January 2010

Washington State Department of Social & Health Services

Fact Sheet:

Aging and Disability Services Administration Chronic Care Management Project

A Look at National and State Data Tells Us

- Virtually all high-cost Medicaid beneficiaries have multiple physical and behavioral health conditions, disabilities, and or frailties associated with aging.
- For people with disabilities, each additional chronic condition is associated, on average, with an increase in costs of approximately $8,400/year. (CHCS Briefing Paper, March 08)
- Nearly two-thirds (61%) of adults on Medicaid have a chronic condition; nearly half (46%) have more than one; almost 83% have 3 or more; Over 60% have 5 or more; *and most of them are in unmanaged fee-for-service medical systems.* (CHCS, October 2007)
- In Washington State, 5% of Medicaid beneficiaries account for 50% of the costs, and many of them are also recipients of home and community based services. (Governor Memo 09/06)

Project Overview

For the past three years, the Aging and Disability Services Administration (ADSA) has been providing the Chronic Care Management (CCM) Project. This model of chronic care management integrates acute (medical) and long-term care services using a service model of largely face-to-face care management for clients identified by the highest 20% cost predictive risk scoring (Predictive Risk Intelligence System - PRISM) and long-term care risk indicators (CARE). It builds on ADSA's existing long-term care case management and in-home service delivery infrastructure through five of the state's thirteen Area Agencies on Aging. Current enrollment is limited to 250 participants. Nearly 5,000 long-term care clients meet the criteria for the project.

"Chronic care management" refers to the department's programs that provide care management and coordination activities for medical assistance clients determined to be at risk for high medical costs. "Chronic care management" provides these key active ingredients:

- Evidence-based assessment and interventions
- Client-centered health action planning
- Use of a health activiation measure survey
- Coordination of health care and other supportive services
- Education and coaching that assists program participants in improving self-management skills to improve health outcomes
- Reduced medical costs
- Improved functional and self-care abilities
- Slowing the progression of disease or disability
- Chronic care management recognizes and provides interventions for the medical, social, economic, mental health/behavioral health, and environmental factors impacting health and health care choices.

FOR MORE INFORMATION, CONTACT:
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The five Area Agencies on Aging providing CCM are:

- Olympic Area Agency on Aging
- Northwest Regional Council
- Pierce County Aging and Long Term Care
- Southeast Washington Aging and Long Term Care
- Aging and Long Term Care of Eastern Washington

ADSA Chronic Care Management Pilot Findings (updated 22 month evaluation results)

The DSHS Research and Data Analysis Division recently completed a 22-month follow-up on impacts of Medicaid costs and mortality for CCM clients, relative to a randomized waiting list control group. Due to the relatively small number of clients enrolled in the pilot and the extreme variability of costs among high-risk Medicaid patients, the findings summarized here did not achieve standard levels of statistical significance. However, the results show promising potential to improve health outcomes and control costs for patients with high medical risk and major functional limitations.

Key Findings:

- CCM enrollees were less likely to have inpatient hospital stays involving emergency room activity. The overall estimated medical cost savings were $253 per month enrolled in CCM.
- Nursing facility costs were lower and in-home care costs were higher for CCM enrollees. Overall long-term care costs were $46 per month higher for clients enrolled in CCM, excluding pilot costs.
- Including the $180 per month cost of enrollment in CCM, the program is estimated to have generated a net savings of $27 per month of enrollment.
- CCM enrollees were less likely to die in the 22-month follow up period. However, mortality impacts that were statistically significant at the 10-month follow-up have moderated.

For more evaluation information on the project, visit:
http://www.adsa.dshs.wa.gov/professional/hcs/CCM/; or
http://publications.rda.dshs.wa.gov/1396/

Why Expand Chronic Care Management Now?

- Saves lives and improves client outcomes
- Serving only 250 of the 5,000 Medicaid only clients who are highest risk for future Medicaid cost
- Building capacity to reach the 12,500 Medicare and Medicaid (dually eligible) clients who are high risk.

Expansion of ADSA CCM Project

- Infrastructure, investment, and ability to study future cost savings should not be lost. Funding for the project should continue and be expanded.
- 5,000 (37%%) of the aged and disabled clients receiving long-term care services in their homes meet the current criteria for CCM (Medicaid only beneficiaries at the top 20% risk group based upon PRISMmodeling).
- 12,500 of the dually eligible disabled and aged population receiving long term care services in their own homes and community based residential settings, such as Adult Family Homes and Boarding homes would benefit from the service.
- Relationship with the beneficiaries and case management infrastructure already exists. Expansion from 250 to 1,000 clients upon submission and approval of a State Plan Amendment has been agreed to by ADSA and the Health and Recovery Services Administration. The ADSA CCM project has the ability to continue the survey and cost analysis secondary to control and treatment group integrity. With expansion, we will be able to measure statistical significance of early findings, determine the longer term effect of the chronic care management intervention, and test ideal length of the intervention.
- DSHS needs more research and experience to determine long-term costs/savings and appropriate length of intervention, and will continue the research evaluation through the next biennium.