MEDICARE & MEDICAID BEST PRACTICES

A Compendium of Managed Care Innovations

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AMERICAN ACTION FORUM

Message From The President

Douglas Holtz-Eakin

Federal government entitlement programs are in fundamental need of reform, especially the Medicare and Medicaid programs. Each is plagued by rising budget costs and inadequate care. Nevertheless, even in this setting Medicare Advantage (MA) and Managed Medicaid (MM) stand out as innovative exceptions to this rule. The American Action Forum has produced this compendium of private sector initiatives within MA and MM to demonstrate how financial incentives can lead to better care for targeted patient populations. The key is to manage conditions in order to avoid debilitating and expensive complications. The result is not simply more care, but better care.

The companies included in this compendium range from small to large, and span insurance companies, health systems, and technology companies. The examples demonstrate that successful solutions can be broad or targeted, use high-tech tools or simple checklists. They can involve patients, providers, pharmacists, caregivers, or all of the above.

Our hope is that this compendium will be a valuable resource for those interested in health policy. Within it are common sense advances that should be implemented throughout the healthcare system; examples of the private sector's ability to innovate; and evidence of the importance of moving our healthcare system away from episodic acute care and into one that can manage chronic conditions, and provide culturally appropriate and patient-specific care.

Unfortunately seniors are about to see their MA plan choices reduced as the Affordable Care Act (ACA) cuts $156 billion from the program. On the Medicaid side, policymakers and plan providers are determining how to integrate Medicaid into the ACA exchanges, reduce harmful effects from members cycling on and off the program, and make sure payment rates are actuarially sound.

Another ACA provision, the Medical Loss Ratio (MLR), will also impact managed care plans by requiring plans to spend 85 percent of all premium revenue on members' medical costs. The 15 percent limit on administrative costs and profit may make it difficult for managed care plans to invest in additional programs and innovations. Should "medical benefits" be too narrowly defined in the future, it would severely limit the extra programs and services available to beneficiaries.

While so much attention has been directed toward the financial problems in government health programs and the shortcomings of the American health care system, it's important to take note of the successes in the private sector and explore how they may be more broadly adopted.

Doug Holtz-Eakin

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Overview:

Highlighting Best Practices and Innovation

In addition to traditional fee-for-service health care financing, both Medicare and Medicaid offer privately operated benefit plans available to beneficiaries. These plans are provided by private insurance companies or health systems for Medicare and/or Medicaid patients. Benefit packages cover specific mandated services and often include additional medical services and even auxiliary non-medical services such as transportation.

Medicare Advantage:

Medicare Advantage, sometimes referred to as Medicare Part C, is Medicare's managed care benefit. In traditional Medicare, Parts A and B cover hospital payments and physician services, respectively. All MA plans cover physician and hospital services and the vast majority include an MA drug plan, so it eliminates the need for plans to have separate plans for drug and health benefits. Many plans provide vision, dental, and hearing services that are not available in traditional Medicare, as well as care coordination and disease management and prevention services.[1]

At present, Medicare Advantage covers 13 million people, which equates to 27 percent of the Medicare population.

The Centers for Medicare and Medicaid Services (CMS) takes bids for MA plans and compares those bids to a "benchmark" rate which is indexed from the cost of traditional Medicare in that county.[2] Plans above the benchmark rate must charge higher premiums to enrollees to cover the difference. In 2012 the average MA premium was $35/month, in addition to the regular Part B premium paid by all but the poorest beneficiaries.[3] If the bid is below the benchmark cost, CMS will issue 75 percent of the difference as a rebate to the company, which plans cannot use as profit but are instead required to put toward lower cost-sharing for beneficiaries or added benefits. Low cost sharing, low premiums, and additional benefits make MA advantageous for seniors with lower incomes who may not be able to afford "MediGap" plans, which can cost upwards of $200 per month.[4]

The most common type of MA plan is a health maintenance organization (HMO), but local or regional preferred provider organizations (PPOs) are growing in popularity, especially in rural areas. The majority of HMO plans have a set list of providers a patient can visit and require a referral from the primary care physician in order to reimburse for a specialist visit.[5] PPO plans have a group of providers on their preferred list but a patient can see other providers at an additional cost.[6] An additional form of MA is a private fee-for-service plan, but these represent a small segment of the MA market and are declining. Lastly, MA plans can also be Special Needs Plans (SNPs), which are only available to a small population who are either dually eligible for Medicare and Medicaid (D-SNPs), need institutional or nursing home-level care (I-SNPs), or have a specific chronic condition (C-SNPs).

Medicaid Managed Care:

Medicaid's Managed Care (MMC) plans are similar to those serving the Medicare population, but are generally targeted toward certain eligibility categories (i.e. children, the disabled, non-elderly adults or nursing home residents) and contract with state Medicaid offices rather than the federal government. At present, 74.22% of all Medicaid enrollees are a part of an MMC plan, and plans are available in all states except for Alaska, New Hampshire and Wyoming.[7]

By coordinating care based on specific populations' needs, MMC has led to significantly lower hospital utilization and drug costs. MMC provides the same Medicaid benefits with little to no cost-sharing, but instead of fee-for-service payments made directly to providers, insurers are paid through capitation and they then determine provider rates. States save by setting a per member rate that is actuarially sound, which is defined as providing for all reasonable, appropriate, and attainable costs. States either set the capitation rate, or plans participate in competitive bidding, to encourage fair rates. Some states combine methods by setting a range of rates, and then allowing bids within that range. The rates are set based on fee-for-service costs, utilization, and any state budget restrictions. Risk adjustments are then applied based on different demographic factors. MMC plans are incentivized to develop innovative methods to manage their population's health, as they profit from staying below spending projections.

There are three main types of Medicaid managed care plans. Comprehensive risk based plans cover the majority of enrollees, operating via a fixed monthly capitation rate. Comprehensive plans are required to cover all mandated Medicaid services including inpatient hospital services, outpatient physician services and prescription drugs. These plans use a health maintenance organization model with a network of providers. Maintaining a solid provider network is a key function of managed Medicaid, since low reimbursement within the Medicaid fee-for-service system deters providers, particularly specialists, from accepting Medicaid patients.

Limited benefit plans are also available, which are supplemental plans that cover specific services such as behavioral care, medical transportation, or dental services. The third type of MMC is a primary care case management plan, a model in which primary care providers are paid a small capitation fee to coordinate and manage a patient's care. These plans are usually used in rural areas where comprehensive managed care isn't available.[8]

According to the 2011 CMS Medicaid Managed Care Enrollment report, 42,384,539 people were enrolled in MMC plans in 2011. Since 2002, the percentage of Medicaid beneficiaries in MMC has grown by 16.6 percent.[91] Even though MMC plans cover almost 75 percent of the Medicaid population, they only account for 22.4 percent of total Medicaid spending, as the managed care patients are disproportionately low-cost children as opposed to disabled adults or elderly nursing home patients. MMC plans incorporate 85.9 percent of all children covered by Medicaid, and only 58.7 percent of adults. States have tried to encourage MMC enrollment with the disabled and elderly Medicaid population, but it is not as prevalent. Currently, only 38 percent of dual eligible seniors participate in MMC.[10]

Trends in Managed Care:

Both Medicaid Managed Care and Medicare Advantage plans have a great incentive to be innovative as a way to control costs. Plans can use initiatives targeted at providers, patients and/or caregivers, as all play a role in achieving better outcomes. While high quality care can be expensive, in general plans aim to control costs in the long-term by reducing premature births, readmissions, adverse drug events, hospital-acquired infections, and unnecessary complications for manageable chronic conditions. It is generally understood that plans spend more on the healthy members than traditional fee-for-service Medicare or Medicaid but are able to keep the sickest members' costs down as compared to the uncoordinated fee for service system.

Currently, the key trends in innovative managed care plans fall under the broader trends of **care coordination**, **targeted services and incentives, patient (and caregiver) engagement, and/or the use of new technology.**

Care Coordination:

It is well documented that gaps in care and ill communication between a patient's different providers can lead to poor quality care. Often there is insufficient coordination between a patient's primary care physician, doctors they see in the hospital, and any post-acute care providers. Managed care plans can incent providers to coordinate care as they have a limited provider network and the flexibility to reimburse for or pay the salaries of physicians, nurses and/or pharmacists who focus on managing a patient and all of their treatment or medication. These plans are in a unique position to pay their providers for care coordination or reward

outcomes, and many are health systems themselves that provide the care in addition to being the insurer.

Targeted Services and Incentives:

Many innovations showcased in this compendium are programs and initiatives targeted to subsets of the population. Plans can develop specific programs for certain categorical populations such as age groups, or clinical conditions and provide additional services appropriate to those care needs. The compendium features plans focused on patients with certain clinical conditions such nursing home level care needs or asthma, as well as certain patient populations such as Spanish speaking members or expecting mothers. These sorts of targeted programs are not feasible within a fee-for-service system and provide great value for managed care patients.

Patient and Caregiver Engagement:

Insurance companies and healthcare systems understand the importance of having patients and caregivers better understand their condition, treatment and resources, as is evidenced by the innovative plans examined in this compendium. Some companies have chosen high-tech solutions for engaging patients outside the providers' office. For example, the Care Innovations Guide allows patients to monitor their conditions at home and communicate with their provider. Other examples of engagement tools are the patient compact signed by surgery patients in the Geisinger Health System and pharmacist coaching to go over any medication complication or compliance issues used by the United Healthcare's Transitions Management Program. In addition, managed care plans seem to have an increased appreciation of the role of family caregivers for elderly patients in facilitating better patient compliance and better communication with providers. For both the Medicare and Medicaid populations, plans that send providers out to the home have a better opportunity to collaborate with the family and understand the patient's environment and daily life.

New Technology:

Mobile health and telehealth inventions have exploded in recent years. Many of these new devices and applications allow providers to stay in close contact with patients and monitor signs and symptoms remotely. Using technology to allow older patients to remain in their homes and be treated there or be discharged earlier for recovery leads to better outcomes, lower costs, and higher patient satisfaction. Technology also helps providers in the care setting to monitor patients, keep track of clinical steps or to interact and communicate with others on the care team. Fee-for-service systems don't often reimburse for these technologies, but managed care plans have more leeway to cover these new technologies or systems as a way to reduce costs and improve care quality.

Resources

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Medicare Advantage Innovations

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Care Innovations Guide

BACKGROUND

Care Innovations is a technology company owned jointly by General Electric and Intel, with a mission to create pioneering healthcare technology. Care Innovations creates technology solutions, including telehealth and smart sensor monitoring, for healthcare and senior living settings. The company has a suite of products available to healthcare organizations that allow patients to remain at home or in independent living situations in lieu of more expensive post-acute care or long-term care arrangements. Several MA plans use these devices and systems for members when appropriate, and in particular utilize Care Innovations Guide for eligible patients.

METHODS

The Care Innovations Guide is an FDA-cleared remote care management system, which includes a computer that is transformed into a home health hub for the patient.

The Guide works for patients who need short-term services following hospitalization, as well as patients with chronic conditions who need ongoing monitoring. It provides an interactive experience for the patient to monitor and record health information that is transmitted to their providers in addition to a user-friendly videoconferencing option.

The software allows interoperability with many providers' electronic health records for automatic integration with the patient's record. Features include accessories such as: blood pressure cuffs, glucometers, and scales that connect to the Guide allowing the patient and provider to monitor vital signs, weight, and other health information. Patients can also use the Guide to receive feedback and personalized health tips.

Care Innovations believes the Care Innovations Guide helps patients become partners in their chronic care management or recovery. By allowing them to take simple biometric measurements or monitor their own vital signs they are participating in diagnostics and treatment in a new way and this engagement will hopefully help patients better understand their condition.

PROGRAM AT A GLANCE

- ✓ Care Coordination
- ✓ Patient Engagement
- ✓ New Technology

Objective:

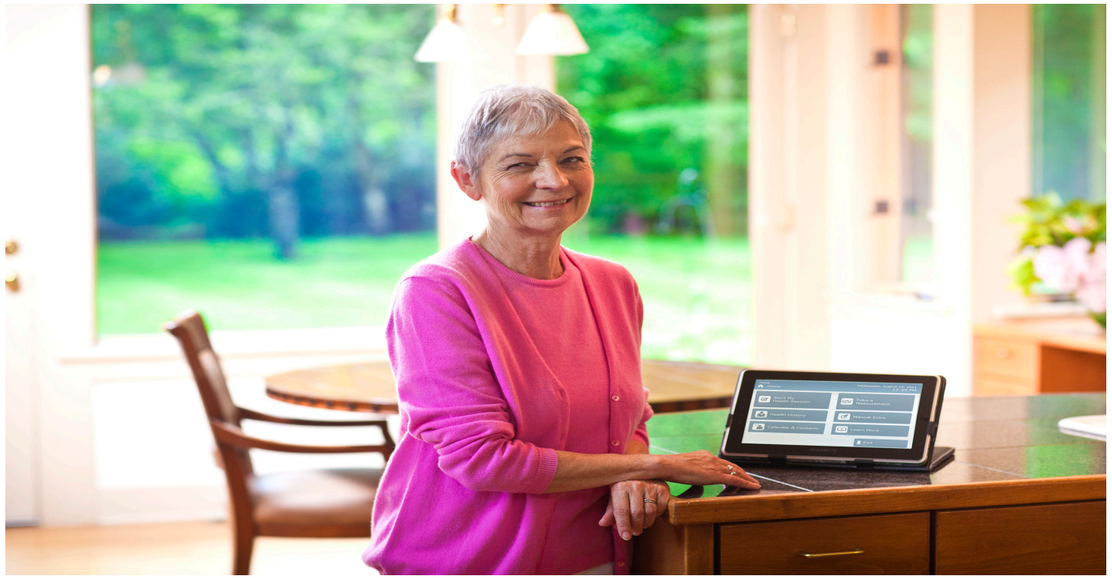
- Use technology to allow patients to continue living at home while providing clinicians and caregivers with necessary information.
- Monitor patients with the goal of preventing complications and addressing health issues before they become emergencies.

Methods:

- The Care Innovations Guide enables home monitoring and patient tracking.
- The Care Innovations Guide device allows patients to plug in blood pressure cuffs, glucose monitors, scales and other accessories to record and submit information to providers.
- The device is easy to use and enables communication to the provider, with alerts for anything unusual.

Outcomes:

- A small pilot in Italy with liver transplant patients was successful
- Humana is currently in the process of a larger study of 2,000 Congestive Heart Failure patients.



OUTCOMES

ISMETT, an Italian healthcare firm based in Palermo, has implemented the Care Innovations Guide in an initial pilot study of 30 patients recovering from a liver transplant. They noted "encouraging" results and plan to expand the pilot to 100 patients and eventually to other conditions.

Humana Cares, a Florida-based division of Humana that is focused on chronic care management, is in the middle of an 18-month pilot project using the Care Innovations Guide for 2,000 Congestive Heart Failure patients. Nurses will be able to monitor and teleconference with patients wherever they are to prevent any complications from becoming emergency situations.

As part of an innovative research study, St. Vincent implemented a remote care management program and selected the Care Innovations Guide platform to facilitate care delivered in the home. In less than two years, preliminary results show that the care management program reduced hospital readmissions to 5 percent for patients participating in the program- a 75 percent reduction compared to the control group (20 percent), and to the national average (20 percent).

RESOURCES

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CareMore Care Centers

BACKGROUND

CareMore is a Medicare Advantage plan that began as a small medical group in California. CareMore MA and Special Needs Plans are now available to seniors in California, Nevada and Arizona and are expanding to New York and Richmond, VA. In 2011, WellPoint aquired CareMore.

METHODS

CareMore's Care Centers only focus on MA members and the unique needs of seniors. For example, the clinics are designed to be safe for elderly patients, with low-glare surfaces, chairs and don't tip, and static resistant carpet that won't interfere with hearing aids.

Like many successful MA plans, CareMore provides coordinated care. However, unlike most managed care plans that depend on a primary care physician or nurse practitioner to oversee all of the care, CareMore has also introduced "Extensivists" to work with their sickest patients. Extensivists are similar to hospitalists, but have a smaller caseload of patients and operate outside the hospital. The Agency for Healthcare Research and Quality notes that CareMore's extensivists, "generally split their time between the hospital, where they round on a small group of members each day, and an outpatient clinic, where they see recently discharged members and other members at high risk of an admission. Once or twice a week, these physicians also see members in [skilled nursing facilities]." Only when someone is deemed stable do they go back to the supervision of a primary care provider. The primary care providers work with the CareMore system but are not employees. As reported in *The Atlantic*, CareMore hires more staff per member than other healthcare systems, given that they tend to have fewer expensive hospitalizations and serious complications.

CareMore works to make medication compliance and treatment compliance easy for patients. The plan provides transportation or in-home visits, has over 60 medications with no co-pay, and provides insulin to diabetics for free. They also extensively track their patients via electronic health record and use in-home remote monitoring devices such as scales and glucometers that send results to the provider. Roughly 75 percent of the CareMore programs would not be covered by traditional Medicare.

PROGRAM AT A GLANCE

- ✓ Care Coordination
- ✓ Remote monitoring/Home care

Objective:

- Provide comprehensive care that prevents worse and more expensive complications or hospitalizations down the line

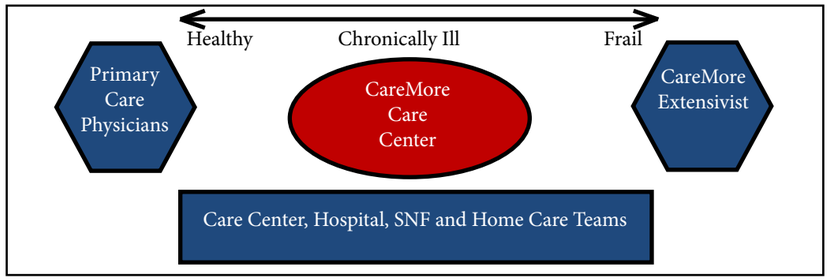
Methods:

- Coordinated care including specific physician "extensivists" who care for hospitalized patients
- Making treatment adherence easy for patients and allowing them to monitor conditions at home
- Extra services such as transportation
- Care centers designed for seniors' comfort and safety

Outcomes:

- Lower costs than other Medicare Advantage plans
- Fewer readmissions than fee for service Medicare
- Fewer amputations among diabetes patients

Figure A: Care Center Model



OUTCOMES

CareMore's innovative approaches have seen very positive results. When they implemented the wireless scales that transmit data to providers, hospitalizations for heart failure patients fell by 56 percent. They also have significantly fewer readmissions than fee for service Medicare. In 2011, CareMore's 30-day readmission rate was 13.8 percent compared to the 19.6 percent average across Medicare fee for service, and their diabetes patients have an amputation rate that is 67 percent below the Medicare average.

CareMore's clinical results have been successful, and they spend less per-member than other plans. They spend more on their healthy patients than traditional, yet their total costs are 18 percent below industry standards. In addition, patient satisfaction appears to be high. Of the patients whose primary care physicians have left the network, 82 percent have chosen to stay with CareMore.

RESOURCES

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My Medication Reminder Text Messaging Program

BACKGROUND

OptumRx, a subsidiary of the United Health Group, is one of the largest pharmacy benefit managers in the United States, specializing in the delivery and clinical management of prescription medications and consumer health products. In September 2010, OptumRx piloted the My Medication Reminder Text Messaging Program to improve medication adherence. Medication adherence, defined as the extent to which patients take medications as prescribed by their physicians, is critical to achieving optimal health outcomes.

However, it is estimated that 20% to 50% of patients are non-adherent, with even higher levels, ranging from 40% to 86%, among the elderly. Not only does non-adherence lead to worse health outcomes, it is also costly. Some 33% to 69% of medication-related hospital admissions are due to poor adherence, resulting in approximately $100 billion in costs per year.

METHODS

In order to combat poor medication adherence and its consequences, OptumRx has developed an innovative program that uses text messaging to encourage patients to take their medications properly.

PROGRAM AT A GLANCE

- ✓ New Technology
- ✓ Patient and Caregiver Engagement

Objective:

- Increase prescription medication adherence, particularly among the elderly

Methods:

- Send enrollees text messages with reminders and the status of their prescription medications

Outcomes:

- Enrollees in the program had significantly higher rates of medication adherence than those who were not, especially for diabetes, heart disease, and depression

Members who are continuously enrolled in a Medicare prescription drug plan (PDP) or a Medicare Advantage and Prescription Drug (MA-PD) plan can voluntarily opt to provide their mobile phone number, mobile carrier, and time zone and choose to receive text message reminders for any combination of the following:

1) Refill – receive a text message that a prescription is eligible for a refill
2) Renewal – receive a text message that a prescription is eligible for renewal
3) Transfer – receive a text that a prescription is eligible for a transfer from a retail pharmacy to a mail order pharmacy
4) Order shipped – receive a text that a prescription has been shipped from the mail order pharmacy
5) Daily reminder – enrollee can choose any hour of the day to receive a daily text message reminder saying “Take your medications today”
6) Prescription-specific dosage reminders – enrollees can set reminders for prescription drugs as well as over-the-counter medications, along with choosing how often they want to be reminded

The program is available for all mobile phone brands and providers.

OUTCOMES

A study conducted of 580 plan members, 290 of whom were enrolled in My Medication Reminders and 290 of whom were not, found significantly higher levels of adherence among those enrolled in the program. Text message reminders led to an 11% increase in adherence, with an estimated savings of $724 per year per member.

When comparing the text-messaging cohort with the control group, researchers found that text message reminders had the greatest impact in the treatment of diabetes, heart disease, and depression.

RESOURCES

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GEISINGER

ProvenCare®

BACKGROUND

The Geisinger Health System, which is both a healthcare provider and an insurer, covers large numbers of Medicare Advantage members in Pennsylvania. Geisinger began its ProvenCare pilot program in 2006. The goal was to show that reduction of cost and an increase in quality of care can coincide. ProvenCare establishes standardized best practices for a given procedure and then tracks them aggressively to ensure implementation. The keystone of ProvenCare is the financial component, a bundling of services where a flat rate is charged for a surgery and any follow up care within ninety days.

METHODS

Geisinger specialists identified 40 essential steps as benchmarks to follow when performing coronary artery bypass graft surgery (CABG), the first procedure tested within ProvenCare. The 40 steps are grouped by when they are to be performed. There are specific steps for pre-operative, operative, post-operative, discharge, and finally post-discharge documentation.

Once implemented into the workflow, the steps are tracked via electronic health record to ensure each is being followed. When ProvenCare began, all 40 steps were taken in only 56 % of surgeries. Now, if any one of the pre-surgery steps are missed, and there is no note from the surgeon explaining the reason, the surgery is cancelled, giving physicians a strong incentive to follow the guidelines.

Geisinger also has the patient sign a "patient compact", which includes a number of statements about the patients pro-active role in their surgery and recovery. The compact includes statements such as, "I will alert my heart surgery team when I don't understand something, when anything worries me, or if anything unexpected occurs, knowing that my heart surgery team will work with me until I am satisfied," and "I will alert my heart surgery team before I stop or start any of my medications so that we can discuss how any change might impact my care."

PROGRAM AT A GLANCE

- ✓ Care Coordination
- ✓ New Technology
- ✓ Patient Engagement
- ✓ Targeted Benefits and Incentives

Objective:

- Increase value of acute hospital treatment services for their MA beneficiaries

Methods:

- Establish exhaustive best practice steps to be followed for each surgery.
- Charge a bundled, flat rate for services, including post-acute care, based on historical costs.
- No additional charges applied for follow-up treatment given within 90 days.

Outcomes:

- ProvenCare was expanded to cover four additional acute treatment services.
- The program achieved a nearly 50% reduction in readmissions after one year of implementation.

"Surgery With a Warranty"

Seeing that many consumer products are guaranteed for a limited time after purchase, Geisinger Health Systems developed ProvenCare to provide a similar assurance for health care procedures. Under ProvenCare, the hospital charges a flat rate for a surgery, plus half of the historical cost of related care for the next 90 days. Any additional costs are absorbed by Geisinger.

OUTCOMES

In just one year, Geisinger saw a dramatic drop in morbidity and complication rates. As a result, the percentage of patients being readmitted within 90 days was cut nearly in half. The pilot program began with only bypass surgery. A study published in the Annals of Surgery found a 16 percent decrease in the hospital stay as well as a reduction of 5.2 percent in hospital charges.

Figure A: 90 Day Readmission Rates, 2008-2009

FY 2008: 413 cases, 51 readmisions

FY 2009: 427 cases, 29 readimissions

Now, ProvenCare has extended to percutaneous coronary intervention (PCI), complete hip replacements, cataract and bariatric surgeries. As Geisinger's chief technology officer noted in a *Health Affairs* article, the innovations are often first derived in populations, such as MA members, for whom the company is both financially and clinically responsible. They then are able to spread those innovations to other patients and to other payers.

RESOURCES

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The Transitions Management Program

BACKGROUND

UnitedHealthcare (UHC) teamed up with Dovetail Health, a company providing geriatric care management services, to deliver a 30-day, pharmacist-led, care management pilot program. The Program is designed to help UnitedHealthcare's AARP MedicareComplete plan members in New Jersey avoid unnecessary post-acute complications and reduce hospital readmissions.

PROGRAM AT A GLANCE

- ✓ Care Coordination
- ✓ Patient Engagement
- ✓ Targeted Benefits and Incentives

Objective:

- By developing a personal relationship between each patient and a Dovetail Health Pharmacist Care Manager, the program aims to prevent readmissions through assessment, education and support.

Methods:

- Pharmacist Care Manager facilitates an in-home assessment and designs an individualized self-care plan for member.
- PCM makes routine follow-up calls throughout program to offer support, answer questions, and provide assistance with managing and coordinating the member's care.
- After 30 days, the PCM evaluates the member's health status and sends a referral to another appropriate care management program that will provide continued assistance with the member's recovery process at home.

Outcomes:

- Data will become available in September 2013, which is 6 months after the program ends.

METHODS

The 30-day program targets Medicare Advantage members, who have been recently released from a hospital or skilled nursing facility and meet defined clinical criteria that indicate they are at high risk for readmission. The program utilizes a Pharmacist Care Manager (PCM), who works with the individual member to facilitate assessments, provide education, and offer continual support to promote behaviors that reduce preventable readmissions.

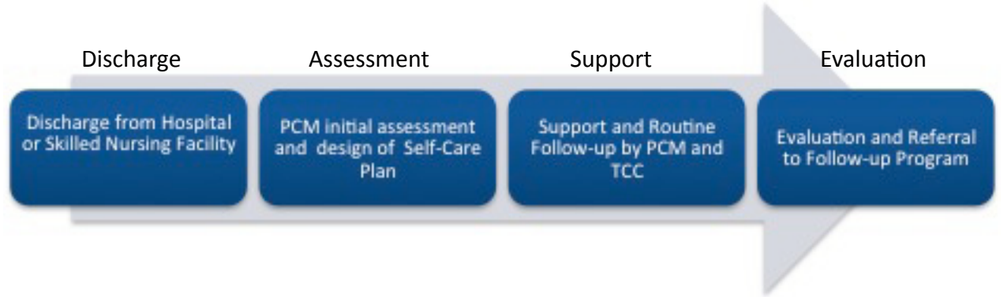
Assessment: The program begins with an in-home assessment by a Pharmacist Care Manager, who is a doctoral-level pharmacist. During this home-visit, the PCM reconciles and optimizes all medications (over-the-counter medications included) and designs an individualized, comprehensive self-care plan for the patient. The assessment enables the PCM to identify potential issues with the member's adherence to their treatment plan and medications; to conduct a home-safety assessment (i.e., determining the risk of falls); and to evaluate the member's mental health and cognitive function. After 30 days, the PCM conducts another level-of care evaluation and, if necessary, refers the member to an appropriate follow-up program to ensure as smooth a recovery as possible.

Education: The PCM educates members to reduce common behaviors that contribute to preventable readmissions. They discuss the patient's medication regimen and how to properly store, administer, dispense and refill medications. In addition, the PCM suggests techniques on how to improve the member's care coordination and medication adherence (i.e., pill-boxes, reminder calls, and positive reinforcement). Members receive coaching on several health and home safety issues, such as chronic condition management and red flag education to identify when changes in their condition require physician assistance. Techniques like simplifying the

member's regimen or organizing a daily routine to promote better medication management enable the PCM to address common readmission factors and change potentially harmful behaviors.

Support: Following the patient home-visit, the PCM makes routine follow-up calls throughout the program to offer member-empowering support. These phone calls serve to answer questions and provide assistance with managing and coordinating the member's care. The PCM refers the member to their doctor(s) and assists in contacting the doctor(s) if they cannot answer the member's questions. They also facilitate advanced-care planning, should the member's chronic conditions worsen. Finally, members, caregivers and physicians are all given copies of the member's medication reprints and self care plans.

Figure A: Transitions Management Program Process



OUTCOMES

The program is currently being evaluated and results should become available in 2013.

RESOURCES

Logo image: https://www.uhcmedicaresolutions.com/en.html

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UNIVERSAL AMERICAN

A Healthy Collaboration℠

Tribute Special Needs Plan

BACKGROUND

SelectCare of Oklahoma designed a Medicare Advantage Special Needs Plan (SNP) called Tribute in August 2005 to meet the needs of people living in skilled or long-term facilities (SNF). SelectCare of Oklahoma is affiliated with Universal American, which is a specialty health insurance company that focuses only on providing products and services to Medicare beneficiaries.

METHODS

Assists in care-coordination by utilizing mid-level practioners

In addition to a primary care physician, a mid-level practitioner (nurse practitioner or physician assistant) helps in the assessment and coordination of the patient's health care needs and the prevention of future health risks.

Focuses services among a specific population and area to best utilize local providers

Tribute HMO SNP is only offered to beneficiaries that require the same amount of care as someone in a nursing home but reside in their home or another community residence. Furthermore, beneficiaries must reside within ten counties in South Central Oklahoma.

Provides a program to help control complex medication regimens

Tribute HMO SNP offers a free service called the Medication Therapy Management Program to certain beneficiaries.

Those automatically enrolled in the program take eight or more drugs every day, have three or more chronic health conditions or spend more than $3,100.20 a year on drugs.

PROGRAM AT A GLANCE

- ✓ Care Coordination
- ✓ Targeted Benefits and Incentives

Objective:

- To provide prevention and intervention that improves the quality of life for members living in nursing home facilities through collaboration between the member's primary care physician and assisting health care staff.

Methods:

- Assign a mid-level practitioner to each beneficiary to assist in the assessment and coordination of health care needs and the prevention of future health risks.
- Help beneficiaries control complex medication regimens.

Outcomes:

- The Tribute HMO SNP has outperformed the mean SNP plan in a variety of measurements according to the Centers for Medicare and Medicaid Services annual HEDIS report.

Specially trained pharmacists work with the member and their doctor to make sure the prescribed drugs are taken safely and appropriately. The pharmacists also help the member better manage their drug therapy.

Assessment	•Perform comprehensive assessments to determine the patient's health status •Visit regularly to ensure that the patient's health status is maintained
Coordination	•Maintain communication between the facilities, physicians and other providers the patient utilizes •Expedite authorization of services that impact the patient's medical care
Prevention	•Identify potential health risks and initiate early intervention •Ensure timely and appropriate use of medical services

OUTCOMES

The Centers for Medicare & Medicaid Services (CMS) in conjunction with the National Committee for Quality Assurance (NCQA) evaluates all SNPs on a variety of measures in a Healthcare Effectiveness Data and Information Set (HEDIS) report. In 2010, Tribute outscored the mean results for all SNPs.

Measures	Mean	Tribute
Appropriate Monitoring of Patients Taking Long-Term Medications	90%	100%
Board Certified Physicians	70%	81%
Care for Older Adults-Advance Care Planning	23%	78%
Care for Older Adults-Medication Review	53%	91%
Care for Older Adults-Functional Status Assessment	28%	82%
Care for Older Adults-Pain Screening	38%	82%
Medication Reconciliation Post-Discharge	30%	46%

RESOURCES

Logo image: http://www.universalamerican.com/

Center for Medicare and Medicaid Services Website. "Medicare: Health Plans: Special Needs Plans: SNP Quality: 2010 SNP Quality Measures Plan Scores." https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/Downloads/2010_SNP_HEDIS_Data.pdf

Video Ethnography

BACKGROUND

Kaiser Permanente, one of the nation's largest not-for-profit health plans, founded the Care Management Institute (CMI) in 1997 to find new evidence-based tools and techniques to increase the quality and decrease the cost of care for Kaiser Permanente patients. Through CMI, Kaiser has pioneered the video ethnography program designed to capture positive and negative trends in care that can be shared and coordinated with physicians. The program is especially effective among Kaiser's Medicare Advantage plan members.

PROGRAM AT A GLANCE

- ✓ Care Coordination
- ✓ New Technology

Objective:

- Reduce hospital readmissions and improve other gaps in care delivery.

Methods:

- Video tape interviews with recently discharged senior outpatients.
- Compile recordings into a 5-8 minute video that highlights positive trends as well as negative care gaps.
- Distribute videos to care providers to coordinate and improve best practices.

Outcomes:

- Video Ethnography and the resulting improvements in home care transition led to a rapid decrease in hospitalizations after heart failure treatment from 13.6% to 9% in six months in one Southern California medical center.

METHODS

Video Ethnography is a program of video-recorded interviews and observations of patients and caregivers to identify care gaps, unmet patient and caregiver needs, and effective practices. Videotaping was found to be particularly helpful with seniors, since these patients are typically not well represented in other quality improvement approaches such as focus groups.

As of June 2012, nearly 40 Kaiser Permanente teams of more than 130 clinical staff, quality-improvement professionals, and clinical and administrative leaders have participated in video ethnography training. Kaiser Permanente has conducted video ethnography projects in relation to surgical services, breast cancer care, outpatient medication administration, care disparities and other clinical areas.

The program involves a four-step process: planning and design, fieldwork, data analysis, and editing of the footage to create the final videos.
A team of video ethnographers will:

- Target individuals and care givers in an appropriate sample that represent the population and characteristics of interest.
- Interview and ask questions that will reveal any problems or effective practices that will be useful to improving care delivery and cost management.
- Analyze data and identify improvement opportunities.
- Edit the footage into five-to-eight-minute videos that document quality improvement opportunities in the voices of patients and caregivers.

- Present the edited and compiled videos throughout the organization to highlight some of the opportunities and priorities for more effective and efficient care.
- Supplement the videos with slideshows or reports that emphasize trends and data from the interviews.

Video Ethnography in action

The Kaiser Permanente South Bay Medical Center conducted a video ethnography program designed to reduce rehospitalization rates for patients after heart failure treatment within thirty days of initial discharge. Most of the targeted patients were seniors with an average age of over seventy-five years at diagnosis. Many of these individuals are enrolled in Medicare Advantage plans. Seniors with heart failure have the highest rehospitalization rate among all adult patients.

The CMI team interviewed and observed seven patients, six of them seniors, and three family caregivers. The team also shadowed staff to observe transitional program processes.

Trends and care gaps that were highlighted:

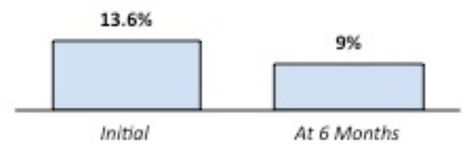
- Understanding how and when to take prescribed medications emerged as a particular challenge.
- Discharge instructions often lacked specific details.
- Home health nurses were unable to access Kaiser Permanente's electronic health records while in patients' homes and did not have a definitive list for medication reconciliation.

The video was presented to all care professionals at the hospital. Almost immediately, home health nurses began working with medical center pharmacists over the phone to ensure that the patients understood their medications and other outpatient procedures.

OUTCOMES

This and other changes in home care transition led to a rapid decrease in readmissions after heart failure treatment from 13.6% to 9% in six months.

Figure A: Percentage of Hospital Readmissions: Seniors Treated for Heart Failure



RESOURCES

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Managed Medicaid Innovations

Table Of Contents

Asthma Disease Management Program

BACKGROUND

Neighborhood Health Plan (NHP) is a managed care organization that has grown substantially since its inception in 1986. The insurer now covers Massachusetts Medicaid (MassHealth), Commonwealth Care, Commonwealth Choice, and other commercial enrollees. In 1999, in response to the high cost of asthma care, and 10% of NHP patients using asthma services, Dr. James Glauber was hired to create the Asthma Disease Management Program (ADMP).

PROGRAM AT A GLANCE

- ✓ Care Coordination
- ✓ Patient and Caregiver Engagement

Objective:

- Decrease unnecessary health complications due to asthma

Methods:

- Identify individuals who are not properly managing their asthma
- Provide primary physicians with in depth information about their asthma patients
- Educate patients about proper care

Outcomes:

- Reduced asthma related ER visits and hospitalizations by more than 30%

METHODS

Dr. Glauber's program is founded on the development of a registry that collects medical and pharmaceutical claims of NHP's members. The database identifies asthma patients who are not adequately managing their condition. A report is generated from this registry four times a year, and a summary is sent to each primary care physician regarding their asthma patients' hospital and pharmacy utilization. In addition, on a bi-weekly basis, a "Trigger Report" is also sent to alert physicians when patients have exceeded their allotted amount of rescue medication prescriptions or have not filled a prescription for a controller drug. Once patients are identified on the bi-weekly report, NHP creates individualized treatment recommendations for the providers, and mails the patient educational material. In addition, identified patients may be assigned a case manager, who helps the patient follow their care plan. The case managers also contact the patient if there are any asthma related hospitalizations or excessive use of medication.

Figure A: Asthma Care Model

Most recently in 2005, NHP introduced their Enhanced Asthma Home Program, which provided home-based environmental interventions. NHP contracted with the Boston Asthma Initiative, a community based organization, to help assess pediatric and adult asthma patients who are compliant with their medication but still have not properly controlled their condition. Once identified, asthma counselors conduct three home visits, where they first administer an Asthma Control Test, which evaluates the current treatment. The counselor then assesses the home environment and educates the patient about different ways to control allergen triggers, such as dust, mold, and pet hair. The patient is also provided with an allergen-proof mattress and pillowcases, a vacuum cleaner, and an air purifier. The counselor finishes at the home by providing the patient with a written plan on how to mitigate any environmental factors. A report is also submitted to the primary care physician outlining the environmental assessment and any recommendations made.

Lastly, NHP recognized that their patients lacked adequate access to spirometry, a diagnostic tool to measure airflow that helps diagnose and monitor asthma and other respiratory conditions. In response they created a pilot program within community health centers, giving them spirometers and training so underserved patients have access to the valuable tool.

OUTCOMES

Figure A: Percentage of Asthma Patients Using Controller Medication

Most notably, the ADMP has successfully reduced asthma related ER visits and hospitalizations by more than 30%. From 1999-2004, the percentage of patients with an asthma-related hospitalization decreased from 3.1% to 2.6%. The percentage of patients successfully using controller medication, which helps patients manage their condition, increased from 49% to 58% with the ADMP; this could be the reason less patients are visiting the ER. More than 90% of the Medicaid asthma patients received the proper amount of medication. Due to around 1,200 trigger reports sent out to physicians each month, NHP also found that 96% of patients thought the educational materials to improved their quality of life. In response to their success, NHP was awarded the Environmental Protection Agency National Leadership Award for Asthma Management in 2010.

RESOURCES

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"Neighborhood Health Plan of Massachusetts (NHP) Snapshot." AsthmaCommunityNetwork.org. <http://www.asthmacommunitynetwork.org/node/3323>.

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Partners in Pregnancy

BACKGROUND

Sentara is a non-profit organization that provides health insurance to residents of southeastern Virginia and northeastern North Carolina. Sentara began offering Optima Health, the first managed care program for Medicaid beneficiaries in the area, in 1984. Optima Health provides the Partners in Pregnancy program free of charge to its members' families, with the end goal of reducing days spent in the Neonatal Intensive Care Unit (NICU).

During pregnancy, a woman's health problems can escalate and can be damaging to both the mother and the unborn child. Pregnancy complications are especially prevalent among lower-income families, including many Medicaid recipients. The Partners in Pregnancy program works to ensure that everything possible is done to prevent pregnancy complications.

PROGRAM AT A GLANCE

- ✓ Targeted Benefits and Incentives
- ✓ Patient and Caregiver Engagement

Objective:

- Improve pregnancy outcomes
- Reduce days spent in NICU
- Promote healthy behaviors

Methods:

- Trained nurses and outreach workers administer services to women with high-risk pregnancies
- Programs are community-based to ensure personalized and convenient care

Outcomes:

- Per Member Per Month costs were lower in both the mothers and the children
- Total days spent in the NICU were reduced

METHODS

Optima Health identified enrollees whose pregnancies were high-risk according to a demographic assessment of risk factors and began administering program services to those members.

Cooperating nurses and outreach workers were trained in various prenatal programs, and follow-up trainings were conducted. The nurses and outreach workers also received two information sheets that would allow for easy reference during home visits. The sheets included various trigger questions that could be used to gauge behaviors and needs of pregnant women, including nutrition, mental health, lifestyle issues, prenatal care, and stress.

A full range of both medical and social services, including transportation to appointments, is available as necessary to ensure the mother is receiving the best possible care. Nurses make home visits, van drivers transport the mother to appointments, and community workers arrange classes on lactation and other parenting skills.

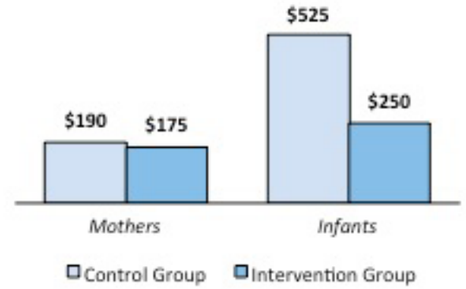
Optima Health cooperated with Children's Health Insurance Program and March of Dimes to train nurses and coordinate guidelines with which to follow up on training.

OUTCOMES

Overall, there were lower per member per month (PMPM) costs among the intervention group than among the control group. The intervention and control mothers' inpatient care costs were $176 PMPM and $185 PMPM, respectively. The change in cost was even more drastic among the infants, whose inpatient costs were $239 PMPM in the intervention group and $539 PMPM in the control group.

Sentara also avoided about 1,600 NICU days in the first 9 months of operation and, as a result, saved roughly $2.3 million.

Figure A: Monthly Patient Costs



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Baby Blocks Program

BACKGROUND

UnitedHealthcare is one of the largest providers of health insurance in the United States. The company has Medicaid programs in 25 states across America. UnitedHealthcare began their Baby Blocks program in the fall of 2011 and is currently available in 8 states to 50,000 pregnant members per year.

METHODS

Baby Blocks is a volunteer enrollment program within a Medicaid Managed Care plan designed to encourage members to make and keep physician appointments during their pregnancy and throughout the first 15 months of their baby's life. This program taps into current lifestyles by using common technologies (e.g. email, texting, mobile phones, desktop platforms) to promote involvement through an interactive website and rewards program.

On the website, members are asked to enter basic information about themselves including their due date, doctor, age, and member ID. Members are then directed to an interactive "Prenatal Board" that displays 13 blocks corresponding to various stages in the pregnancy where appointments are imperative to properly assess the unborn baby's and mother's health. Members are reminded about appointments twice via text or email according to their specified preference. After attending a doctor's appointment, the member clicks on the appropriate block. In certain appointment blocks, a gift box icon is visible in the bottom left corner to indicate that the member will receive a gift upon completion of that appointment. After the baby is born, a "Postpartum & Well-Child Board" appears. This stage has 10 blocks corresponding to doctor's visits throughout a 15-month period. There are four gift boxes within this interactive board.

The gifts associated with member's appointment completion are practical and inexpensive, but provide important incentives for mothers to engage themselves in their own care. The initial gifts for each board, $20 gift cards to Old Navy, a diaper bag, or Fisher-Price blocks, carry the highest value. At each milestone the mother has the option between two gifts. While some gifts, like books or stacking blocks, are for cognitive development purposes, others are important to keep baby healthy and safe. Among these types of gifts are a baby thermometer, first aid kit, bath spout cover, and childproofing kit.

PROGRAM AT A GLANCE

- ✓ Targeted services and incentives
- ✓ New technology

Objective:

- •Reduce rates of low birth weight and NICU admission
- •Reduce rates of maternal and infant/ child hospitalization
- •Increase timeliness and frequency of prenatal, post-partum, lead testing and well-child visits

Methods:

- •Two email or text reminders prior to and after scheduled appointments
- •Interactive board on website and mobile site to engage patients in their care
- •Reward program gives incentives to patients to schedule and attend appointments
- •Pregnancy and parenting tips provided at each checkpoint

Outcomes:

- •30% of eligible members enrolled in the program.
- •7,098 prenatal appointments logged
- •55% retention rate from prenatal board to postpartum board

Figure A: Milestones and Gifts for Baby and Mother

Milestones and Gift Options		
Milestone	**Option One**	**Option Two**
Baby Blocks Enrollment	Durable, Black Diaper Bag	$20 Old Navy Gift Card
24 Week Prenatal	Spout Cover for Baby Safety	Teething Rattle with Mirror
32 Week Prenatal	First Aid Kit	Pooh and Friends Blanket
Birth	Digital Baby Thermometer	Rubber Duck Bath Toys & Water Thermometer
Postpartum Visit	Fisher-Price Blocks	$20 Old Navy Gift Card
Six Month Well Child	Feeding Kit: Bowl, Fork, Spoon	Duke the Frog Bib
Lead Screening	Childproofing Kit	*Goodnight Moon* Board Book
15 Month Well Child	Shower and Bath Accessories for Mother	Lauri Soft Puzzle

OUTCOMES

Baby Blocks is still a new program, but initial results have been very positive. Pilot programs in Ohio, Pennsylvania, Rhode Island, and Maryland currently have 2,296 actively engaged members. These members have logged 7,098 prenatal appointments, and 55 percent of women who gave birth have now begun "playing" the "Postpartum & Well Child Board." Interim Pennsylvania quality measures indicate year-over-year improvements in both timeliness and frequency of prenatal care. In June 2012, the percentage of UHC Medicaid members making the recommended number of prenatal visits jumped 11 percentage points over the same time the prior year. The program recently expanded into Arizona, Florida, Michigan, and Tennessee to potentially reach 50,000 more members in 2013.

RESOURCES

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Prescription Management Program

BACKGROUND

Founded in 1985, Health Net, Inc. is one of the nation's largest managed health care companies with a network of 6.8 million members.[1] Based in California, Health Net's managed Medicaid program insures the second largest proportion of Medi-Cal members in the state.[2] Of the more than 675,000 enrollees, 70 percent are under the age of 19.[3] In order to better serve this population, Health Net has underaken an innovative program to reduce inappropriate prescription of antibiotics to children and adoslecents that has subsequently been extended to adults.

PROGRAM AT A GLANCE

✓ Targeted Benefits and Incentives

Objective:

- Reduce over-prescription of antibiotics to children and adolescents

Methods:

- Quarterly performance reports for physicians, including a list of patients who had been inappropriately prescribed antibiotics
- Educational materials, including clinical guidelines provided to "heavy prescribers"

Outcomes:

- Inappropriate prescribing has been reduced in all areas where measurements took place

METHODS

Overprescription of antibiotics, particularly to children suffering from upper respiratory infections (URIs), is a common problem in medicine that increases the risk of antimicrobial resistance. This is especially dangerous for children who need access to effective antibiotics throughout their lives.

Health Net has taken the following steps to combat this phenomenon:

1) Quarterly reports for Physicians – Each quarter Health Net sends a letter to physicians who overprescribed to patients. The letter includes a table that compares the physician's prescribing record to physicians in the same network. Included with the letter is the list of patients who were inappropriately prescribed medication for URIs.

2) Educational resources for heavy prescribers – Physicians who are in the top 20% of prescribers receive copies of relevant clinical practice guidelines related to the treatment of URIs and other common viral infections. Additionally, these physicians were provided with educational material for parents and patients, explaining the problems of over prescribing. Physicians also received "prescription pads" that include check-off boxes where doctors can "prescribe" over-the-counter medications and other home based treatments. Health Net expanded the pads to include space for physicians to write additional instructions, including how to avoid catching a cold.

OUTCOMES

As a result of Health Net'sefforts, rates of inappropriate prescriptions decreased. Physicians treating a high volume of children and adolescents who did not prescribe antibiotics to 80% of more of these patients following a URI diagnosis rose from 49.4% during the baseline period to 69.9% during the same period two years later. Improvements occurred in all counties where measurements were taken. Further, in February 2008, Health Net identified 235 physicians inappropriately prescribing, but by August 2009 the number had dropped to 80.

As a result of the program's success, Health Net has expanded the program to include inappropriate prescriptions to adults suffering from acute bronchitis.

RESOURCES

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"TeleSalud" Health Hotline

BACKGROUND

Molina Healthcare of California Partner Plan Inc., or simply Molina Healthcare, provides Medicaid services to California citizens in Riverside, San Bernardino, Sacramento, and San Diego counties. Of the approximate 198,245 people enrolled in Molina Medi-Cal plans, roughly 65% identify themselves as Latino, with 45% of individuals preferring to speak Spanish. To provide better healthcare for a large portion of their enrollees, Molina Healthcare provides bilingual and culturally appropriate services.

PROGRAM AT A GLANCE

- ✓ Patient and Caregiver Engagement
- ✓ Targeted Benefits and Incentives

Objective:

- Improve quality of care and access for Spanish speaking patients

Methods:

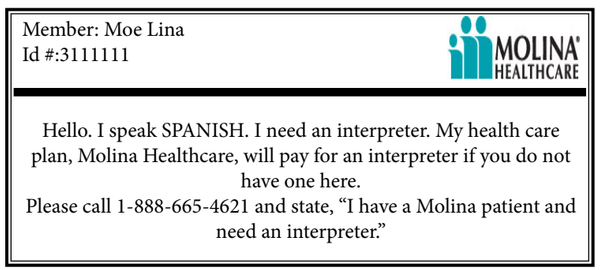
- 24 hour access to bilingual registered nurses
- Interpreter services
- Cultural training programs

Outcomes:

- Monthly cost savings of $2,500
- 26 less ER visits per 1,000 patients
- High patient satisfaction

METHODS

While evaluating a previous program, Molina Healthcare realized that only 2% of callers had been Spanish speaking on their outsourced nursing hotline. They found that patients were discouraged by automated help lines and often intimidated to seek proper care because of language barriers. In response to this deficiency, Molina started TeleSalud in 2004, a 24 hour bilingual nurse advice line. To teach enrollees about TeleSalud, Molina gives identification cards to all new members with the toll-free phone number and provides members with an easy to understand educational health booklet. Thirty bilingual operators take calls, and can transfer patients to talk to one of eight bilingual registered nurses to receive clinical advice, forming a two tiered service. TeleSalud also provides interpreters when patients are at clinical settings if the member shows their membership card. This is crucial as physicians are supposed to have interpreters available but often are unable to provide them.


Member: Moe Lina
Id #:3111111

MOLINA HEALTHCARE

Hello. I speak SPANISH. I need an interpreter. My health care plan, Molina Healthcare, will pay for an interpreter if you do not have one here.
Please call 1-888-665-4621 and state, "I have a Molina patient and need an interpreter."

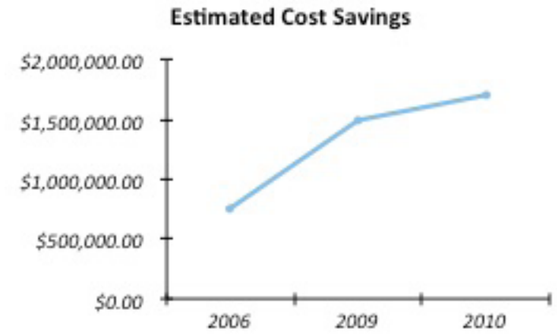
All calls are tracked in the centralized data system, and patients are called again the next day to follow up and provide any more guidance needed.

Since Molina Healthcare is grounded in Hispanic ownership, they have also formed the Molina Institute for Cultural Competency, which conducts research and provides support to providers in reducing health disparities. They schedule training sessions with network providers, and address any specific needs of their population, while improving their cultural knowledge. In addition to the core training, providers can also partake in special educational sessions such as "Access Issues for Rural Hispanics, Native Americans, and Socially Isolated populations." Ongoing support is provided through online resources and the publication "Partners in Care." These initiatives foster a corporate culture in their Medi-Cal program that addresses the patients' needs, and encourages adaptive behavior by providers.

OUTCOMES

Compared to Molina's previous nurse advice line, the TeleSalud program increased the volume of Spanish speaking patient users by 58%. The increase in calls was correlated with fewer ER visits. During the pilot, patients with TeleSalud averaged 191 visits per 1,000 members, while those without the program averaged 217 visits per 1,000 members. Fewer ER visits translated into cost savings, estimated around $2,500 per month. After full implementation, Molina estimated saving over $750,000 in 2006, $1.5 million in 2009, and $1.7 million in 2010. In addition to cost savings for Molina, an estimated 99% of all patients who called TeleSalud were satisfied with the service they received. Because of Molina's success, it now offers its self-operated nurse line to three outside organizations.

Figure A: TeleSalud Estimated Cost Savings 2006-2010



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UPMC Health Plan

UMPC "*For a New Beginning*" Maternity Program

BACKGROUND

The University of Pittsburgh Medical Center (UPMC) is a $10 billion health system that insures more than 1.8 million Pennsylvanians. UPMC for You, the company's managed Medicaid plan, is one of the most highly rated managed care plans in the nation and insures more than 156,000 low-income individuals.

From 2004 to 2007, the Center for Health Care Strategies worked with Medicaid providers, including UPMC for You, to reduce racial and ethnic health disparities. From this effort emerged the UPMC for a New Beginning Maternity Program, which is devoted to increasing the number of women who receive prenatal care. Research has shown that the benefits of prenatal care are strongest for socially disadvantaged women.

METHODS

Inadequate prenatal care has been associated with low-birth-weight infants, premature births, neonatal mortality, infant mortality, and maternal mortality. UPMC has developed several strategies to increase prenatal care among its member population.

In 2004, UPMC conducted focus groups with enrollees in Braddock County, the program's original site, and found a lack of knowledge about their maternity program. In order to improve community awareness, UPMC placed posters throughout the community and hired a mobile outreach representative to locate women who could not be reached by telephone.

PROGRAM AT A GLANCE

- ✓ Patient and Caregiver Engagement
- ✓ Targeted Benefits and Incentives

Objective:

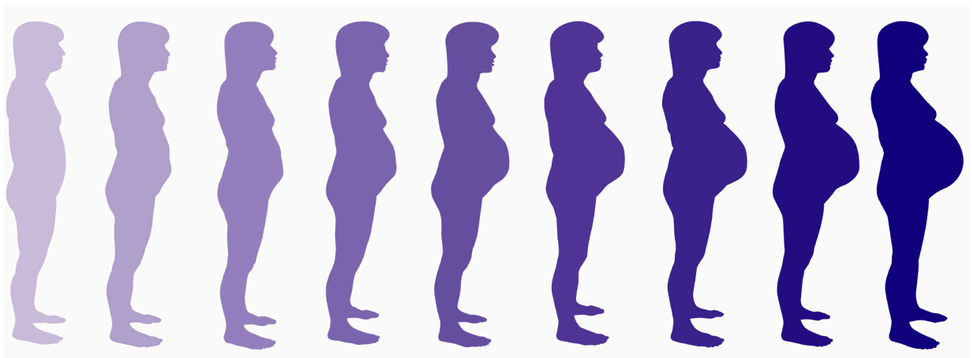
- Increase the number of women receiving prenatal care and improve birth outcomes, particularly among ethnic and racial groups

Methods:

- Spread awareness of the maternity program through posters in communities, mobile outreach, and the use of doulas
- Offer incentives for seeking prenatal care

Outcomes:

- First trimester identification increased from 20% to more than 40%
- During the pilot program, underweight births for African American women dropped from 20% in 2004 to 0% in 2005, and among all women from more than 20% to 8%.



Additionally, in 2006, UPMC introduced the Birth Circle Program, which enables enrollees to see doulas. Doulas are trained to provide non-medical, emotional and informational support before, during, and post pregnancy. The women who are recruited to be doulas come from the community, enabling them to better understand and serve the population.

UPMC for You offers women who complete the maternity program an infant car seat or a portable play yard. In order to be eligible for the rewards, enrollees must: visit a doctor within 13 weeks of pregnancy, enroll in the program before 34 weeks of pregnancy, keep all prenatal visits, have all routine lab tests ordered by the doctor, keep all phone appointments with a program representative, and sign and return a consent form.

OUTCOMES

UPMC for You has achieved positive results in expanding prenatal care and in reducing underweight births. In Braddock County, first trimester identification increased from about 20% in 2004 to more than 40% in 2005. Additionally low weight births for African Americans declined from more than 20% in 2004 to 0% in 2005. Among all women in the county, low weight births declined from more than 20% to about 8%.
For its efforts the National Committee for Quality Assurance has recognized UPMC for You with its "Recognizing Innovation in Multicultural Health Care Award."

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Anthem Blue Cross Telehealth

BACKGROUND

In California, 30% of the population is enrolled in Medicaid (Medi-Cal), and 55.1% of those people are a part of a managed care plan. As a major insurer, Anthem Blue Cross contracted with the L.A. Care Health Plan to provide Medi-Cal managed care services to residents in Los Angeles, as well as independently in 11 other counties in California.

PROGRAM AT A GLANCE

✓ New Technology

Objective:

- Increase access to specialty care for Medicaid patients

Methods:

- Provide specialty care to more residents by live video or store and forward consults

Outcomes:

- More than 32,000 specialty video consults for Medi-Cal patients

METHODS

According to the 2010 Census, 40.96% of California residents are considered to live in rural areas. These residents do not always have access to the proper care needed, therefore reducing health equity across the state. Access to specialists is a pervasive problem throughout the Medicaid programs, as reimbursement levels are often far below amounts paid by Medicare or private insurance. In California, only 57.1% of physicians accept new Medicaid patients, due to a low 56% reimbursement rate relative to Medicare, making it harder for individuals to find specialist care when they need it. Anthem Blue Cross addressed this problem in 1998 through a telemedicine initiative, becoming the only private health plan in California to support a comprehensive state wide telehealth program. Once patients are approved by their primary care physician and insurer, they can utilize telehealth in two ways:

1. Live video consult—the primary care physician and patient talk to a specialist through a live video conference.
2. Store and forward consult—medical data and images regarding a patient's condition can be sent to a specialist to solicit advice.

Figure A: Telehealth Care Model

If…	Then it's best suited for…
The specialist needs to interact with the patient	Live video
The specialist needs the presenter to manipulate the patient	Live video
Sufficient information (such as images, data, dictated comments, lab results) about the patient's condition can be assembled	Store and forward

Source: Anthem Blue Cross

The consults are conducted in one of 81 presentation sites, which are spread out throughout California. At the sites, primary care physicians can conference with any of the 34 specialists at 19 different centers. The most common specialties sought out in the program are optometry, psychiatry, dermatology, endocrinology, and pediatric neurology.

At each presentation site, Anthem Blue Cross ensures that there is at least one telehealth site coordinator. The coordinator is trained to use all of the telehealth equipment, identify patients who could benefit from the services, and ensure each patient gives informed consent before any consultation. All of this information is recorded, and a monthly utilization report log is sent to Anthem Blue Cross. In addition, both presentation and specialty sites maintain strict electronic medical record privacy, and adhere to any state and federal standards.

OUTCOMES

In October 2011, the Anthem Blue Cross Telehealth program fostered more than 32,000 specialty consultations for Medi-Cal patients. One dermatologist said she had held more than 2,500 consults in the past 10 years, helping people who otherwise would have had no access to specialty care. The telehealth program also produced a high level of patient satisfaction as shown by one patient's comment that: "This appointment was very insightful, both in technology and personal information. It made me feel like I have much more will to keep fighting my disease." The program has been successful ensuring access to specialists for patients who may not have been able to get in-person appointments.

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Innovations For Dual EligibleS

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Care Improvement Plus Special Needs Plan

BACKGROUND

XL Health is a leader in managed care, specifically providing special needs plans (SNPs) for Medicare beneficiaries with chronic conditions (C-SNPs) and low income seniors. XL Health plans exist for those patients who are jointly eligible for Medicare and Medicaid (dual eligibles) as well as Medicare-eligible adults with chronic conditions. The Care Improvement Plus SNPs are available for those eligible for Medicare who also have a diagnosis of diabetes or heart failure and focus on better managing those conditions.

METHODS

Care Improvement Plus plans use a variety of strategies to better manage their diabetes and heart failure patients. Like many MA plans, Care Improvement Plus SNPs cover more than the required services and include vision, dental and podiatry services. The value of this plan lies in the repeated interactions with providers in order to manage all aspects of the patient's disease, including end of life care. Key components of the plans include:

House Calls:

Patients receive a house visit from a physician or nurse practitioner within 45 days of enrolling in the plan as well as a visit if they are discharged from the hospital. This is convenient for patients and allows the clinician to better understand the patient's living situation and care needs.

Nurse Care Management:

Nurses interact with patients via 24 hour hotlines and coaching calls, as well as coordinate care among the patients' many providers through teleconference calls.

Advanced Illness Program:

Nurses who are skilled in end of life care work with patients and caregivers to determine their wishes for care at that point. The nurses can help arrange advance directives, hospice and or palliative care.

PROGRAM AT A GLANCE

- ✓ Remote monitoring/Home care
- ✓ Care Coordination
- ✓ Targeted Benefits and Incentives

Objective:

- Better care for plan enrollees with diabetes and/or heart failure and those dually eligible for Medicare and Medicaid.
- Providing care that is affordable and accessible to these hard to reach populations.

Methods:

- All enrollees receive house calls from a physician or nurse practicioner
- 24 hour nurse hotlines
- Additional services covered including vision, dental and podiatry.

Outcomes:

- A comprehensive study published in Health Affairs found that plan enrollees with Diabetes, when compared to a similar population using FFS Medicare, had higher physician visits and fewer hospitalizations.
- The results were even more pronounced among non-white patients.

OUTCOMES

Care Improvement SNP has been successful in getting its plan enrollees to visit their doctor, and as a result they experience fewer hospitalizations. A study comparing risk adjusted plan members with diabetes to a group using traditional fee for service (FFS) Medicare beneficiaries was recently published in Health Affairs. Researchers found that, in total, SNP plan members had 7 percent more office visits than their counterparts on FFS Medicare and the difference was greater among non-white enrollees, with 26 percent higher visits. Overall, SNP enrollees had 19 percent fewer hospital days, an effect that, like the office visit data, was more pronounced in non-whites, as non-whites had 27 percent fewer hospital days than their FFS counterparts. Readmission data, shown in Figure A, was also different between the two groups with 21.1 percent of all diabetes patients in 5 states for SNP enrollees versus 26.7 of diabetes patients served by traditional Medicare in these 5 states. The results suggest that the Care Improvements Plus SNP is more successful than traditional Medicare at managing Diabetes and that the differential is even greater when looking at minority enrollees.

Figure A: Comparing Readmission Averages

Readmissions per admission	XL Health SNP %	FFS Medicare %
All diabetes patients		
Five states combined	21.1	26.7
South Carolina	19.9	24.4
Georgia	21.1	24
Texas	22	28.2
Missouri	22.9	26.7
Nonwhite diabetes patients		
Five states combined	21.5	28.8
South Carolina	20.6	25.8
Georgia	20.8	25.8
Texas	23	29.5
Arkansas	23	28.3
Missouri	26.4	33.3

RESOURCES

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PRESBYTERIAN

Hospital at Home Program

BACKGROUND

Presbyterian Health Services (PHS) is based in Albuquerque, New Mexico and has been in business for over 100 years. The company is New Mexico's only private non-profit healthcare company and now runs 8 hospitals and covers 650,000 lives. After reading about the Hospital at Home program developed by researchers at Johns Hopkins School of Medicine and Public Health, PHS implemented their version of the program in 2008. PHS first opened the Hospital at Home program to Medicaid Managed Care and Medicare Advantage plan members, and expanded to additional commercially insured patients in 2010.

METHODS

Hospitals are not only very expensive, they can be dangerous for seniors in poor health for a variety of reasons. There are risks of falls, functional decline, hospital-acquired infections, and it is difficult to manage the transition from the hospital to post-acute care or to the home.
Patients qualify for the Hospital at Home program if they meet the following criteria.

1. A diagnosis of one of the qualifying acute conditions: exacerbations of congestive heart failure, chronic obstructive pulmonary disease, community-acquired pneumonia, cellulitis, deep venous thrombosis, pulmonary embolism, complicated urinary tract infection, nausea and vomiting, or dehydration
2. The patient is sick enough to be hospitalized but does not need an Intensive Care Unit
3. Resides within 25 miles of a participating hospital in Albuquerque

The above-listed conditions were chosen because they result in frequent hospitalizations but can be appropriately treated within the home.

A patient can come into the Hospital at Home program from an emergency department or urgent care center or can be referred from home health providers or other physicians.
If needed, they are transported home and the program's staff arranges for any necessary equipment to be delivered. From that point they are visited every day by a physician who is only responsible for five patients and who is available at all hours in the case of an emergency. Nurses also visit once or twice daily to administer medication and check in on the patient. At other times, clinicians are available via telephone and a telehealth unit that has a blood pressure monitor, glucometer, oximeter, stethoscope and videoconferencing abilities.

Discharge is similar to a patient being discharged from a hospital, with the program staff and clinicians coordinating discharge instructions, follow-up appointments, communicating with the primary care provider and handing the patient off to any post-acute care. Most of the patients go from having the Hospital at Home to having less intensive home health care.

PROGRAM AT A GLANCE

- ✓ New Technology
- ✓ Targeted Benefits and Incentives

Objective:

- Reduce costs and increase patient satisfaction by treating patients who would traditionally be treated in a hospital in their homes.

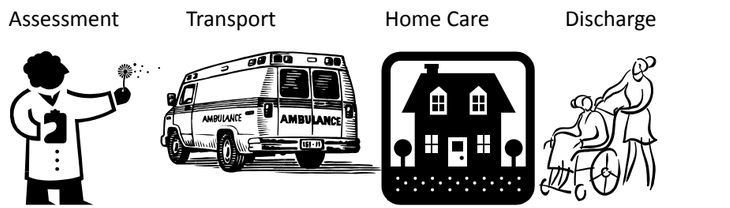
Methods:

- Rather than admitting certain patients to the hospital, the PHS sends them home with clinicians and equipment so they can receive hospital-level care in their homes
- Have physicians and nurses visit as well as use telehealth
- Quality metrics are measured and recorded as they would be in a hospital
- Coordinated discharge process involving post-acute care providers and primary care physician

Outcomes:

- Costs were 19 percent less than the comparable hospitalized group
- Hospital at Home participation was correlated with a 38 percent reduction in mortality at 6 months when compared with hospital admission
- A nearly 50% reduction in readmissions after one year of implementation.

Figure A: The Hospital at Home Model



OUTCOMES

After the original implementation of the program an assessment found that most hospital admissions occurred on the weekends when, originally, physicians were not available and they then altered the program to provide physician coverage 7 days a week. A *Health Affairs* study looking at PHS's Hospital at Home program saw a 19 percent reduction in cost for those patients treated at home. An additional meta-analysis of the program found that participating in Hospital at Home was correlated with a 38 percent reduction in mortality at 6 months. Patient satisfaction was higher among Hospital at Home participants than for the control group at the hospitals.

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Universal Healthcare Nursing Home Diversion Program

BACKGROUND

Universal Health Care Inc. is a Florida-based firm that provides managed care plans for the Medicare and Medicaid population. Florida has waivers that allow their Medicaid eligible adults with long-term care needs to receive non-institutional care in other settings, including a nursing home diversion waiver. Medicare and Medicaid benefits are then administered through private companies who are paid a capitated rate per patient. Universal Healthcare Inc.'s Nursing Home Diversion Program is available to seniors in Florida who are dually eligible for Medicare and Medicaid and have long-term care needs that would qualify them for nursing home care.

PROGRAM AT A GLANCE

- ✓ Care Coordination
- ✓ Remote Monitoring/Home care

Objective:

- Allow patients to stay at home or in community living arrangements rather than enter nursing homes

Methods:

- Provide comprehensive services that go beyond medical care or help with the Activities of Daily Living in the home.
- Specific services needed by Florida residents such as hurricane preparedness.
- Case managers with low caseloads, with an alternative case manager on call at all times.

Outcomes:

- A study done by Florida's Office of Program Policy Analysis and Government Accountability found that seniors recieving care in the home or community cost over $2300 less per month than their counterparts in nursing homes.

METHODS

The Nursing Home Diversion Program provides services comparable to what a senior might receive in a nursing home, well beyond traditional medical benefits, but provides those services in the home or assisted living facility (ALF). If the senior resides in an ALF, the plan will pay part of the cost. Each enrollee is assigned a case manager who will work with the patient and their family to determine the Plan of Care. A patient's specific case manager is available during office hours but one is always available via emergency cell phone.

Long-term care services

The services available to enrollees are not only long-term care services that help with Activities of Daily Living (ADLs) but also include risk reduction assessments, home accessibility alterations, adult companions, in-home help with chores, delivered meals, family training and escorts. These services would never be covered by traditional Medicare but are necessary to keep seniors with functional limitations in their homes or assisted living facilities. Seniors on the plan are dual eligible for Medicare and Medicaid, which requires them to have low or moderate income and low assets; thus, they may not be able to afford the auxiliary services or equipment they need to live comfortably at home. The plan is able to provide those necessary services and still care for them at costs far below that of nursing home care. Additionally, the plan offers services like hurricane preparedness that are specifically helpful to their coastal Florida enrollees.

Medical Services

The plan offers medical services such as dental, vision, and hearing services that go beyond what the Fee for Service Medicare plans cover. In addition, there is a 24 hour nurse hotline available to any Universal Healthcare plan member.

OUTCOMES

The plan ensures quality by regularly giving plan members surveys to verify that their needs are met and that they are satisfied with the services.

Florida's Office of Program Policy Analysis and Government Accountability studied all of the waiver programs throughout the state and found that, on average, those receiving care in the community cost $2,349 less per month than those in institutional care and noted in their report that these programs effectively delayed nursing home placement.

RESOURCES

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The Senior Care Options Plan

BACKGROUND

Commonwealth Care Alliance is a Massachusetts not-for-profit care delivery system, created in 2003 by Robert J. Master to serve special needs populations. Commonwealth Care Alliance focuses exclusively on the care of Medicare and Medicaid's most complex and expensive beneficiaries. In 2003 Commonwealth Care Alliance partnered with Massachusetts Medicaid to develop the Senior Care Options Plan. The Senior Care Options Plan has developed innovative solutions to care for the unique and costly dual eligible population by aligning payment incentives, and delivering coordinated, patient-centered health care.

PROGRAM AT A GLANCE

- ✓ Targeted Services and Incentives
- ✓ Care Coordination

Objective:

- Deliver tailored care through aligned payment initiatives and consistent management of disease. Reduce emergency room visits and hospitalizations.

Methods:

- Primary care teams evaluate enrollees to determine medical, behavioral, and social needs
- Tailors a program of care to a particular patient based on the PCT assessment
- Provide nontraditional services that benefit overall health

Outcomes:

- Fewer admissions and shorter hospitalizations
- Higher medication reconciliation rate after discharge
- Fewer ICU days per patient

METHODS

In order to join the Senior Care Options plan, adults must be Medicare and Medicaid eligible, and live within the Commonwealth Care Alliance service area.

Members who qualify for the program are divided into four groups based on the clinical severity of their condition. The four designations are: patients in institutional settings; patients living at home but eligible for nursing home care according to Medicaid criteria; patients with Alzheimer's disease or another chronic mental illness; and relatively well, generally ambulatory patients with a common array of aging-related chronic care conditions.

Once a patient's clinical severity has been evaluated, they are appointed a primary care team (PCT). This primary care team is made up of a primary care physician (PCP), a nurse practitioner, and a geriatric support service coordinator. However, unlike most care team models, the nurse practitioner, as the care coordinator, serves as the lead. As one physician working within the plan's network put it, "I am not the head of the primary care team, the nurses are."

Upon enrollment, this PCT further evaluates the member's conditions. The nurse practitioner and PCP assess the medical, behavioral, and social circumstances of each member. Geriatric support service coordinators evaluate each member's capabilities to determine whether community-based services, such as transportation, adult daycare, and meal preparation and delivery, are needed. The geriatric support service coordinator also evaluates home safety and if proper family caregiver support is present.

The Senior Care Options Plan is able to provide many non-traditional services because of the freedom in its contract with Commonwealth Care Alliance. With this freedom, the PCT can authorize services, not covered by most plans, without worrying if the prescribed services will be reimbursed. Acupuncture, massage, and even transportation to church on Sundays have been authorized in the past.

Many nurse practitioners make unscheduled house calls to check up on the patient and their living conditions, provide guidance, and answer any questions the caregiver may have. In addition, beneficiaries are able to make same-day appointments to see the nurse practitioner.

OUTCOMES

The plan was evaluated using data from 2009 to 2011. In this time period, the rate of medication reconciliation after a hospital discharge increased from 45 to 76 percent. Thirty-day hospital readmission rates declined from 20.2 percent in 2009 to 18.1 percent in 2010. Average hospital length of stay fell from 5.21 days to 5 days. A more recent focus of this plan has been to help patients better and more proactively manage preferences for end of life choices. Since this effort started in 2009 there has been a 16 percent increase in patients dying at home. Intensive care unit days per decedent also dropped from an average of 2.72 to 1.5 days.

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