ROBERT GRAHAM CENTER

Policy Studies in Family Medicine and Primary Care

BRIGHT SPOTS IN CARE MANAGEMENT IN MEDICARE ADVANTAGE

EXECUTIVE SUMMARY

A BLUEPRINT FOR EFFECTIVE CARE MANAGEMENT

A Fragmented System

Care fragmentation is a consistent characteristic of the U.S. health care system. On average, Medicare patients see seven physicians at four practices.[1] A staggering 75% of hospitalized patients are unable to identify the clinician in charge of their care.[2] The negative impact of poor coordination can be seen in the prevalence of repeated tests and conflicting information between clinicians.[3,4] Nearly 20% of Traditional Fee-For-Service (FFS) Medicare beneficiaries are re-hospitalized within 30 days of discharge, and half of those patients failed to see their primary care provider (PCP) in the interim.[5]

Fragmentation burdens providers as well, with the average primary care physician interacting with 229 physicians at 117 different practices for Medicare patients.[6] A 2012 National Academy of Medicine (NAM) report concluded that care delivery fragmentation leads to coordination and communication challenges for patients and clinicians and estimated that $765 billion of health care spending is wasted, or leads to little improvement in health or in quality. The authors estimated that $130 billion of waste is attributable to inefficiently delivered services.[7]

One strategy to achieve cost savings and improvements in quality care is care management. The Agency for Healthcare Research & Quality (AHRQ) defines care management as a team-based, patient-centered approach designed to assist patients and their support systems in managing medical conditions more effectively.[8] Despite its growing popularity, the evidence supporting care management is mixed with one large demonstration failing to generate savings.[9] Proponents of care management point to wide variation among programs. This report reviews the research and features that are prevalent among successful practices that function within the framework of Medicare Advantage.[10,11]

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This report examines care management under Medicare Advantage, with the premise that the financial framework of risk based, capitated payments under Medicare Advantage offers the opportunity to improve service delivery through care management to better meet patient needs and improve outcomes. It is important to identify and better define the essential elements prevalent in these successful models of care management so they can be replicated by plans and providers and incentivized by policymakers. The report concludes with the identification of essential elements of effective care management and recommendations to policymakers.

Report Methodology

In partnership with the Better Medicare Alliance, the Robert Graham Center sought to identify characteristics of effective care management and explore how it is being successfully implemented in Medicare Advantage. Review of prior literature, insights solicited from experts, and intensive site visits to identified successful models in the field provided the content for this report. The development of the blueprint for effective care management is based on an environmental scan detailed in a literature review (Appendix 1), information and insights gained from a facilitated convening of a group of Medicare Advantage and care management experts (Appendix 2), and field visits to identified Bright Spots in Medicare Advantage financed care management programs. Four Bright Spot case studies are detailed in this report (Section 2):

- **CareMore**, a Medicare Advantage payer and provider aligned model.
- **GRACE Model Indiana University Health Medicare Advantage Plan** where the GRACE Model is currently used by providers to manage a portion of their Medicare Advantage patients.
- **InterMed**, a physician-owned medical group with care management services available for all of its patients including their Medicare Advantage patients.
- **Johns Hopkins Medicare Advantage Plan**, a payer and provider utilizing community health workers to manage Medicare Advantage patients.

GRACE Model Indiana University Health Medicare Advantage Plan

PROVIDER | States Covered: Indiana*

MA Care Management Plan Initiated **2011**

11,000 MA PATIENTS — **300 in the CM program**

1 MEDICAL DIRECTOR | **3 TEAMS** ONE NP & SW

In-home care that supports PC, with focus on 12 geriatric conditions.

Serves Urban and Rural | Transitions of care | EMR: Cerner

AFFILIATIONS: Indianapolis VA Medical Center, Indiana ADRC Care Transitions Program, Indiana University Health MA Plan and ACO

CareMore

PROVIDER AND PAYER

MA Care Management Plan Initiated **2003**

80,000 MA PATIENTS | **60** PHYSICIANS

140 CASE MANAGERS, CARE EXTENDERS, AND SOCIAL WORKERS

Extensivists and broad care teams managing chronic disease and transitions of care

Serves Urban Only | Transitions of care | EMR: NextGen | Portal Software

States Covered: California, Nevada, Arizona, Ohio, Virginia, Georgia, Iowa, Tennessee

AFFILIATIONS: Anthem

InterMed

PROVIDER | States Covered: Maine

MA Care Management Plan Initiated **2008**

4,400 MA PATIENTS | **89** PHYSICIANS

NP/PA CARE MANAGERS

Focus on transitions of care and pod structure that foster trust and continuity

Serves Urban and Rural | Transitions of care | EMR: ECW

Johns Hopkins Medicare Advantage Plan

PAYER | States Covered: Maryland

MA Care Management Plan Initiated **2016**

5,000 MA PATIENTS | **6,383** PHYSICIANS*

3 CARE MANAGERS — Licensed certified social work - clinical

Innovative use of community health workers

Serves Urban and Rural | Transitions of care | EMR: Epic | Epic Software

*Physicians in network

Blueprint for Effective Care Management

Drawing on the environmental scan, expert convening, and Bright Spot site visits, a blueprint was developed that synthesizes the lessons learned and identifying the five key findings of effective care management. This "Blueprint for Effective Care Management" is summarized in Figure 1.

Figure 1: A Blueprint for Key Components of Effective Care Management

Blueprint Key Finding 1

VALUE BASED PAYMENT SYSTEM

Fragmentation is a consequence of a FFS Medicare payment model that incentivizes visits, procedures, and tests rather than early intervention, cost savings, and care coordination to improve the quality of care. Throughout the study period, the importance of payment as the driver of delivery and team composition was mentioned time and again. Interviewed providers stressed that Medicare Advantage has tremendous potential to facilitate effective care management.

First, Medicare Advantage allows payers and providers to "get on the same team" and align care and quality incentives. A participant at the convening commented that payers and providers have historically had adversarial relationships. The incentives inherent in Medicare Advantage's capitated (fixed) monthly payment for patients encourage providers and payers to work together and share data at the level of population health and in real time for individual patient care. These incentives align to enable providers to think creatively about delivering care and innovate. With more flexible payment, Medicare Advantage plans are able to work with providers and patients to tailor services to meet patients' needs with appropriate practitioners and in appropriate settings.

Second, the prospective nature of Medicare Advantage payment allows organizations to invest in the infrastructure needed to execute effective care management, including new staffing, new communication avenues, and data analysis. Finally, Medicare Advantage allows providers to manage populations, as well as individuals. With a defined panel of patients and providers, along with incentives to improve coordination and quality, interviewees reported that Medicare Advantage allows them to design systems around the needs of the patients.

Blueprint Key Finding 2

CULTURE OF CARE MANAGEMENT

At the organizational level, these Bright Spots in Medicare Advantage care management spend considerable resources creating, maintaining, and building a new culture organization wide. In addition to training new hires on processes, these organizations select for "culture fit" and build orientation curricula around acculturation. Validating the NAM report recommendations, the Bright Spots model continuous learning, with clear intent to be open to innovations in the design and operation of standing infrastructure and operations. Use of data and involvement of staff at all levels, as well as encouragement to be flexible were concepts often mentioned as important to the culture in the successful models. For example, CareMore developed a homegrown process for generating a real-time, daily census of hospitalized patients, which includes hospitals they do not staff. All four of the Bright Spots devote resources to acquiring data about their patients and use those data to iteratively inform their risk stratification processes.

These organizations crafted cultures that value collaboration, where hierarchies are flat and all team members have a seat at the table. The staff are not merely working at the top of their license but actively contribute novel ideas to the care plans. At InterMed, all staff benefit when organizational goals are met through an incentive program. At CareMore, care managers lead team meetings to ensure that non-provider perspectives are heard. Providers are actively "stepping back to allow others to step up."[12]

Bright Spot team members commented that care management is most effective when incentives are aligned between payers and providers. But, in practice, InterMed does not distinguish between Medicare and MA patients with respect to the care provided. Throughout this study, interviewees pointed out the challenges payers face when trying to change provider behavior and commented frequently that it was the changed incentives that aligned payers and providers to take new actions that move everyone towards the same goal. Providers comment that the plan "gets out of the way" and allows them to "think outside the box" to take care of patient needs. While providers may seek to minimize unnecessary hospitalizations, they are not typically rewarded for doing so, with most of the financial benefit going to payers. When the payer and the provider are aligned with the goal to keep people out of the hospital, care can be provided in other settings most appropriate to patient needs. The fact that providers share in the savings that result is a strong incentive. The possibility of shared savings in value based payments to providers was mentioned at times indirectly and at times quite specifically.

Blueprint Key Finding 3

EFFECTIVE TEAMS

Experts and interviewees told stories about how the current FFS Medicare payment and IT systems contribute to poorly coordinated care. The interviewees talked about how providers are often "sharing information" without "communicating," which leads to suboptimal care. In contrast, team members at the Bright Spots model communication leading to a shared awareness of the patient's needs, goals and care plan. In sharp contrast to many health systems, handoffs have structured meetings with pre-specified times, consistent attendees, and clear roles and responsibilities. In the GRACE model developed at Indiana University School of Medicine, the team meets weekly to facilitate this level of communication to ensure that all the providers are in agreement and working together on the care plan for the patient.

One tactic that allows for shared awareness of the plan for the patient and real-time resolution of questions is the co-location of team members. At InterMed, team members are located in the same facility. One provider said that "it's about turning the chair around and talking to somebody." While co-location facilitates "getting on the same page," these organizations are getting beyond clinic walls and into homes and communities to "see the full picture." The GRACE model is built around home visits while community health workers at Johns Hopkins try to visit each member in their homes at least once each year. Meeting patients in their homes not only strengthens relationships but also provides the care team with important information about the safety and social needs of patients. Once needs are identified, these community health workers are uniquely positioned to connect patients with existing community resources because they are from and live in the same communities as their patients.

Blueprint Key Finding 4

CUSTOMIZED PATIENT CARE

At the patient level, successful care management programs are adept at customizing plans to individual patient needs. Effective care management is customized by identifying patient needs, uncovering the resources, competencies, goals, preferences, and values of the patients and deviating from protocols as needed to meet patients where they are. One of the experts interviewed added that care managers need to know when to deviate from protocols and that such deviations provide opportunities to generate creative solutions from broader care teams. In addition to tailoring protocols to match patient's needs and goals, these organizations encouraged "can-do" attitudes to facilitate the right care, at the right place, at the right time, with the right person. This means addressing all barriers to improved health regardless of whether they are medical, social, financial, or psychological in nature. Johns Hopkins community health workers provide members with their direct phone numbers and ask patients to contact them for "anything they need." At GRACE, the team will enroll spouses or widows if they see they would benefit from their services.

Finally, these Bright Spots value continuity, centered around the patient's needs. At InterMed, nurse practitioners and physician assistants provide transitional care and work with a specific pod of physicians. These teams are rarely altered so that patients are receiving transitional and primary care from the same group. At CareMore, the same extensivist, or physicians who bridged hospital care with outpatient follow up, sees the patient in the hospital, at the skilled nursing facility, and at the post discharge visit.

Blueprint Key Finding 5

FOUNDATION OF TRUST

Elements such as value based payments and customized individual care plans are essential, but not sufficient to facilitate successful care management without a foundation of trust. To improve outcomes, it was repeatedly stated that providers have to enhance trust between the organization and the team, among team members, and between the team and the patient. The act of co-locating a care manager and provider in the same physical space does not guarantee improved coordination. Instead, the team members have to use co-location to increase face-to-face communication with each other and with patients. Interviewees commented that trust was the "missing link" in many care management programs and that effective care management had to have a very "human touch."

Each Bright Spot took advantage of a flexible payment system and adaptive delivery models to engender trust between patients, their care teams, and between team members within care management teams. Finally, successful care management also hinged on patients, providers, and teams trusting the broader health care organization's systems and motivations. Building this trust depended on the organization working within payment models and financial incentives that are based on quality and outcomes, not the volume of services.

The strengthening of all these elements together create the blueprint that makes for successful care management. The elements of this blueprint—having the same provider treating the patient in the hospital and in the outpatient setting, visiting patients in the home, stepping back to allow care managers to step up, and doing whatever it takes to tailor plans to individual needs—builds trust and this trust is essential to improving outcomes.

Barriers to Implementation

Interviewees identified multiple barriers to the implementation of effective care management programs. Many described difficulty with IT harmonization across inpatient and outpatient settings and in some cases between care management applications and electronic health record (EHR) feeds. Absent solutions, shared awareness of the full range of patient's needs and patient's engagement with the system is hard to achieve. Others described payment-related challenges in achieving effective care management. Absent coordination of incentives, care management programs often result in offices hosting multiple care managers. Different care managers provide different services and use different inclusion criteria. This leads to confusion for both the patient and provider, and distraction from the objectives of each program.

Finally, all of the programs had difficulty coordinating care across all settings. CareMore has providers in the hospital, skilled nursing facility, and transitional care settings, but has less exposure to primary care. InterMed provides access to primary and transitional care but is less present in the hospital. While a shrinking cohort of primary care providers follow their patients across all care settings, value based payment models provide incentives for a higher degree of continuity. Establishing a level of coordination between care settings has proven to be difficult, and yet there are effective efforts to enhance care management and comprehensive care in a wide variety of models.

Challenges aside, plans and providers across the country are taking advantage of the flexibility offered by Medicare Advantage to build care management processes that work for providers and patients. Enabling expansion of care management that is consistently available to beneficiaries provides the potential for improved care and outcomes at reduced cost for millions of beneficiaries. This report captures evidence from Bright Spots capable of informing adminstrators and provider about the definitions, principles and characterisitics of effective care management. In doing so, we hope to support the development of mechanisms to incentivize plan, health system, and provider leadership to use care management to meet the goals of cost effective care and improved outcomes for Medicare beneficiaries.

Policy Recommendations

Effective care management is evolving and numerous Bright Spots exist that demonstrate health outcomes, lower cost, and increase patient and provider satisfaction. Medicare Advantage plans work with provider groups to align goals and incentives to drive innovation. These microenvironments require flexibility and active engagement between payers and the provider/delivery system provider/delivery system to manage complex care and improve patient outcomes. Below are key policy recommendations based on the findings in this report.

Recommendations for Service Delivery Reform Through Care Management

Continuity was found to be a key measurable feature associated with successful care management. The Bright Spot models of care management were built on the core concept of continuity of care for provider teams and the complex patients. The implementation of this care delivery focused on comprehensive, protocol-driven care, targeted to the most complex and chronically-ill patients. These concepts are central to achieving high-value care.

In the era of national health care reform driven by payment and delivery system changes, attention should be paid to the benefits of flexibility, continued innovation, and adaptability for payers and providers to achieve desired outcomes. The impact of policy, payment and protocols driven by these concepts were clearly evident in these Bright Spots in care management. Specifically, expanded use of effective care management through service delivery reform would be enhanced by:

Further evaluation and testing of models based on the blueprint for effective care management presented in this report.

Evaluation of differences in outcomes and cost between plans and provider organizations that use care management models and those that do not.

Expansion of provider contracts in value based, risk assumption models that include care management under Medicare Advantage.

Recommendations for Payment Reforms Through Care Management

A key feature emerging from these Bright Spots is the power of prospective flexible payments with simple, yet clear incentives to deliver on cost and quality outcomes. This payment framework provides the foundation for effective care management strategies at the at the organization provider team and patient levels. Shifting focus from maximizing volume of services delivered by physicians has allowed the organizations studied to coordinate incentives aimed at critical end outcomes.

Medicare Advantage's capitated payments enable flexibility, cultures of collaboration, and continuous learning about how best to achieve evidence-based, enhanced protocols for chronic disease management. It also promotes the development of multidisciplinary teams, which recognized data-driven, regular communication is essential for care management. More flexibility in plan design and supplemental benefits could further enable Medicare Advantage plans to develop effective care management strategies. The literature review suggests that wide implementation of care management practices will improve the care of all Medicare Advantage patients. Further implementation of effective care management through payment reforms would be enhanced by:

Incentives for the use of risk stratification to identify high need, high risk patients.

Coordination by primary care for each managed patient.

Incentives for the use of care management teams that include appropriate personnel, including a Registered Nurse, Social Worker and/or a CHW working closely with clinical staff.

Align different payment system and benefits dually eligible individuals and patients with multiple chronic conditions through the use of value based capitated payment.

Flexibility in payment and coverage to enable providers to treat patients at the most appropriate site of care and to offer additional benefits as needed to meet care goals.

The success of the four Bright Spots highlighted in this report suggest that payer flexibility, and empowerment of providers to focus on aggregate cost and quality outcomes presents a blueprint for successful care management.

ACKNOWLEDGEMENTS

Support for this research was provided by Better Medicare Alliance. The views presented here are those of the authors and not necessarily those of the Better Medicare Alliance or its directors, officers, or staff.

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