Briefing Summary—Health Plan Innovations: Caring for Medicare and Medicaid Patients with Chronic Illnesses

This event was held Friday, January 27, 2012, in Washington, D.C., at the Capitol Visitor’s Center.

Federal and state policymakers have struggled for years to find more effective ways to care for the most frail and chronically ill patients in Medicare and Medicaid. Patients often receive treatment from several different health care providers with little or no coordination of care. Many patients are confused about their medications, forget to take them, and have unanswered questions. And many people face financial and other life challenges that make it difficult to carry out instructions about follow-up appointments, nutrition, and physical activity. As a result, patients often suffer preventable complications and have multiple emergency room visits and hospital readmissions that drive up health care costs.

Rising costs among Medicare and Medicaid patients with chronic illnesses—particularly “dual eligibles” (those eligible for both programs)—consume a large and growing portion of Medicare and Medicaid budgets. The Agency for Healthcare Research & Quality (AHRQ) reports that the five percent of Americans with the highest health care expenditures account for 50 percent of health care costs.\(^1\) Addressing the quality and cost challenges for Medicare and Medicaid patients with the greatest health care needs has become a top national priority.

Health insurance plans have been at the forefront of efforts to improve systems of care for Medicare and Medicaid patients with chronic illnesses through initiatives that go beyond what traditionally has been available in fee-for-service programs. These initiatives have had many positive results, including hospital and nursing home readmission rates that are below those reported in fee-for-service Medicare and Medicaid. At AHIP’s Capitol Hill briefing, Health Plan Innovations: Caring for Medicare and Medicaid Patients with Chronic Illnesses, a panel of experts from four health plans described their innovative tools and techniques to help patients with chronic illnesses manage their conditions and avoid preventable, costly hospitalizations; readmissions; emergency room visits; and nursing home stays.

Three main themes emerged from the discussion:

- Traditional models of care must be adjusted to meet the unique needs of patients with complex conditions, particularly those who are dually eligible for Medicare and Medicaid.

- To achieve better health outcomes and avoid preventable hospitalizations among patients with chronic conditions, it is important to address not only individuals’ medical needs but also issues—such as transportation, affordable housing, hunger, health literacy, and home safety—that affect patients’ ability to manage their conditions.

- Success in improving the health and well-being of patients with chronic illness requires careful coordination of services, regular follow-up with patients and physicians, and support from a multi-disciplinary team of professionals and paraprofessionals that often includes one-on-one, in-person contacts.

INTRODUCTION

AHIP President & CEO Karen Ignagni opened the briefing by laying out the challenges that policymakers and health care providers face in trying to improve the quality of care and lower costs for Medicare and Medicaid patients with chronic illnesses. She noted the health plans have shown leadership in taking on these challenges, and she mentioned the recent paper by Ken Thorpe2 which reported that increased reliance on health plans and other coordinated care approaches offers great potential to enhance health care quality and reduce costs in caring for dual eligibles.

Molina Healthcare: Care Transitions for Medicaid Disabled and Medicare SNP Populations

Indira Paharia, Vice President of Care Integration for Molina Healthcare, described the health plan’s innovative approach to helping disabled Medicaid beneficiaries and dual eligibles transition back to their communities following hospitalization. Transitions are particularly difficult when patients are homeless, have serious mental illnesses, are unable to read, or have other health literacy challenges. After finding that traditional care transitions models were insufficient to meet the needs of these patients, Molina developed a specialized Care Transitions program in Washington State in 2010.

The health plan’s Care Transitions staff provide extensive in-person services to help members fill their prescriptions, understand their medications and take them correctly, access follow-up care from primary care physicians and behavioral health practitioners, and follow their care plans. They meet with members wherever it is most convenient, such as in Molina’s clinics, in skilled nursing facilities, in trucks or vans, and even in fast food restaurants. Furthermore, they use program materials and tools designed to meet the needs of people with lower education levels and cognitive deficits.


When homeless members are being discharged from hospitals, Molina’s nurse health coaches and community health workers help them find both temporary and permanent housing. Health coaches and community health workers also help beneficiaries obtain a broad array of social services, including transportation, financial assistance, energy assistance, Medicaid, and Food Stamps. Molina staff also arrange for long-term care evaluations and services, and they communicate with health and social service providers on patients’ behalf as needed. They may work with patients for three months or more to help them transition successfully back into the community.

During her presentation, Dr. Paharia told the story of L.T., a Molina member who was discharged from the hospital after treatment of ulcers on both feet, MRSA, and gangrene that had required amputation of several toes. A Molina nurse health coach and community health worker met with him many times in the van where he was living and arranged for needed home care services. Ultimately he regained the ability to walk and is considering moving into temporary housing. Based on the outcome in this patient’s case and the many other successes Molina has achieved in improving patients’ health, Dr. Paharia noted that “No matter how sick someone is, they can improve their life circumstances” with the right help.

**Molina Healthcare: Results**

Since May 2011, hospital readmission rates for members served through Molina’s Care Transitions program have dropped by more than 50 percent (from 22 percent to 10 percent). In contrast, the national average readmission rate for disabled Medicaid beneficiaries and dual eligibles is 16 percent. See Figure 1.

**Figure 1.** Outcome for Molina Healthcare: Readmission Rate for Molina Healthcare Care Transitions Enrollees, May through November 2011

Source: Molina Healthcare.  


**XLHealth Corporation:**  
**Caring for Members with Diabetes**

Laurie Russell, Vice President of Quality Strategy and Outcomes for XLHealth Corporation, described the services that the company’s Medicare Advantage Chronic Conditions Special Needs Plan (C-SNP) provides to help the most seriously ill beneficiaries with diabetes live safely at home.

More than 89,000 Medicare Advantage and Medicaid beneficiaries are enrolled in the plan in 12 states (Arkansas, Georgia, Illinois, Indiana, Iowa, Maryland, Missouri, New Mexico, New York, South Carolina, Texas, and Wisconsin). Over half of the program’s
participants are dual eligibles. XLHealth’s model of care—described in the January 2012 issue of Health Affairs—includes six key components:

- **HouseCalls.** Physicians and nurse practitioners visit patients at home for 40 to 60 minutes to conduct health risk assessments, provide preventive care, and identify needs for lab tests and follow-up visits primary care physicians. HouseCalls doctors and nurses also conduct a comprehensive review of patients’ medications to identify and address any side effects and potential adverse interactions. They address any gaps in care that could lead to complications or hospitalization. They also provide flu shots and conduct urine tests, foot exams, and depression screenings, as well as nutritional assessments.

  Based on findings during HouseCalls visits, XLHealth clinicians work with beneficiaries’ physicians to develop individualized care plans. Beginning in 2012, HouseCalls doctors and nurses are providing the “medical home” for patients who do not already have a regular source of care.

- **Nurse Care Management.** Nurse care managers lead multidisciplinary teams (with primary care physicians, specialists, pharmacists, social workers, dietitians, and others) to discuss patients’ progress within their treatment plans and address gaps in care. Nurses also keep in touch with patients by phone to provide health coaching and answer questions.

- **PharmAssist.** Pharmacists contact patients by phone to gather information about their prescriptions and identify issues—such as duplicative use of medications, side effects, gaps in care, adverse drug interactions, and dosing errors—that can lead to complications and preventable hospital admissions. Pharmacists work with patients’ care teams to address these issues before problems occur.

- **Transitions of Care.** When patients transition from one care setting to another, XLHealth’s physicians, nurses, and social workers conduct in-person visits and assessments by phone to ensure smooth communication between health care providers and caregivers, promote continuity of care, and avoid problems that lead to hospital readmissions.

- **Social Services.** Beneficiaries enrolled in the C-SNP have the opportunity to work with staff who monitor public and community-based programs and can help with applications for Medicaid, energy assistance, subsidized phone service, nutrition assistance, and other types of services.

- **Connected Care.** Specially trained nurses are available to visit patients with life-threatening or terminal illnesses to discuss end-of-life wishes, offer guidance, and coordinate advance care planning to ensure that services are provided according to patients’ needs and preferences. The program offers hospice and palliative care options when appropriate.

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A recent study of the program by XLHealth and AHIP found that risk-adjusted hospital days per enrollee among C-SNP members in five states (South Carolina, Georgia, Texas, Arkansas, and Missouri) were 19 percent lower than those of beneficiaries enrolled in the Medicare fee-for-service program. Risk-adjusted physician office visits were 7 percent higher among C-SNP enrollees than among comparable fee-for-service enrollees. See Figure 2.

For more information, contact: Jessica Pappas, Senior Public Relations Manager, 410-735-8725, jpappas@xlhealth.com. Slides from this presentation are available at: http://www.ahip.org/XLHealthSlides.aspx.

Dr. Timothy Schwab, Chief Medical Officer at SCAN Health Plan, showed a video featuring patients and caregivers served through SCAN’s Special Needs Plan (SNPs), which offer extensive home-and community-based services to help patients with chronic conditions and complex health care needs live in their communities for as long as they are able. Based on SCAN’s work with these patients, Dr. Schwab commented that “If you focus on special populations, you can accomplish incredible things.” He then discussed the model of personalized, patient-centered care that the SNPs provide to people with chronic conditions, those who are dually eligible for Medicare and Medicaid, and people who need help with activities of daily living at a level equivalent to that provided in a nursing home. Nearly 17,000 people in California and Arizona are served by the program. Nurses and social workers serving...
as case managers visit beneficiaries to evaluate their needs and to coordinate medical, social, and behavioral health services. For example, they may help members access home-delivered meals, durable medical equipment, and behavioral health care. Case managers also help beneficiaries apply for Medicaid, subsidized housing, programs to pay for prescription drugs, and home energy assistance. They help patients make doctors’ appointments, check whether they need help getting to the doctor, and can arrange for free or low-cost transportation as needed.

Case managers reassess members’ needs at least once a year or whenever there is a significant change in health condition. Additionally, they check in with members regularly by phone to see how they are feeling and whether they need additional assistance. Beneficiaries can contact their case managers at any time to ask questions or to request help.

Dr. Schwab then shared details about SCAN’s End-Stage Renal Disease (ESRD) program, which is offered through a Chronic Condition Special Needs Plan (C-SNP). The program has served more than 600 people in California over a five-year period. People participating in the program are either on dialysis or have had kidney transplants. More than 80 percent of participants are dual eligibles, and they have complex health and social service needs. The program offers a unique model of care coordination, with the nephrologist serving as primary care physician and dialysis nurses serving as case managers. Nurses help patients make dialysis appointments; arrange transportation to appointments as needed; monitor dialysis procedures to ensure patient safety; track key measures of dialysis quality; and facilitate smooth communication between patients and all of their health care providers.

**SCAN Health Plan: Results**

A University of Southern California study found that Medicare beneficiaries discharged from nursing facilities who enrolled in a SCAN program that included care coordination and home- and community-based services were 26 percent less likely to re-enter nursing facilities for long-term stays than beneficiaries in the Medicare fee-for-service program who were not receiving these benefits.

From January-June 2010, SCAN’s ESRD program reached or exceeded five out of five improvement target thresholds established by the Centers for Medicare & Medicaid Services (CMS) as part of the ESRD Demonstration Quality Incentive Program for that time period. The program also met or exceeded six out of six national target thresholds.

For more information, contact: Peter Begans, Senior Vice President, Public and Government Affairs, 202-756-2279, pbegans@scanhealthplan.com. Slides from this presentation are available at: http://www.ahip.org/SCANSlides.aspx.

**CareMore Health Plan: A Model for Caring for Those at Greatest Risk**

Alan Hoops, Chairman and CEO of CareMore Health Group, described the unique model of care that CareMore Health Plan is providing to Medicare Advantage and Medicaid members with chronic conditions such as heart failure, end-stage renal disease, chronic kidney disease, obstructive pulmonary disease, behavioral health conditions, and diabetes. See Figure 3.
CareMore provides care to 60,000 Medicare Advantage members in California, Arizona, and Nevada. Twenty percent of its members are dual eligibles. The health plan focuses on providing comprehensive and intensive services to frail and chronically ill members, and it closely monitors non-frail members while helping them manage their chronic conditions to delay the onset of frailty. Upon enrollment and again on an annual basis, beneficiaries have a one-hour health assessment, called a Healthy Start Visit, at a CareMore Center.

During the visit, beneficiaries discuss their medical histories, review medications with clinicians, and undergo any needed lab tests, as well as screening for depression, dementia, and other illnesses. Based on findings from these screenings, beneficiaries are enrolled in team-based chronic disease management programs for conditions such as heart failure, end-stage renal disease, chronic kidney disease, chronic obstructive pulmonary disease, hypertension, behavioral health conditions, and diabetes. Nurse practitioners and medical assistants provide the majority of preventive care and disease management services. CareMore's multi-disciplinary clinical team (which includes hospitalists (called extensivists), nurse practitioners, mental health professionals, social workers, and care managers) coordinate medical, behavioral health, and social services for patients. Primary care physicians continue to monitor their patients, treat acute and unusual illnesses that do not require hospitalization, and refer patients to specialists as needed.

CareMore's extensivists provide inpatient care and post-discharge follow-up in CareMore Centers and

**Figure 3.** The Essentials of CareMore’s Model

- **Clinical Control** - CareMore extensivists determine when a patient requires proprietary services and programs.
- **Speedy Deployment** - Proprietary services and programs can be deployed within minutes.
- **Efficient Allocation of Clinical Resources** - The model replaces physician labor with skilled, allied health professionals such as NPs, MAs, therapists and dieticians.
- **Early Intervention** - Proprietary resources and predictive modeling allow for early intervention to prevent acute episodes.

Source: CareMore Health Plan.
visit patients in skilled nursing facilities. Behavioral health specialists and social workers also participate in patients’ care teams as needed.

CareMore uses electronic health records, as well as a remote monitoring system for patients with hypertension, heart failure, and diabetes so that nurse practitioners can immediately address any problematic changes in key health indicators such as blood pressure and weight.

To support patients and their caregivers in following care plans, CareMore offers no-cost transportation to its medical centers, podiatry services, house calls by physicians and nurse practitioners, help with non-clinical problems, and caregiver support.

**CareMore Health Plan: Results**

The hospital admission rate for CareMore members is 24 percent below the national average, and hospital lengths of stay are 38 percent shorter.

The 30-day hospital readmission rate for CareMore members is 15 percent, compared with 20 percent in the overall Medicare population.

The amputation rate for CareMore members with diabetes is 60 percent less than the national average for people with diabetes who have wounds.

CareMore’s most recent patient satisfaction survey found that 97 percent of patients are very satisfied or somewhat satisfied with their health plans, and more than 80 percent have recommended the company to friends.

On the 2009 Annual Consumer Assessment of Healthcare Providers and Systems (the Agency for Healthcare Research & Quality’s survey on patients’ experiences with health care), CareMore scored 8.81 out of 10. The national average is 8.47, and the California average is 8.57.

For more information, contact: Carolyn Hicks Mayle, Senior Director, Federal Affairs, WellPoint, Inc., 202-628-7848, Carolyn.hicksmayle@wellpoint.com. Slides from this presentation are available at: http://www.ahip.org/CareMoreSlides.aspx.

**ADDITIONAL RESOURCES**

For additional information about the briefing (including presenter biographies and other materials) or other innovative programs for Medicare and Medicaid patients, contact Ellen Bayer, Executive Director, Special Projects at ebayer@ahip.org or 202-778-3275, or visit http://www.ahip.org/Innovations_Series/.

For more information about research initiatives at the Center for Policy and Research, contact Jeff Lemieux, Senior Vice President, at jlemieux@ahip.org or 202-778-3277 or visit www.ahipresearch.org.