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PA plan confronts dramatic shift in case mix

Predictive modeling plus intensive case management deliver solid results for Medicaid plan

Anticipating the needs and costs of a Medicaid population is challenging even in the best of circumstances; some recipients float in and out of the system so frequently that it is difficult to establish any kind of consistent care, and there are always social barriers that keep some people from accessing needed services. However, health planners at Philadelphia, PA-based AmeriHealth Mercy felt as though they had these difficulties under good control -- at least until 1997. That's when the state mandated that the health plan begin to cover individuals on SSI (Supplemental Security Income) as well as the TANF (Temporary Assistance for Needy Families) population.

"In a very short period of time we went from being a health plan that was 90% TANF to a health plan that was 70% TANF and 30% SSI," explains **Jane Israel, RN**, executive director of clinical initiatives for AmeriHealth Mercy. "In the next year or two, pharmacy costs and acute care admissions went through the ceiling. All services related to

managing this aged, blind and disabled population escalated."

Administrators did some tinkering, and made a few missteps, but they eventually realized they needed a more dramatic solution that took into account the extent to which the needs of their population had changed. It took some time to devise, but the end result is a system of care that is working so well for AmeriHealth Mercy that developers are eager to share the approach with other organizations facing similar challenges.

'Reactive case management'

Developers began the process of building a more responsive health model by conducting a thorough analysis of their new SSI members. "What we found was that these members were much, much sicker. They required services from specialists that we did not have in our network at the time because we had been dealing primarily with a younger population that was pretty healthy," notes Israel. "We had a lot of members with special needs like hemophilia, sickle cell disease, and AIDS. And many of the individuals had multiple chronic illnesses -- not just one, so the services they needed were broad."

When these members were hospitalized, investigators concluded that the decision-making was appropriate and the patients were managed well. However, there was a big gap on the case management side, stresses Israel. "What we were doing was reactive case management -- what I refer to as patch and repair," she explains. "Rather than finding the mem-

Figure 1: Traditional Medical Management Models



- Focus on minimizing utilization
- Reactive model
 - Episode of illness
 - Event driven
 - Threshold / trigger met
- Short term management & interventions
- High probability of re-occurrence
- Implementation of short term programs to reduce costs
 - Quality of care
 - ER management

Source: AmeriHealth Mercy, Philadelphia, PA.

bers who had needs, care issues, and complicated chronic illnesses before they went into the hospital, we were reacting to a hospitalization.”

Upon discharge, these individuals would typically receive support and services on a short-term basis, and then the case management would cease. However, it would not be long before many of these members were hospitalized again. “We would see these people over and over again in the hospital,” emphasizes Israel. “We were fixing things for the short term, but not really managing these persons’ needs for the long term.” (See Figure 1.)

Risk stratification

Armed with a better understanding of the SSI population, developers implemented a predictive modeling program to sort their members into risk categories based primarily on claims and demographic information. “For us to get started we wanted to first identify who the sickest members in the health plan were, and at the same time look at the needs of the entire population,” says Israel, noting that the members were ultimately categorized into four risk levels. (See Figure 2.)

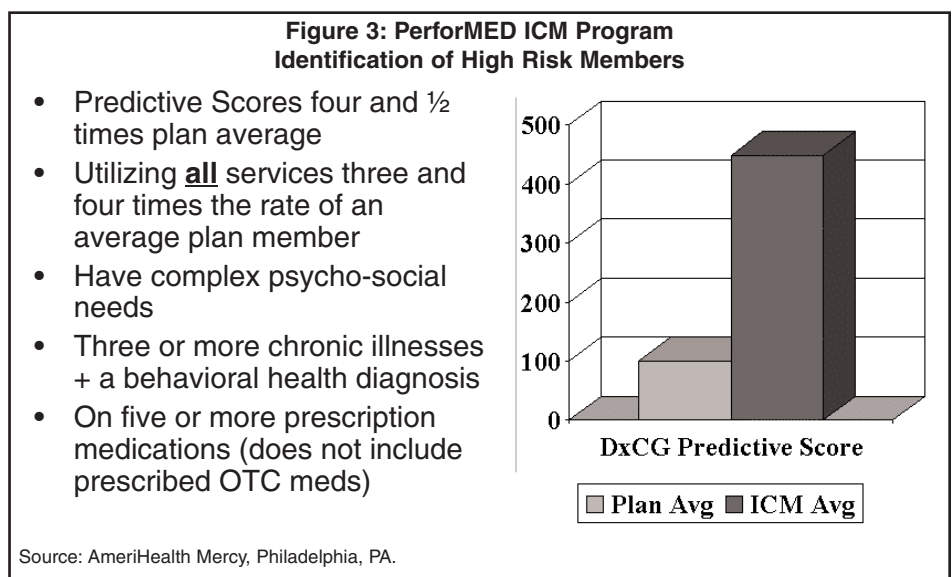
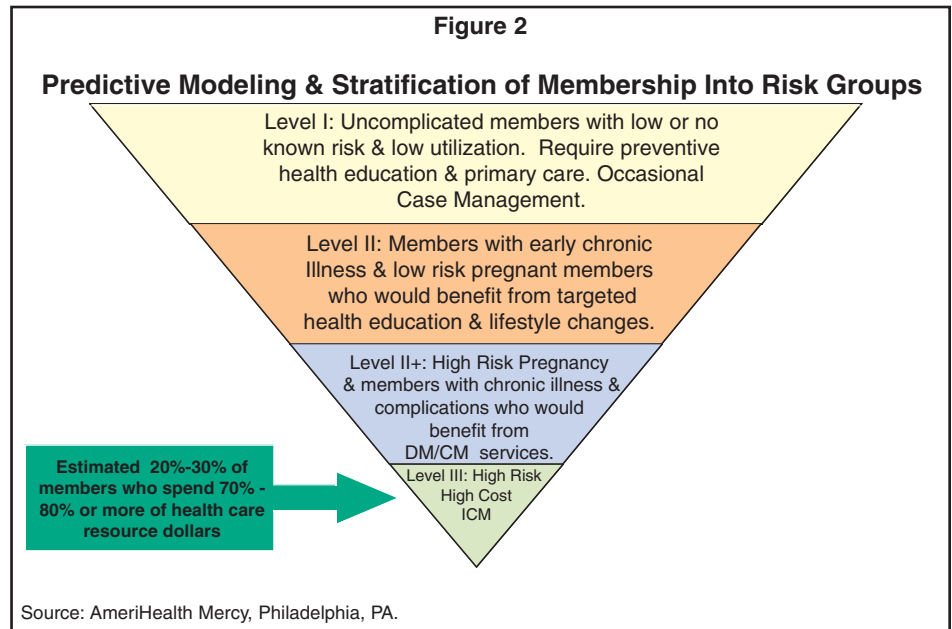
Members at highest risk comprised just 20% of the plan membership. However, they accounted for as much as 80% of health care expenditures. These members were, essentially, 4.5 times sicker than the health plan average, based upon the individual risk scores assigned by the predictive model. (See Figure 3.) And, as expected, this group consisted largely of the newer SSI members. “What we saw was incredible utilization at all levels,” notes Israel. “These were members who had 3 and 4 times the rate of hospital and ER admissions; they were on five or more prescription medications -- not including OTC medicines or behavioral health drugs; and they had very complex psychosocial needs.”

Engaging high-risk members

From this information, developers concluded there were definite steps they could take to stabilize the plan’s high-risk members and bring down the rate of hospital

and ER utilization in this group. Further, they established that while optimal health is always an ideal to work toward, individuals with advanced, multiple chronic diseases would probably need supplementary care and support on a long-term basis. “Our goals were to reduce ... utilization of the hospital and ER, and to improve quality of life,” explains Israel.

To accomplish these tasks, administrators attempted to connect with the members identified as high-risk to enroll them in the plan’s new program of care, called PerforMED Intensive Case Management (ICM). Identified members would also receive an urgent needs assessment so that any immediate needs or barriers could be dealt with right away. (See Figure 4.) “As we began to work with this population, it was clear that they had a lot of problems obtaining their medications, and sometimes even getting outside their homes to



get their prescriptions filled. They also had difficulty getting transportation to physician offices, and they had difficulty getting food into their homes. There were many social issues," says Israel. By completing the urgent needs assessment, health plan staff could take immediate steps to alleviate these types of problems could be addressed, and the plan could begin to educate the members about a new nurse support line, available 24 hours a day.

Once outreach and enrollment was completed, developers initiated the next phase of the program -- the heart of the program, involving ICM. This process, which is carried out by experienced nurses and social workers along with support staff, begins with a comprehensive assessment of an individual's needs, covering physical and mental health as well as a member's understanding of his illnesses. In many cases, this assessment can be done by phone, but when needed case managers can conduct the assessments during a home visit.

The information collected from this assessment is then entered into a software program which automatically builds a plan of care for the member. At this stage, the case manager works with the member and his or her physician to identify the most important issues to work on over the next 90 days to six months. At the same time, the case manager begins to move on to phase three of the program, which focuses more specifically on management of chronic illnesses.

"If I have a member with CHF, we will be focusing on making sure he is on the right medicines, following the appropriate diet, and weighing himself daily -- the combination of things we know through clinical guidelines are most significant and important to do," adds Israel. Further, where appropriate, case managers will steer members towards centers of excellence or specialists within the health plan's network who have demonstrated expertise in dealing with a particular condition or special need.

Staying in close touch

In addition to handling the traditional case management and DM functions, Israel emphasizes that program staff coordinate behavioral health benefits for members. "Our

staff are trained to listen for signs a member is depressed or unstable, or is not compliant with his behavioral health medications," she says. "We have learned through lots of studies that if behavioral health is not stabilized, you will not make headway with medical stabilization either."

Also, Israel stresses that identified members are always enrolled in ICM unless they indicate that they do not wish to participate. "The goal here is really to coordinate their care, and to let member know that there is really someone there who cares about them."

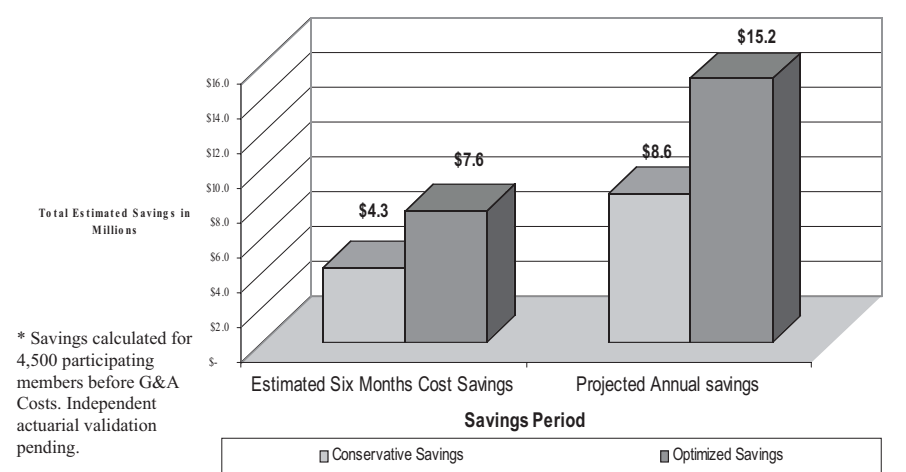
By staying in close touch, administrators have found that members are much more likely to call into the program for assistance before they are so sick that hospital or ER utilization is necessary. "They call and get the help they need," says Israel. "If they are having difficulty getting access to the physician's office, we have had

Figure 4: Member Health Education & Management Program

Rapid Response Call Center	Intensive Case Management	Chronic Illness Management
<ul style="list-style-type: none"> •Outreach & Enrollment •Urgent Needs Screening •Rapid Problem Resolution •24-7 Nurse Support 	<ul style="list-style-type: none"> •Comprehensive Assessment •Personnel Care Plan •Member & PCP Communication 	<ul style="list-style-type: none"> •Disease Specific Assessment •Behavioral Health Care Coordination •Outcome Monitoring •Ongoing Follow-up with Member and PCP •"Best Practice" Approach
Integrated Care Management IS Application: Care Connect Predictive Modeling Member Identification		

Source: AmeriHealth Mercy, Philadelphia, PA.

Figure 5: Estimated ICM Treatment Group Savings Represents an 11% - 20% reduction in pmpm costs



Source: AmeriHealth Mercy, Philadelphia, PA.

great success removing those barriers and getting the patient in to be seen.”

Substantial savings

Using a variety of methodologies, investigators compared estimated savings from the 4,500 initial participants in the PerforMED ICM program with 7,500 members of the health plan with similar characteristics who were not enrolled in the program. They found that savings were substantial, representing an 11% to 20% reduction in PMPM costs. (See Figure 5.) These calculations do not take into account general and administrative costs, but even the conservative estimates show several millions dollars of savings -- more than enough to offset the program’s expenses, according to Israel.

Armed with this data, the health plan is now making every effort to identify and enroll all eligible participants, and this effort is being bolstered by strong provider support for the program.

“We have physicians who have been encouraging us to take every member into this program who is referred because it reduces the administrative burden for them,” says Israel. “They don’t have the ability in their offices to provide this kind of support to members, and these members are very needy. What we find is that physicians appreciate getting the feedback and having someone else to help coordinate all the pieces of care.”

Looking forward

The health plan has also developed interventions geared toward members categorized by the predictive modeling program to be in lower risk levels, Israel points out. These include preventive outreach programs for childhood immunizations, high-risk pregnancy services, and some traditional DM programs. “We identify what the population needs, and we try to match the intervention to what the needs are,” she says.

However, the primary focus of the program is on the high-risk group where analysts have found so many opportunities for improvement and cost savings. In fact, the success of the effort has prompted AmeriHealth Mercy to consider marketing the approach to other Medicaid health plans facing similar challenges.

“Our mission as an organization is to care for our members, and as we see what is going on in other states, we feel we have a solution here that could help them as well,” notes Israel. “We are rapidly enrolling the remaining members of our SSI population into program, and looking internally at how to get this product packaged and out. I really would like to make this available to others.”

Editor’s note: For more information about the PerforMED ICM program, contact Rick Buck, VP, Corporate Communications for AmeriHealth Mercy at 215-863-5102. ❖