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

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XLHealth
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
IN ELBONIA

I’M FROM AMERICA AND I’M HERE TO FIX ALL OF YOUR PROBLEMS.

YOUR ARROGANCE IS OFFENSIVE. WE WILL FORM AN ARMED RESISTANCE AND FIGHT YOU TO THE END OF TIME!

UM... WHY?

IT’S JUST SOMETHING WE DO.

DM Zealot

DM Skeptics
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
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


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

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**

<table>
<thead>
<tr>
<th>HCC Number</th>
<th>Clinical Condition</th>
<th>Incremental Payment</th>
<th>Prevalence</th>
<th>Degree of Undercoding</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCC16</td>
<td>Diabetes with Neurologic or Other Specified Manifestation</td>
<td>$2,900</td>
<td>30+%</td>
<td>High</td>
</tr>
<tr>
<td>HCC17</td>
<td>Diabetes with Renal or Peripheral Circulation Manifestation</td>
<td>$3,900</td>
<td>15+%</td>
<td>High</td>
</tr>
<tr>
<td>HCC18</td>
<td>Diabetes with ophthalmologic or unspecified manifestation</td>
<td>$1,700</td>
<td>20%</td>
<td>Moderate</td>
</tr>
<tr>
<td>HCC149</td>
<td>Chronic Ulcer of Skin, Except Decub.</td>
<td>$3,000</td>
<td>&gt;5%</td>
<td>High</td>
</tr>
<tr>
<td>HCC177</td>
<td>Amputation Status, Lower limb</td>
<td>$4,200</td>
<td>3 to 4%</td>
<td>High for old amputations</td>
</tr>
</tbody>
</table>
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.

QUESTION: IS IT MORE IMPORTANT THAN SAFETY?

OOH... I FORGOT ABOUT THAT ONE.

QUESTION: IS QUALITY MORE IMPORTANT THAN OBÉYING THE LAW?

WELL, PROBABLY NOT.

IF WE COULD MAXIMIZE SHAREHOLDER VALUE BY SELLING LOWER QUALITY ITEMS...

...WOULDN'T WE HAVE A FIDUCIARY RESPONSIBILITY TO DO IT?

I'M SURE IT'S IN THE TOP FOUR.

WHAT IF WE HAD TO LIE TO ACHIEVE QUALITY?
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)

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little</th>
<th>Moderate</th>
<th>Very much</th>
<th>All day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>✓</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>✓</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>✓</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>✓</td>
<td>2</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>✓</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>✓</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>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</td>
<td>0</td>
<td>1</td>
<td>✓</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself in some way</td>
<td>✓</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

**add columns:** 2 + 10 + 3

**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

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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)

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)
- 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

Activities schedule
(Click in # to link to list)
- Welcome call
- HRA
- BCE (dropdown of location)
- coaching call
- followup assessment
- annual assessment
- Flow assessment (ESRD)
- Referral (dropdown)

Due next 30 days

Activities schedule
(Click in # to link to list)
- Welcome call
- HRA
- BCE (dropdown of location)
- coaching call
- followup assessment
- annual assessment
- Flow assessment (ESRD)
- Referral (dropdown)

Quick Hits
% of patients eligible & need evaluation for Quick Hits
(click on □ 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
**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.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Failure Symptoms</td>
<td>Explain your heart failure symptoms to your doctor at every visit.</td>
</tr>
<tr>
<td></td>
<td>What should I do when I have symptoms such as breathing problems, weight gain or other heart failure symptoms?</td>
</tr>
<tr>
<td></td>
<td>Should I ever take an extra water pill? If yes, when should I take an extra water pill?</td>
</tr>
<tr>
<td>ACE inhibitor medication</td>
<td>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?</td>
</tr>
<tr>
<td>Beta blocker medication</td>
<td>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?</td>
</tr>
<tr>
<td>Statin medications</td>
<td>What was my last LDL cholesterol?</td>
</tr>
<tr>
<td></td>
<td>Do I need statin medications to get my LDL cholesterol below 100?</td>
</tr>
<tr>
<td></td>
<td>What other suggestions do you have to help me get my LDL cholesterol down?</td>
</tr>
<tr>
<td></td>
<td>How often should I have my LDL checked?</td>
</tr>
<tr>
<td>Blood thinners</td>
<td>Should I be taking aspirin to help prevent a heart attack or stroke?</td>
</tr>
<tr>
<td></td>
<td>How much should I take?</td>
</tr>
<tr>
<td>Extra water pills</td>
<td>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?</td>
</tr>
<tr>
<td>Low sodium diet</td>
<td>I have not been following a low sodium diet carefully</td>
</tr>
</tbody>
</table>
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.

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

**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.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Currently Prescribed</th>
<th>Consider Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASA Therapy: Consider ASA in diabetics over the age of 21</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Lipid Management: Consider statin to achieve LDL &lt;100 or &lt; 70 in patients with overt CVD</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>ACE/ARB: Consider use in all diabetics with proteinuria and/or HTN</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>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 achieve blood pressure targets.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Smoking Cessation: Medications plus behavior modification</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Retinal Exam: Annual dilated retinal exam recommended by the ADA.</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Podiatry Consult: History of ulcers, amputation, peripheral vascular disease</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

3006 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 xxx-xxx-xxxx.

I acknowledge that I have received and reviewed this form  
Signature: __________________________ Date: __________________________

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