

How Can an MA Plan Best Manage its Critically and Chronically Ill Members?

From Your Executive Director, Lori Medlen



Hello RISE Members:

Instead of the traditional RISE newsletter, I'm writing this as a "blog"-type communication, simply because the topic - **Managing Medicare Advantage Members with Chronic, Complex Cases** - is itself complex, and one that I've not explored before. So, I'm going to give you *my interpretations* of what was said to me during several interviews with industry experts. It's a fascinating topic, and during the past month or so, I spoke with:

- Beverly Hansen, *Director of Care Management*, **VIVA Health**
- Dr. Eric Rackow, *President and CEO*, **SeniorBridge**
- Lisa Slattery, *VP Quality and Integrated Care*, **Health First**
- Dr. Randall Williams, *CEO*, **Pharos Innovations**
- Ayo Kalejaiye, *President*, **Medisoft Rx**

Thanks to all of these people for giving their valuable time to this project.

Statistics, statistics . . .

Some of the statistics interviewees rattled off* are pretty astounding - I mean, yowser! (Urban Dictionary says "yowser" IS a word, so there - even though Microsoft is doing the red squiggly thing underneath it).

*20% of members account for 86% of costs, with the top 1% driving 27% of costs

*90% of every \$1 spent is on chronic conditions

*2/3rds of hospital admissions are due to self-care issues

*20% of Medicare patients are re-admitted to the hospital within 30 days; the rate jumps to 25% for heart failure

*1/3 of Medicare patient discharges are to nursing homes, yet nursing home care is difficult to monitor or control

*On average, patients with dementia can cost a health plan 40% more than other patients

*100% of RISE Executive Directors are named "Lori" 😊

*Note: *these numbers were given to me over the phone; I have not verified them - except for the last one.*

What are the Difficult-to-Manage, Chronic and Costly Conditions?

Everyone I spoke with agreed that the "Big 3" diseases and conditions causing concern were:

1. Heart Failure (most total dollar impact)
2. COPD
3. Diabetes

Other conditions mentioned included mental illness/dementia, cancer, and end-stage renal failure. But, as with most things, the devil's in the details. For instance:

- Ensuring a member has a scale at home may be crucial for cardiac patients, yet even something so simple can require an in-home visit
- Many seniors are hesitant to seek mental health services, so a "life coaching" approach may be more effective
- Medication reconciliation was mentioned often as a huge problem: Lisa Slattery of Health First said that patients may not understand medication instructions and moreover, complications often occur when patients *change* medications or have multiple providers prescribing different medications. Obviously, if a patient has dementia or other behavioral health issues, the problem gets worse.
- Evaluating patient functionality is extremely important, said Dr. Eric Rackow of SeniorBridge. Dr. Rackow stressed the necessity of evaluating patients' limitations regarding instrumental activities of daily living (IADL) and basic ADL. Some of the *instrumental* activities include the ability to use a telephone, ability to shop and self-transport. Some *basic* ADLs include dressing and undressing, and self-feeding.

Indeed, there are so many potential issues and problems with the chronically and acutely ill, it boggles my mind. And that's where data comes in ... and further boggles my mind!

Data, Technology, and the "Impactable" Patients

Beverly Hansen of VIVA Health uses the term "impactable" to describe the patients they are trying to identify as potentially needing care interventions. At VIVA, they use an algorithm developed internally using claims data, escalating claims and hospital admissions data to identify these patients.

By contrast, Pharos Innovations, headed by Dr. Randall Williams, has a device-free system that uses the phone and the internet for patient monitoring and reporting. The patients report every day; if they don't, they receive a reminder. The data is then processed by Pharos and used by plans and hospital care teams to coordinate services.

Dr. Rackow of SeniorBridge says they use some remote monitoring as well as a tablet-style device to enable communications about a patient's condition, in addition to their at-home services.

Some plans are using predictive modeling to combine claims, pharmaceutical, lab and enrollment data to predict which members are most at risk. Ayo Kalejaiye of Medisoft Rx says his firm's predictive modeling product also indicates *why* particular patients are at risk. He indicated that although some larger plans can afford to integrate all this data, it's more difficult for smaller plans to manage. Medisoft Rx's product is geared to mid-size and smaller plans.

Care Management Approaches and Incentives

Once the "impactable" (I love that word!) patients are identified, what can a plan do next? Beverly Hansen says VIVA uses field-based care managers and social workers to help the critically and chronically ill members. Beverly stressed the importance of the field-based approach, noting that, for example, patients can easily give erroneous information over the phone.

Health First uses a variety of methods to impact care. Ms. Slattery said they tackle the issue from various angles, from in-home physician visits, to nurse outreach, phone outreach and disease management programs - the level of care varies depending on patient needs. To stratify the patients, they use data based on frequency of hospitalization and known high risk conditions, including assessing patient mobility (e.g., home-bound or bed-bound). In addition, Ms. Slattery's 4.5-star plan puts a lot of effort into its post-acute care transitions programs. Plus, they are developing a special program for patients with dementia *and* a palliative care program.

Furthermore, Health First participated in the AHRQ Project Red, a 6-month pilot focused on transitional care management for heart failure patients. Ms. Slattery indicated that

although only 1 in 4 eligible patients hospitalized with CHF participated, they still saw significant reduction in readmission rates using the Discharge Advocate model.

SeniorBridge, Dr. Rackow stated, provides in-home care management with home health aides to facilitate not only patient care, but patient functionality and behavioral health issues that may otherwise be overlooked.

Incentives:

Pharos Innovations' Dr. Williams also noted the increasing use of various incentive programs for both patients and providers to impact care management. For instance, some plans will waive drug co-pays for medications affecting chronic conditions, or pay providers a care coordination fee, or perhaps a bonus in the case of FFS providers.

What Else Was Mentioned?

Other issues brought to my attention:

- To what extent should a plan evaluate members' care plans based on single diseases versus looking at them as a population? How should you allocate resources, for example, between an intensive diabetes care management program vs. broader initiatives?
- "The financial and clinical people don't talk", someone said, with the implication that this needs to change
- Different models of care, including ACOs, PCMHs, and Medicare/Medicaid integration in some states, will affect this whole picture. Mr. Kalejaiye of Medisoft Rx noted that predictive modeling may become more important as organizations become more responsible for *everything* in a patient population
- CMS will start penalizing the worst 25% of hospitals with the most readmissions, meaning a greater emphasis on care transition management throughout the industry. CMS plans to target the areas of heart failure, pneumonia, and heart attacks.

What Strikes Me About All of This...

What strikes me about all of this is that *data is so important to care management* - not only claims data alone, but integrating lab data, enrollment data and pharmacy data *with* claims data - for a true picture of a member's needs and care gaps. But managing data is expensive, which brings me to...

The next thing that strikes me: the difference between the small and larger plans. The larger plans have more resources to analyze the data, yet the small plans "run into [our] members in the grocery store", so care management should be much easier for them; it's obviously simpler to manage fewer people.

And I have a suspicion that behavioral health (evaluations and care) is another key piece - and perhaps, somewhat *neglected* piece - of this puzzle.

Finally ... WOW this is long! Please comment; any further insight is welcome to this relative novice.

Many Thanks,

Lori Medlen, Executive Director

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