services.

I. Diabetes Assessment	Population	Frequency
BMI (height and weight)	♂ ♀	Each visit
Level of activity/exercise	♂ ♀	Each visit
Diet/nutrition status	♂ ♀	Each visit
Alcohol use	♂ ♀	Each visit
Dental exam	♂ ♀	Initial visit; then twice per year
Tobacco use	♂ ♀	Each visit
Bone mineral density*	♀	At least once after menopause
Depression using PHQ-2**	♂ ♀	Each visit
EKG	♂ ♀	Initial visit; after age 50 as indicated
HbA1c (target < 7)	♂ ♀	Initial visit; then quarterly
Thyroid test (TSH)	♂ ♀	Initial visit; then annually or as indicated
Lipid panel (complete) Total cholesterol < 200 LDL < 100	♂ ♀	Patients ≥ 18 At least annually

Code Key: Disease Management Assessment Codes S0315 - initial, S0316 follow-up

General Physical and Mental Health

Provider Support Tools

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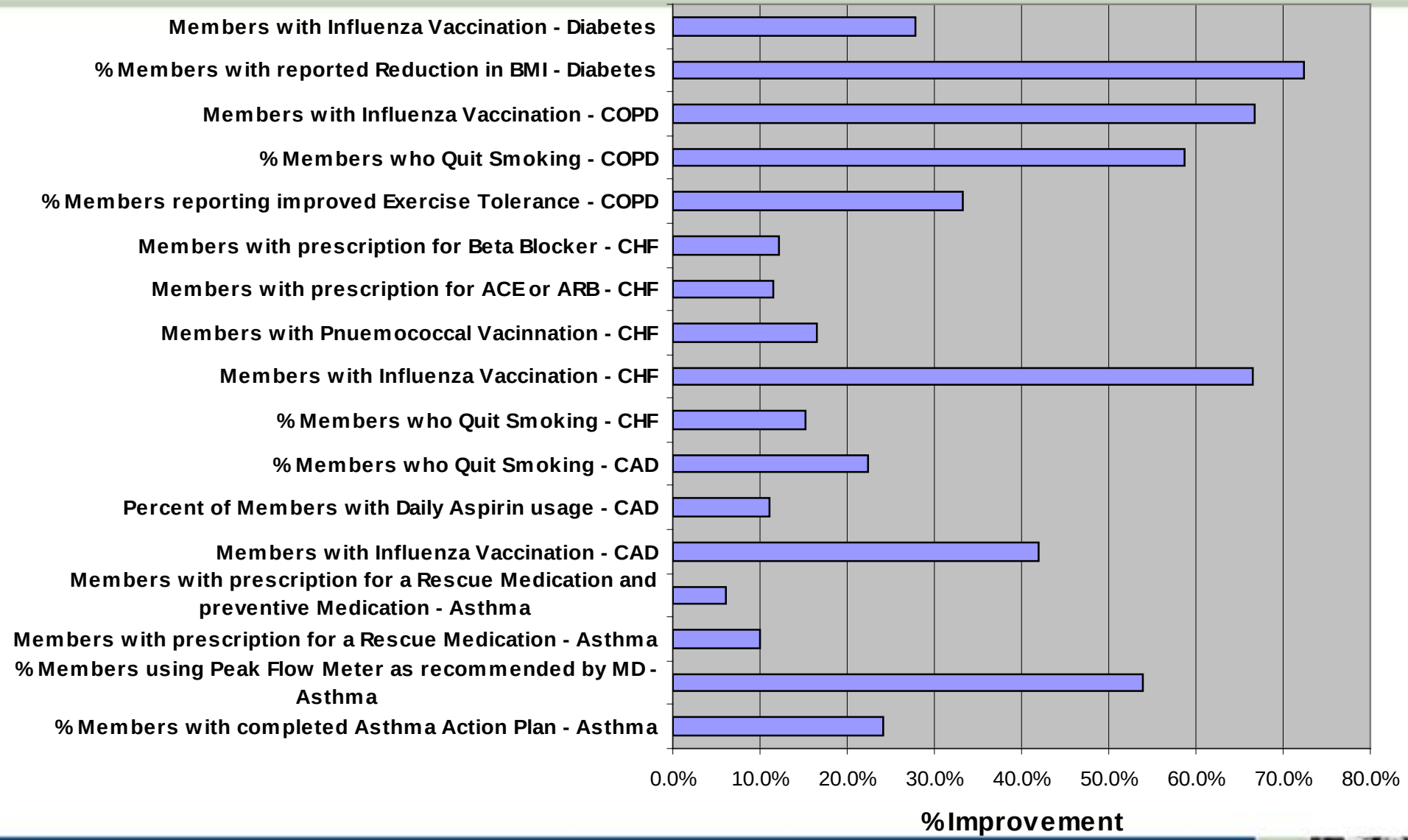
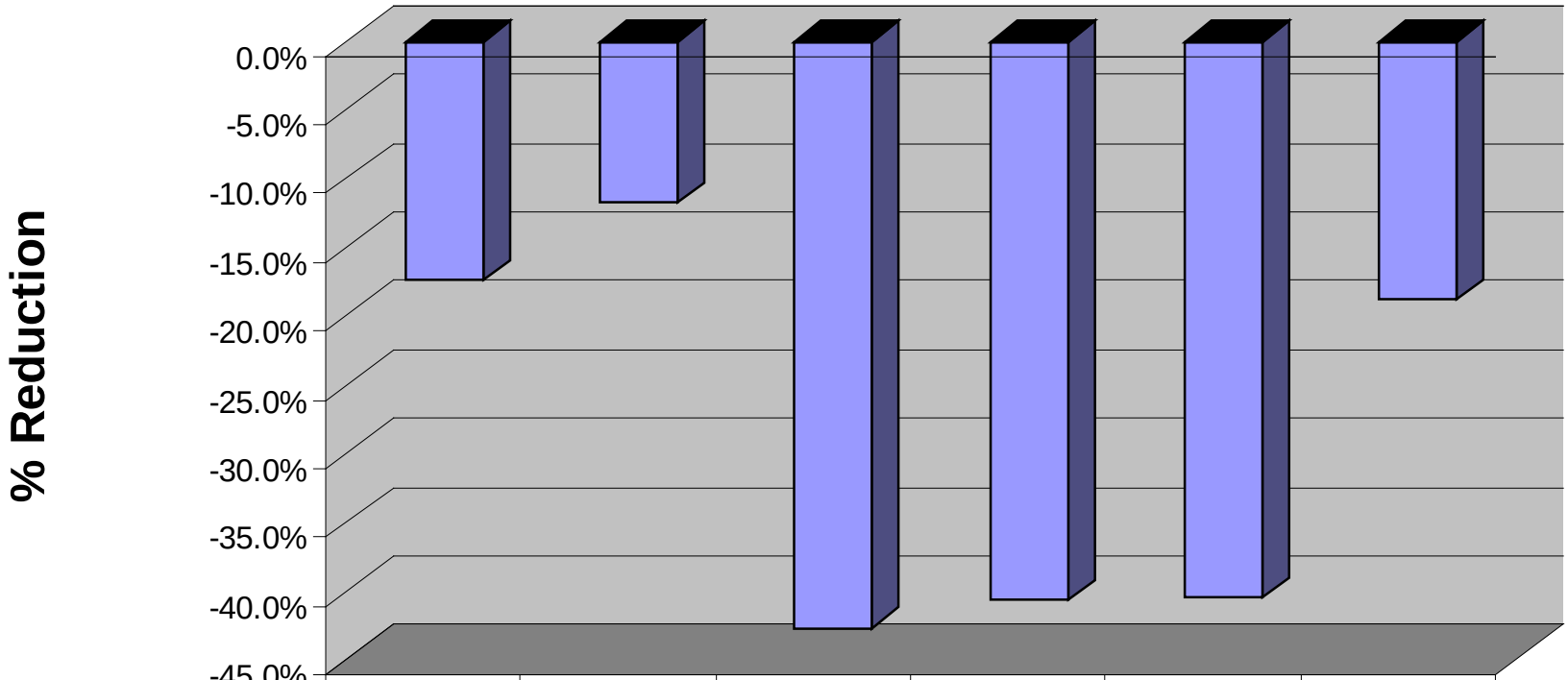
Wyoming Case Study – Clinical Outcomes



Wyoming Case Study – Utilization Impacts



	Members with ER Encounters	Total ER Encounters	Members with Inpatient Admissions	Members with Readmission	Total Inpatient Admissions	Average Inpatient LOS
Key Metrics	-17.4%	-11.7%	-42.7%	-40.6%	-40.5%	-18.8%

Third-Party Validated Savings of Nearly $30 Million over First Two Years

State of Missouri Case Study - Summary

- Began in 2007; 280,000 members
- Eligible Members
  - Age, Blind and Disabled (ABD) not enrolled with Managed Care Organization
  - Low-Income (TANF) Children and Adults
- Covered Conditions - Co-morbidities are managed in conjunction with the targeted disease
  - Asthma
  - CAD
  - CHF
  - COPD
  - Diabetes
  - GERD
  - Hyperlipidemia
  - Hypertension
  - Sickle Cell
- Program Components
  - Health & Wellness: all members
  - Disease Management: 118,000 members
  - Case Management: 9,000 members
- Mental Health
- Medical Home Facilitation
- Pay for Participation/Pay for Performance

Missouri Case Study - Program Benefits

Participant Benefits

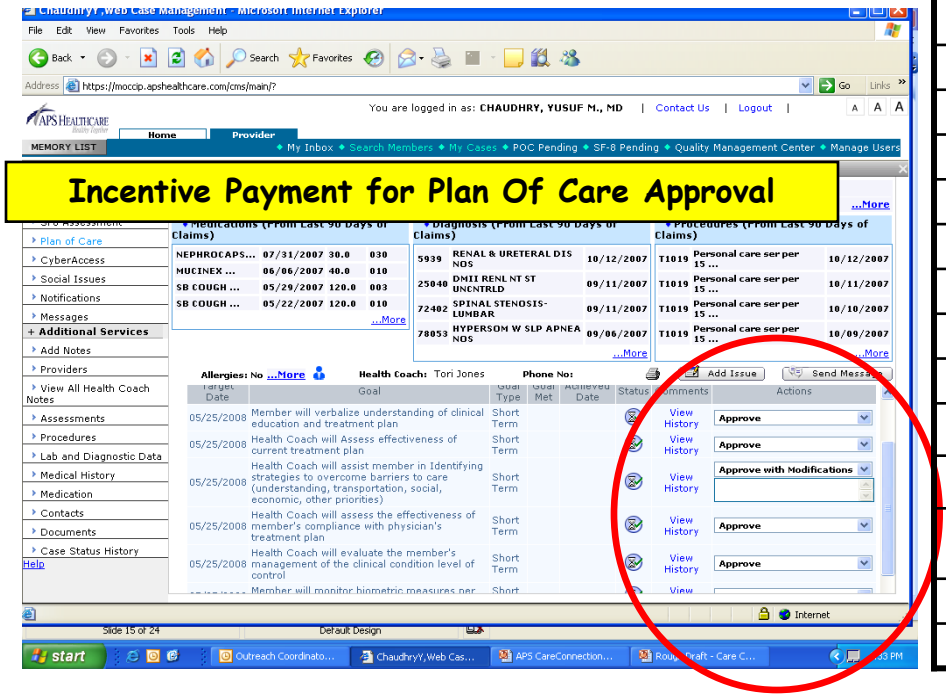
- Link to “Healthcare Home” with their own Primary Care Provider
- Individual Plan of Care for chronic care improvement
- Improved health and overall quality of life
- Risk assessment and stratification through predicative modeling
- Holistic and disease specific assessment
- Extensive participant outreach and self management education
  - A 24/7 nurse line
  - Printed and web-based material
- Coordination with care providers, community resources and social services
- Improved health and overall quality of life

Provider Benefits

- Collaboration with CCIP Health Coach via secure internet based portal
- Physician assisted health risk surveillance
- Reduced administrative burden in managing CCIP participants
- Incentive payments for participation and positive outcomes (P4P)
- Collaboration/support of provider’s treatment plan and goals using evidence-based guidelines
- Coordination with community agencies
- Vigilant monitoring of the participant’s progress and outcomes by APS Health Coaches
- Source of new patients
- Healthier and more adherent patients

Missouri Pay-for-Performance (P4P) Program

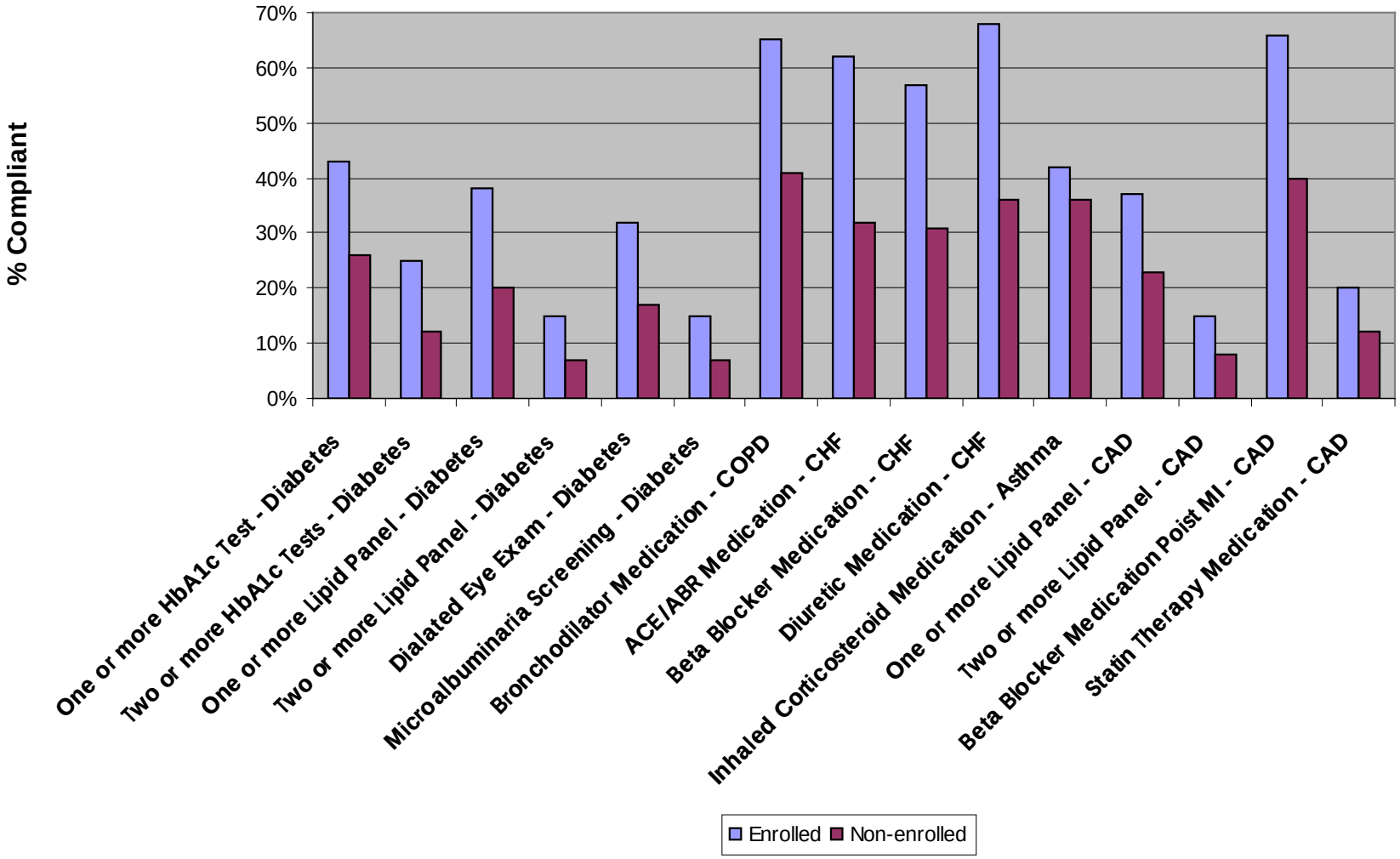
- Per encounter payments for office visits and program participation
- Annual lump sum payment based on achieving satisfactory outcomes measurements within target patient population



Incentive Payment for Quality Metrics

Disease State	Effectiveness Measure	Target Goal	P4P Weight
Asthma	Use of Inhaled Corticosteriod	>70%	5%
Asthma/C OPD	Use of Inhaled Bronchodilators	>70%	5%
Asthma/C OPD	Providing Influenza Immunizations	>70%	5%
Asthma/C OPD	Providing Pneumococcal Immunizations	>70%	5%
GERD	Attempt to Step-down H2A or PPI Therapy	>50%	8%
CHF	Use of ARB or ACE Inhibitor	>70%	7%
CHF	Use of Beta Blockers	>70%	7%
CAD	Measurement of Lipid Profile Performed	>70%	7%
CAD	Treatment with Statin Medication	>70%	7%
All Cardio	Providing Influenza Immunizations	>70%	5%
All Cardio	Providing Pneumococcal Immunizations	>70%	5%
Diabetes	Measurement of A1c Performed	>70%	6%
Diabetes	Measurement of Lipid Profile Performec	>70%	6%
Diabetes	Performance of Dilated Retinal Exams	>70%	6%
Diabetes	Urinary Microalbumin or Glomerular Filtration Rate Measurement	>70%	6%
Diabetes	Providing Influenza Immunizations	>70%	5%
Diabetes	Providing Pneumococcal Immunizations	>70%	5%

Missouri Case Study – Clinical Outcomes



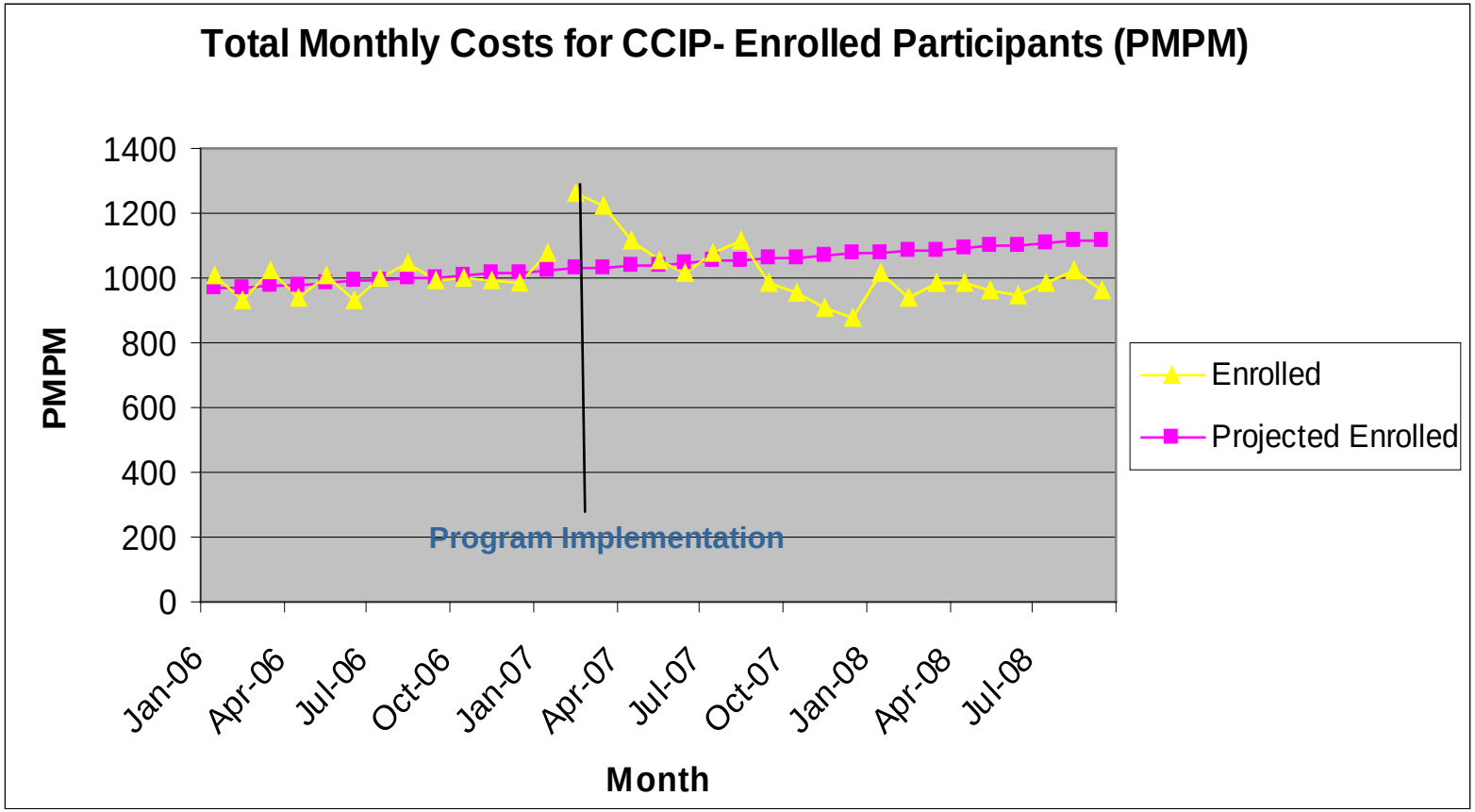
Missouri Case Study – Utilization Impacts

- October 07 – September 08 utilization below trend projection resulting in:

- ER Utilization Reductions
  - Average reduction of 106 visits per 1,000
  - 58% reduction in ER utilization rate compared to projected

- Inpatient Utilization Reductions
  - Average reduction of 73 admissions per 1,000
  - 44% reduction in inpatient admission rate compared to projected

Missouri Case Study – Fiscal Impact



Oct 07 – Sept 08 total costs below projection resulting in:
$128 average PMPM reduction for enrolled participants
$155 million annual reduction (7.8% reduction in total costs)

What is Working

Statewide centralized health management infrastructure efficiently facilitates enhanced clinical outcomes and cost avoidance.

Effectiveness achieved through supporting providers by coordination and linking of the services available in the healthcare system.

- Medical home linkage enhances continuity of care
- Analytic tools at providers' disposal to support better decision-making
- APS CareConnection@ facilitates coordination among providers through integrated individualized Plan of Care
- Health Coach services address gaps in care
- Development and administration of incentives aligned with best practices