Disease Management for the Institutionalized Patient Population

The Disease Management Colloquium
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Agenda

- Introduction
- Overview of the Opportunity
- Challenges in Managing this Population
- Alternatives
- Summary of Market Activity

Introduction

- **Institutionalized patients have traditionally been excluded ("carved-out") from disease management contracts.**
  - Not easily managed by telephonic interventions
  - No easily placed in a single disease category (more often multiple chronic conditions and poly-pharmacy issues)
  - The health plan has no "eyes and ears" on the member to implement any intervention.
- **For this reason, most health plans and disease management companies do not have disease management programs for institutionalized members.**
- **However, the cost of this population is causing many payors to develop strategies to manage these members. Examples include:**
  - Federal government: CMS inclusion of institutionalized population in the Chronic Care Improvement Program/Medicare Health Support Program
  - State Government: Medicaid Request for Proposals (RFP), such as the state of GA
  - Private Sector: Growth of several companies focused on caring for institutionalized population (more on slides #12 and 13)
- **The anticipated growth in long term care needs makes this a timely discussion!**

Overview of Opportunity
Why Manage this Population?

- **Case finding: easy, as members are in institution**
- **Stratification: easy, they are all high risk (with few exceptions)**
- **Intervention: easy, provide them with basic primary care services they are not currently receiving**
- **Outcomes: data already captured by MDS; outcomes generated in months, not years**

Overview of Opportunity
From Perspective of MA Plan

- **Some covered lives will end up as institutionalized members**
- **As long as the members pays their premium, the MA plan is responsible for Part A (hospitalization and SNF) costs**
- **Yet a typical MA plan has no control over medical decision-making in the nursing home setting:**
    - The MA plan has no on-site staff (economically not feasible)
    - The vast majority of hospitalizations are 911, and so there are few opportunities for pre-certification review or UM.
- **Clinically complex members + no medical management = recipe for disaster**
- **The "disease management" intervention for these members in to provide primary care services in the nursing home vs. in the emergency room**

Overview of Opportunity
Sample Math

- **20,000 Medicare Advantage (MA) plan**
- **200 to 300 institutionalized members**
- **1 to 2 hospitalizations per member per year**
- **$10,000 per hospital admission**
- **Annual hospitalization cost of between $2 million and $6 million!**

Challenges in Managing this Population

- **The members reside in multiple locations**
  - These 200 to 300 members may be in 50-100 nursing homes
  - Low volume in high number of nursing homes prevents traditional on-site case management
- **The members are not easily managed by telephone**
  - Many won't have a phone (impaired mental status)
  - Telephone management may interfere (or be perceived to interfere) with nursing care being delivered by the institution.
- **Nursing homes are not an ideal "partner"**
  - They have different financial incentives then a MA plan, especially regarding hospitalizations
  - Given the small number of MA residents, it is difficult to get their attention
  - Facilities are "Mom and Pop" in nature

Alternatives
Three Possibilities

- **#1: Ignore institutionalized members**
- **#2: Manage them (creatively)**
- **#3: Embrace the population (and create a product-line)**

Alternatives
"Ignore" Strategy

- **This is the strategy of many MA plans**
- **Positive: does not require resources to implement**
- **Negative: huge cost savings opportunity missed, the problem gets worse as MA population grows and ages**

Alternatives
"Manage" Strategy

- **Managing this population requires an on-site presence**
- **Typical strategies involve a mix of on-site:**
  - Nurse Practitioners
  - Case Managers
  - Physicians ("SNFists")
- **The challenge is that for the economics for any on-site strategy to work, the MA plan must aggregate as many institutionalized members in as few nursing homes as possible**
  - This usually involves narrowing the nursing home network
  - More MA members in fewer homes results in better nursing home partners
- **Positive: annual cost savings potential in excess of > $500,000 for typical MA plan with 20,000 members**
- **Negative: requires resources to implement a program, changes to nursing home network require time to implement**

Alternatives
"Embrace" Strategy

- Create a health plan tailored to institutionalized population
- The Evercare Demonstration project has lead to the creation of an Institutionalized Special Needs Health Plan (part of the Medicare Modernization Act)
- Positive: huge business opportunity to manage the 1.0 million eligible institutionalized residents ($20-30 billion of premium); proven models exist
- Negative: significant commitment required to embrace this challenging population (and most MA plans have limited experience in managing)

Summary of Market Activity
"Manage" Strategy

Care Guide (formerly Coordinated Care Solutions)	**Case manager model in partnership with MA plans**
FLACS	**Physician model in partnership with MA plans**
Inspiris	**Nurse practitioner model in partnership with MA plans**
Senior Metrix	**Data and case management model in partnership with MA plan**

Summary of Market Activity
"Embrace" Strategy

Care Plus	**Institutionalized Special Need Health Plan in FL**
Evercare	**Institutionalized Special Need Health Plans in AL, AZ, CO, CT, DC, DE, FL, GA, MA, MD, ME, MN, NC, NJ, NM, NY, OH, PA, RI, WA, and WI**
Fidelis Senior Care	**Institutionalized Special Need Health Plan in MI**
Inspiris (formerly Geriatrix)	**Institutionalized Special Need Health Plan in AZ**