A Comprehensive Survey of Managed Care Organization (MCO) Medication Adherence Intervention Programs

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Introduction

Medication adherence is defined as the extent to which a patient takes one's medications as prescribed by his or her healthcare providers. Medication non-adherence is understood as a costly and dangerous problem. In the U.S. alone, it is estimated to incur $290 billion in avoidable healthcare expenditures each year. On an individual basis, annual spending for non-adherent patients with hypertension and diabetes is approximately $4,000 greater than for patients who are adherent to their medications. In addition, non-adherent patients suffering from heart failure are hospitalized 2.5 times more frequently than those who adhere to their medication regimens, resulting in a profoundly diminished quality of life, while driving up healthcare costs. This problem will continue to get worse as more patients will continue to take multiple medications to treat chronic conditions.

While medication non-adherence is a serious problem, its origins are complex and not fully elucidated. Some of the more commonly accepted causes of non-adherence include complex treatment regimens, adverse drug reactions, forgetfulness, socioeconomic issues, health literacy, and personal beliefs.

Managed Care Organizations (MCOs) and other stakeholders of patient medication adherence seek to enhance current medication adherence intervention programs as some 50% of patients do not take their medications as prescribed.

The purpose of this study is to examine the current landscape of MCO medication adherence programs and to identify areas that require improvement. The study also examines the need for more enhanced predictive analytics platforms.

Methods

This research-survey was conducted in Spring 2014 and involved 30 MCOs. Each MCO was interviewed about their current medication adherence intervention programs.

Interviews involved a questionnaire consisting of open-ended and multiple-choice questions. The questionnaire was divided into three basic components: general questions regarding existing medication adherence programs, types of interventions used and their individual effectiveness, and how patients are selected to receive interventions. Respondents also discussed any unique services their programs provide and any future plans of expansion.

All data was recorded by 5 interviewers and then reanalyzed by the authors.

Study Population

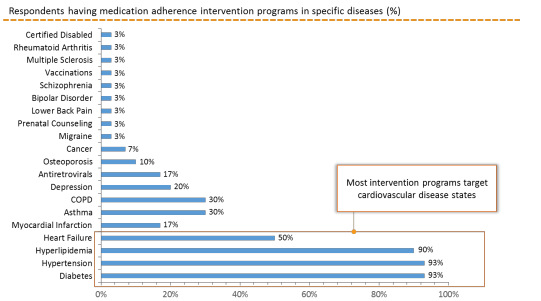
All 30 MCOs interviewed have medication adherence intervention programs that target their patient population. The MCOs vary in size and coverage demographics. 19 of the organizations are classified as small MCOs (enrollment <200,000), while 11 are classified as large MCOs (enrollment >200,000). The surveyed MCO populations encompass most of the continental United States as well as Puerto Rico.

The coverage demographics of these MCOs include Commercial, Medicare, and/or Medicaid. Overall, 53% of MCOs cover a commercial population, 80% cover a Medicare population, and 27% cover a Medicaid population. The highest coverage combinations are Commercial and Medicare, and Medicare and Medicaid, which account for 23% of the population and 17% of the population, respectively.

The study interviewed employees in charge of their respective medication adherence intervention programs.

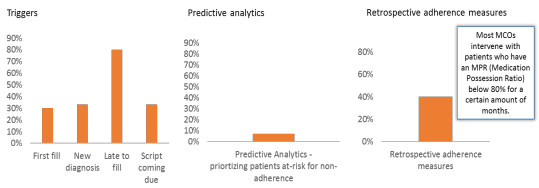
Results

To which of the following diseases do your current intervention programs apply? n = 30



How are patients selected to receive interventions through your intervention programs? n = 30

Below are three common methods MCOs use to select patients for interventions

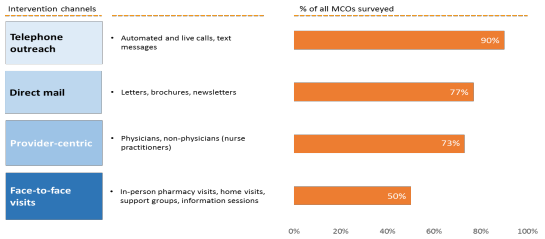


Most MCOs use some combination of methods to determine when patients get interventions.

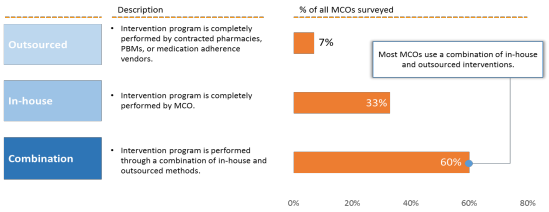
- For example, many MCOs intervene with patients who are late to fill their prescriptions (triggers) and/or have an MPR below 80% in the last 6 months (retrospective adherence measures).

Results (cont.)

What types of interventions does your medication adherence program use? n = 30

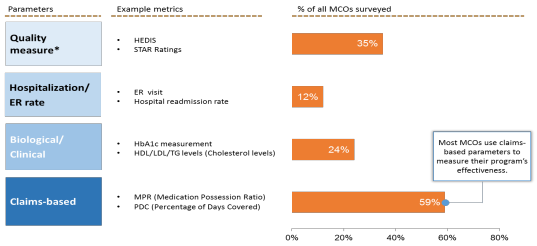


Are your interventions conducted in-house or outsourced? n = 30



Many MCOs perform provider-centric interventions in-house and outsource automated call interventions to contracted PBMs and/or medication adherence vendors.

How do you measure the effectiveness of your existing medication adherence program? n = 15



Discussion

Most MCO medication adherence program interventions are directed at patients with chronic cardiovascular disease states (diabetes, hypertension, hyperlipidemia, and heart failure). Cardiovascular diseases are a primary concern for MCOs because of the chronic use of medications/therapies that are associated with the management of such disease states. Furthermore, there is a strong association with medication non-adherence and increased hospitalization rates.

Most MCOs use triggers and retrospective adherence measures to select patients for interventions. MCOs seem to follow a rule-based approach (using specific demographic profiles and pre-defined events to trigger interventions) rather than treating each patient individually. One way to implement a more personalized approach is through predictive analytics. While only 7% of MCOs currently use predictive analytics, over half of the surveyed MCOs plan on incorporating some type of analytics platform. Many are interested in adopting a platform that identifies interventions most likely to engage patients and influence their behavior, avoiding wasteful spending on interventions with patients who will not need them. These enhanced programs are dynamic and self-learning and can rapidly adapt to new intervention techniques.

MCOs focus on four intervention channels to improve patient adherence: telephone outreach, direct mail, provider-centric, and face-to-face visits. These interventions are conducted through a combination of in-house and outsourced techniques. MCOs perceive current approaches as only moderately effective because of a failure to intervene before patients are non-adherent and a failure to personalize interventions. This relative ineffectiveness of current interventions has been implicated in previous studies.

Overall, while most MCOs currently have medication adherence programs, many are dissatisfied with their overall effectiveness and are interested in expanding to platforms that allow for a more personalized approach to address medication non-adherence.

Conclusions

The study results suggest that most MCO medication adherence programs target chronic, co-morbid cardiovascular disease patients through a system of triggers and retrospective adherence measures. Most MCOs intervene using telephone outreach, direct mail, provider-centric, and face-to-face visits through a combination of in-house and outsourced methods. This approach is seen as only moderately effective as it fails to personalize interventions and intervene before a patient becomes non-adherent.

Limitations

The questionnaire only recorded data from MCOs who agreed to participate in the survey. This is a potential source of non-response bias.

References

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For in-depth research data visit **www.allazohealth.com/mco-adherence-study**