Disease Management in Medicare: Early Lessons from Medicare Health Support and Chronic Care Special Needs Plans

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Objectives

1. **To provide an overview of the Medicare Health Support (MHS) Program and Special Needs Chronic Care Plans (C-SNPs)**

2. **To provide our view of the six critical competencies for launching a Chronic Care Special Needs Plan**

3. **To describe the XLHealth targeted care management approach for senior populations**

4. **To share some "lessons learned" from our Medicare Health Support Program in Tennessee**

DM Zealot

DM Skeptics

Medicare Changes with the Times

The Medicare Modernization Act of 2003 (MMA)

Two key goals:

- **Improve the quality of care and life for seniors living with chronic illness**
- **Contain or reduce cost associated with chronic care**

A key element:

- **Initiate voluntary chronic care improvement programs (CCIP) with the Medicare FFS system, now called Medicare Health Support (MHS),**
  - **Select care management vendors to pilot the program**
  - **Not truly a "demonstration" but outcomes will be evaluated**

Medicare Changes with the Times cont.

The Medicare Modernization Act of 2003 (MMA)

- **Promote coordinated care health plans, the Special Needs Plan (SNP), in the Medicare Advantage (MA) program**
- **Many other aspects, all represent major care delivery model changes**

Medicare Health Support

Phase I: Pilot Program

- Vendors
  - **8 care management companies selected**
  - **3 yr pilot kick off in 2005**
  - **Various care management models**
  - **Multi-disease focus (HF and diabetes)**
- Design
  - **Voluntary enrollment of FFS Medicare beneficiaries**
  - **Participants remain in FFS Medicare**
  - **Disease Management services provided**
- Outcome
  - **A set of quality measures and expectation of 5% net savings**
  - **If goals met, CMS may expand the program**

Who is the Medicare Beneficiary with Special Needs?

Three basic types of SNPs

1. **Dually eligible for Medicare and Medicaid (i.e. “dual eligibles”)**
2. **Institutionalized/Long term care**
3. **One or more severe or disabling chronic conditions**

Special Needs Plans **(SNPs)**

- SNPs are growing rapidly
- 276 SNPs in 2006
  - **over 600,000 beneficiaries enrolled**
  - **Only 13 of these were chronic illness SNPs (C-SNPs) with 72,000 enrollees**
- 473 SNPs in 2007
  - **over 840,000 enrollment as of 3/07**
  - **84 of these are C-SNPs with 81,000 enrollees**
    - **Increased interest in 2007 due to full risk adjustment in MA premiums**

XLHealth & Care Improvement Plus

- XLHealth now has C-SNPs under our own Care Improvement Plus program in 6 states and one joint venture C-SNP with HIP
  - **Diseases: Diabetes, HF, COPD, ESRD**
- Starting with our small Maryland pilot in 2006, we have added over 15,000 seniors in the first 4 months of this year
  - **Average member represents $13,000 - $18,000 in annual medical expense prior to joining (ESRD = $80,000+)**
- Members received Part D plan, custom formulary, other benefits to improve access to care

6 Competencies for a Successful Chronic Care SNP

1. Member acquisition
2. Member engagement
3. Aggressive case and disease management
4. Appropriate utilization management
5. Medication therapy management
6. Assuring appropriate revenues for the high risk population

1. Member Acquisition

- Our initial approach in 2006 was to use two "channels"
  - **Provider-based marketing and mass media**
- In 2007 we expanded into two additional channels
  - **Broker sales**
  - **Community based marketing**

2. Member Engagement

- In a C-SNP this is less of a problem than in traditional DM programs imbedded in traditional health plans
- Members usually join with the expectation of participating in the DM program
- You are not relying on inaccurate claims data to identify patients

3. Effective Disease & Case Management

- It is difficult to achieve financial goals in patients with chronic disease and high spending without effective CM/DM
- Denying services (aggressive prior authorization processes), is unlikely to work with the elderly who have serious illnesses
  - **Fewer "elective" hospitalizations and bed-days**
  - **High likelihood of disenrollment if UM is too intrusive**
- Disease Management and CM is what CMS is promoting within the C-SNP model

4. Appropriate Utilization Management

- In FFS medicine, we know that >15% of services and procedures are not necessary
- It is not cost-effective or acceptable to "manage" all services
- Strategy: focus on high-cost services with high potential for inappropriate use
  - **Skilled nursing, home care, etc.**
  - **Inpatient UM depends on payment model**

*Kahn KL, KosecoffJ, Chassin MR, et al. The use and misuse of upper gastrointestinal endoscopy. *Ann Intern Med.* 1988;109(8): 664-70.
*Seematter-Bagnould L, Vader JP, Wietlisbach V, et al. Overuse and underuse of diagnostic upper gastrointestinal endoscopy in various clinical settings. *Int J Qual Health Care.* 1999;11(4): 301-8.
*Winslow CM, Solomon DH, Chassin MR, et al. The appropriateness of carotid endarterectomy. *N Engl J Med.* 1988;318(12): 721-7

5. Medication Therapy Management

- Medication "conflicts" and adherence are major problems for patients with chronic disease
  - **Typical C-SNP patient on 4 or more drugs**
  - **These are prescribed by multiple providers**
  - **Typical conflicts:**
    - **Drugs not indicated in the elderly**
    - **Drug-drug interactions**
    - **Duplicate meds (brand and generic)**
    - **Wrong dosing**
  - Pharmacy-based MTM programs have demonstrated significant cost savings*

*Borgsdoef LR, Knapp KK, Niano JJ
American Journal of Hospital Pharmacy, Vol 51, Issue 6, 772-777

*Lee JA, et al
Am J Health –Syst Pharm – Vol 59 Nov 1, 2002

Medication Non-Adherence Drives Up Healthcare Costs

Failure to take medication as prescribed:

- Causes 10% of total hospital admissions
- Causes 33% of CHF hospital admissions
- Causes 75% of Schizophrenia admissions
- Causes 68% of resistant/mutated HIV virus
- Results in $100 billion/year in unnecessary hospital costs
- Causes 22% of nursing home admissions
- Costs the U.S. economy $300 billion/year

(N Engl. J Med 8/4/05, National Pharmaceutical Council, Archives of Internal Medicine, NCPIE, American Public Health Association, AIDS 2006 20:223-232)

6. Assuring Appropriate Revenue

- Premiums from CMS are fully risk-adjusted based on HCCs derived from the ICD9 codes on provider claim forms from the prior year

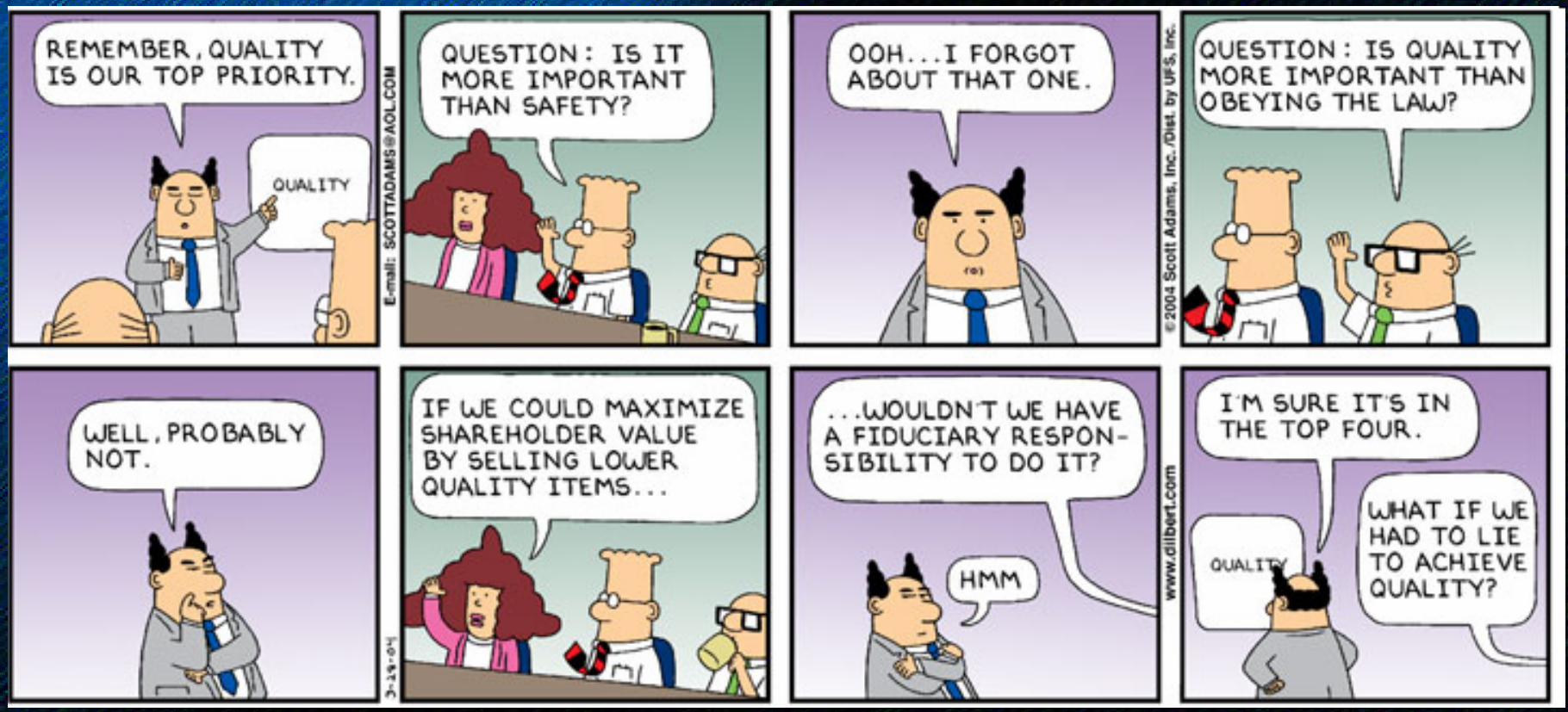
  - **Physicians and hospitals routinely do not code for all chronic conditions in a given year**
  - **Ex: an amputation not be coded for year**
  - **Ex: patients with diabetic neuropathy may only have diabetes coded**

Undercoding = Underpayment

HCC Opportunity Analysis by Code (DRAFT 2007 MA Payments per CMS 2/06)				
HCC Number	Clinical Condition	Incremental Payment	Prevalence	Degree of Undercoding
HCC16	Diabetes with Neurologic or Other Specified Manifestation	$2,900	30+%	High
HCC17	Diabetes with Renal or Peripheral Circulation Manifestation	$3,900	15+%	High
HCC18	Diabetes with opthalmologic or unspecified manifestation	$1,700	20%	Moderate
HCC149	Chronic Ulcer of Skin, Except Decub.	$3,000	>5%	High
HCC177	Amputation Status, Lower limb	$4,200	3 to 4%	High for old amputations

6. Assuring Appropriate Revenue (continued)

- Once a member is in your C-SNP (or any MA plan) for one year, you can proactively identify "hidden" chronic diagnoses and CMS will retroactively adjust your premiums
  - **There are strict timelines and rules for doing this**
  - **There must be an "audit trail" to the actual diagnosis in a chart – you can't infer a diagnoses**
  - **Tactics = chart audits and provider education**


REMEMBER, QUALITY IS OUR TOP PRIORITY.
QUALITY
QUESTION: IS IT MORE IMPORTANT THAN SAFETY?
E-mail: SCOTTADAMS@AOL.COM
OOH...I FORGOT ABOUT THAT ONE.
QUESTION: IS QUALITY MORE IMPORTANT THAN OBEYING THE LAW?
©2004 Scott Adams, Inc./Dist. by UFS, Inc.
WELL, PROBABLY NOT.
IF WE COULD MAXIMIZE SHAREHOLDER VALUE BY SELLING LOWER QUALITY ITEMS...
3-19-04
...WOULDN'T WE HAVE A FIDUCIARY RESPONSIBILITY TO DO IT?
HMM
www.dilbert.com
I'M SURE IT'S IN THE TOP FOUR.
QUALITY
WHAT IF WE HAD TO LIE TO ACHIEVE QUALITY?

The Problem

What do you do when suddenly faced with thousands of new Medicare enrollees in need of Care Management?

XLHealth
Our Approach

- **Robust Multi Disease Management**
- **Complex Case Management**
- **Partnership with INSPIRIS (Long term care)**
- **Limited Utilization Management**

Key Strategies:
Primary Risk Stratification

- **Identify patients at highest risk for immediate outreach**
  - **Use available information**
    - **Predictive Modeling**
    - **HCC (Hierarchical Condition Categories) data**
    - **Claims**
    - **Self reported disease profiles**

Key Strategies:
Establish a strong patient / care manager relationship

- **Engagement is not easy**
- **Face to face communication important**
- **Local care managers essential**
- **Involve Care Givers**
- **Over 90% of participants said they would recommend the program to friends and family with similar conditions***

*DSS Research, Inc. Fort Worth,Texas Nov/Dec 2006

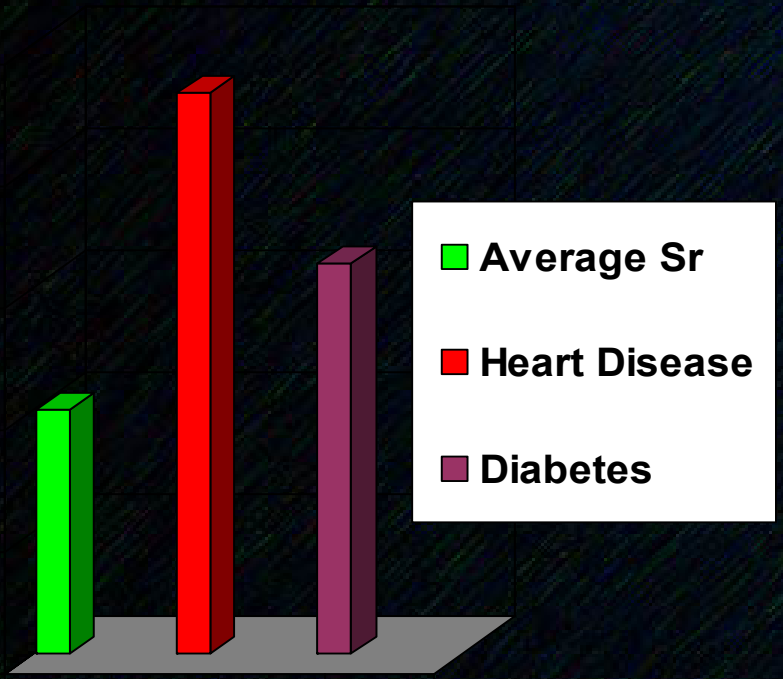
Key Strategies:
Telephone Coaching

GOALS: Education, Empowerment, Motivation

- **Supports face to face assessment**
- **Call center approach efficient for high volume activities such as telephonic health coaching**
- **Coaching topics are dynamic and prioritized by care management algorithms**
- **Education Library useful**

Key Strategies:
Depression screening

- **Higher rates of depression in chronic illness**
  - **Average older adult: 5-10%**
  - **Heart Disease: 15-23%**
  - **Diabetes: 11-15%**
- **Medical Costs are 2-3X higher with depression**
- **Care Management is more challenging due to decreased adherence and self-care**



Katon W: Clinical and health services relationships between major depression, depressive symptoms and general medical illness. Biologic Psychiatry, 2003

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: John Q. Sample DATE: _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	✓	3
2. Feeling down, depressed, or hopeless	0	✓	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	✓	3
4. Feeling tired or having little energy	0	1	2	✓
5. Poor appetite or overeating	0	✓	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	✓	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	✓	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	✓	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	✓	1	2	3
add columns:		2 +	10 +	3
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). **TOTAL:**		15		

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all: _____
- Somewhat difficult: ✓
- Very difficult: _____
- Extremely difficult: _____

Key Strategies:
Depression Interventions

- **Share results of PHQ9 with patient**
- **Recommend patient discuss results with physician if positive for depression or if in treatment and still feeling poorly**
- **Rescreen**
  - **Only 30% achieve remission with initial drug**
  - *If not improving, the treatment needs to change*
- **Education-**
  - **Major depression rarely gets better on its own**
  - **Medication and psychotherapy are effective**
  - **Must continue treatment even if feeling better**

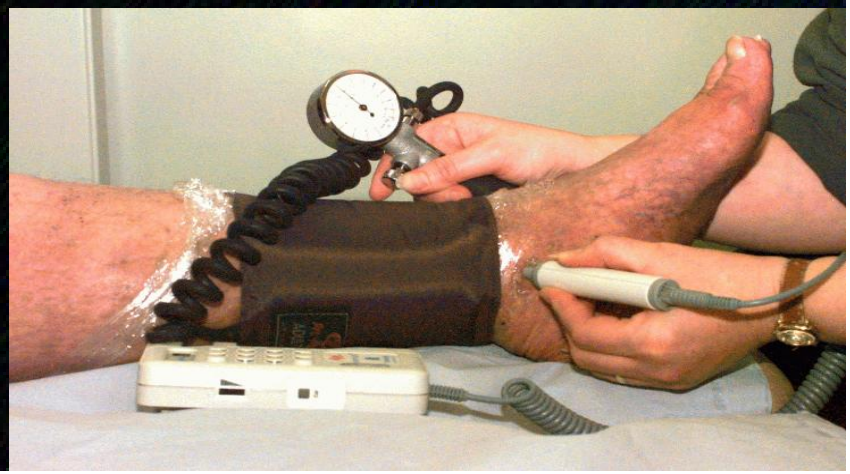
Key Strategies:
Identify the "Quick Hits"

- Where do you start?
  - **Medicare patients' needs are many**
  - **Every care manager will have a different opinion about priority interventions**

- Effective strategy: "Quick Hits"
  - *Can be achieved quickly and have a high impact on reducing serious medical complications that are costly…*
  - **Interventions requiring major behavioral change are NOT "Quick Hits" (Smoking cessation, weight loss)**

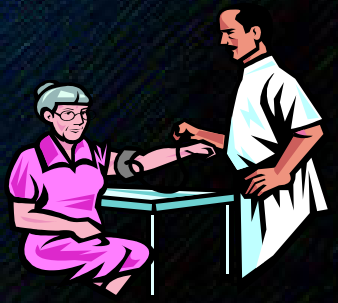
Diabetes
"Quick Hits"

- Appropriate medications: ACE/ARBs, Aspirin, Statins
- Blood Pressure screening and treatment of hypertension
- Lower extremity screening for neuropathy and vascular deficits
- Treatment of current ulcers and wounds



Key Strategies:
Continually Refine Interventions

- Dynamic risk stratification using claims and assessment data
- Flexible plan of care responsive to changes in patient condition and disease states
- Seamless coordination between Disease Management and Complex Case Management



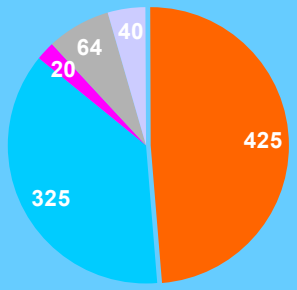
Key Strategies:
Never Lose Sight of the Key Indicators

- Assure that Care Managers know key indicators and metrics
  - **Clinical**
  - **Financial/Utilization**
  - **Risk Stratification**
- Provide aggregate (panel) as well as individual patient data
- Integrate reporting into the care management IT system and make it available to front line staff

Care Manager Dashboard

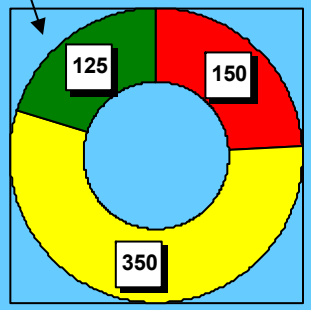
Patient Panel 625

(New past 7 days + 24)



HF
Diabetes
COPD
ESRD
SRSP

Click on # to view patient list



High risk **Mod risk** **low risk**

❖Active Program

(click on to view patient list)

78% Disease mgt
10% CCM
12% UM

❖Care Mode

(click on to view patient list)

80% center
5% home
10% telephonic
3% custodial NH
2% mailings only

❖Interventions

(click on to view patient list)
% patient panel eligible for & need intervention

20% telemonitoring scale need
30% digital scale need
32% diabetic shoes need
28% temp device need
12% blood glucose meter need
16% protein supplements need
22% Sureseal band aids

Daily triggers

(click to view patient list)

Inpatient census 32
Urgent activities 32
Post D/C calls 24

❖Last patient contact date

(click to view patient list)

> 90 days = 40
60-90 days = 30

Activities schedule (Click in # to link to list)	Overdue #	Today	Due next 30 days #
Welcome call			
HRA			
BCE (dropdown of location)			
coaching call			
followup assessment			
annual assessment			
Flow assessment (ESRD)			
follow up intervention			
Referral (dropdown)			

Utilization triggers

(click ▫ to view patient list)

▫ top 20 patients by total $
▫ top 20 patients by # acute care hospitalizations
▫ # of HF patients ≥ 3 admits/ 12months

Quick Hits

% of patients eligible & need evaluation for Quick Hits

(click to view patient list)

32% ACE/ARB need
24% Short acting bronchodilator need
35% Statin need
28% Daily weights need
38% LDL need
42% Aspirin need
37% Diuretics need
56% PRN diuretic need
38% Spirometry need
45% Beta blocker need
34% BP out of range
35% BP value need
13% Falls Risk
34% HbA1c value need
12% Depression PHQ9 ≥ 10
12% Depression PHQ9 ≥ 20
31% Annual flu vaccine need
15% Pneumonia vaccine need
34% LVEF need
62% DRE need
35% LEX exam need
15% Current LEX wound
3% Vascular access type (catheter> 3months)

Key Strategies:
Partner with Physicians

- Physician partnership is essential
- "Quick hits" cannot be addressed without physician intervention. WHY – many require prescriptions or orders
- Provide patient progress reports
- Encourage feedback but limit requests
- Consider physician incentive programs

XLHealth
Inform. Empower. Excel.

Ask Your Doctor

Visiting your doctor 2-4 times a year is important to staying healthy. If you have not seen your doctor in the past 6 months please make an appointment to see your doctor. The following questions are based on answers you gave your XLHealth nurse. Be sure to take this list of questions with you. Talk to your doctor about each of the health questions below.

Topic	Questions
Heart Failure Symptoms	**Explain your heart failure symptoms to your doctor at every visit.** **What should I do when I have symptoms such as breathing problems, weight gain or other heart failure symptoms?** **Should I ever take an extra water pill? If yes, when should I take an extra water pill?**
ACE inhibitor medication	**I have heard that ACE inhibitor medication can help people with heart failure or people that have had a heart attack. Would an ACE medication help me?**
Beta blocker medication	**I have heard that people with heart failure or people who have had a heart attack should be taking beta-blocker medications. Would a beta-blocker medication be right for me?**
Statin medications	**What was my last LDL cholesterol?** **Do I need statin medications to get my LDL cholesterol below 100?** **What other suggestions do you have to help me get my LDL cholesterol down? How often should I have my LDL checked?**
Blood thinners	**Should I be taking aspirin to help prevent a heart attack or stroke? How much should I take?**
Extra water pills	**I check my weight every day for extra water weight. Is it safe for me to take an extra water pill if I gain too much weight or have heart failure symptoms? If yes, would you write instructions for when I should take an extra dose?**
Low sodium diet	**I have not been following a low sodium diet carefully**

XLHealth
Inform. Empower. Excel.

Date: November 14, 2006 **Doctor:** _____

Participant: _____ **Age:** 91 **Participant ID #:** _____

Your patient is currently in our diabetes disease management program. The information in this letter is based on *self-reported* medical history and/or claims data. Checkmarks indicate reported risk factors for hospitalization or complications. Question marks indicate missing information.

Risk Factors for Hospitalization or Diabetic Complications			
	Inpatient admission < 6 months	✓	Self-reported symptoms consistent with depression
✓	Blood pressure≥130/80		Participant smokes
	A1C >7% (ADA target <7%): ADA Target		Poor adherence: Medications
	A1C >10% (ADA target <7%): High risk for complications	✓	Poor adherence: Diabetic Diet
	Microalbuminuria		Poor adherence: Glucose self-monitoring
	Hypercholesterolemia (LDL>100)		Cognitive issues (confusion, dementia)
✓	History of foot ulcers/ amputations		

RECOMMENDED INTERVENTIONS The following interventions are consistent with the 2006 American Diabetes Association guidelines for management of patients with diabetes. Checkmarks indicate, based on *self-reported* medical history and/or claims data, whether the member is currently on the recommended therapy or whether therapy should be considered.

Intervention	Currently Prescribed	Consider Intervention
ASA Therapy: Consider ASA in diabetics over the age of 21		✓
Lipid Management: Consider statin to achieve LDL<100 or < 70 in patients with overt CVD	✓	
ACE/ARB: Consider use in all diabetics with proteinuria and/or HTN		
Hypertension: Initial drug therapy for those with BP≥140/90 should be with a drug class demonstrated to reduce CVD events in patients with diabetes (ACE, ARBs, Beta Blockers, diuretics and calcium channel blockers). Multiple drug therapy is generally required to acheive blood pressure targets.	✓	
Smoking Cessation: Medications plus behavior modification		
Retinal Exam: Annual dilated retinal exam recommended by the ADA.		✓
Podiatry Consult: History of ulcers, amputation, peripheral vascular disease		✓

2006 Diabetes Guidelines

If you would like to contact XLHealth about this patient, or would like additional information about the XLHealth program, please feel free to call x-xxx-xxx-xxxx.

I acknowledge that I have received and reviewed this form

Signature:_____ **Date:**_____

Please fax this form to XLHealth at xxx-xxx-xxxx.

Key Strategies:
Partner with Pharmacists

- **Pharmacists bring added value**
- **Respected by physicians and patients**
- **Expert at medication therapy management**

- **Offer “visits” with a local pharmacist in person or via phone**
- **Direct communication with physicians regarding drug interactions and gaps in care**

Key Strategies:
Manage Transitions Between Settings

Hospital admissions and transfers can be hazardous to the patients health!

- **High risk for miscommunication between providers**
- **Lack of electronic medical records and coordinated systems of care cause errors**

Opportunity for improvement

- **“Post discharge call”**
- **Reduce readmissions**

Key Strategies:
Complex Case Management Component

- **Traditional DM interventions less relevant to patients with severe or life threatening illnesses**
- **Provide additional support for the most complex, needy patients and care givers**
- **Social work component important**
- **Limited patient load (< 100 per case manager)**

Key Strategies: INSPIRIS Partnership

- Nursing home residents need a different strategy
- Dedicated Nurse Practitioner model
- Clinical Approach
  - Proactively avoid acute episodes (falls, ulcers)
  - Medication Management
  - End of life/advance directives
- Guidelines
  - Utilize American Medical Directors Association (AMDA) chronic care and acute problem guidelines

Medicare Health Support: Early Lessons Learned

- Caveat: Public results will be reported in the reports to Congress. The first report is August 2007.
- Engagement is hard work, we spent the first 6 months of the program "enrolling" beneficiaries
  - The population-based model made engagement a necessary but not sufficient condition for success
- Special populations require new approaches
  - Many of the beneficiaries had very serious co-morbid problems due to HCC cutoff (>1.35)
  - Beneficiaries in LTC facilities
  - Significant rates of dementia were encountered
  - People living in rural areas with poor access to providers and our screening centers

Medicare Health Support: Early Lessons Learned (cont.)

- Enrollee satisfaction is very high
  - Over 90% of enrollees would recommend the program to a friend or family member
- We are only 16 months into the 3 year program, but we are satisfied with the impact of the program so far.

Summary

- There now are multiple models for delivering DM programs to Medicare beneficiaries in addition to tradition MA plans
  - **MHS Phase I**
  - **Chronic Care Special Needs Plans**
  - **Other CMS Demonstrations**
- There are 6 key competencies for successful C-SNPs
  - Engagement is a key driver in both models but critical in MHS
- Chronic Care Special Needs Plans provide a dynamic model for improving quality and reducing costs for our Medicare system

Summary cont.

- Care Management (DM/CM) in the Medicare population is challenging and requires multiple strategies
  - **Focusing on "Quick Hits" is helpful**
  - **Personal relationship with the care manager is key**
  - **Keeping key indicators accessible to front line staff is essential**
  - **Nursing home residents require a different approach**
- CMS is testing a variety of approaches through MHS and other chronic condition demonstrations.