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INTEGRATED PATIENT-CENTERED CARE MANAGEMENT IN THE MEDICARE SUPPLEMENT POPULATION

A VIABLE SOLUTION TO FRAGMENTED CARE AND ESCALATING COSTS

MARSH & McLENNAN COMPANIES

EXECUTIVE SUMMARY

- Results of a voluntary care management pilot program suggest that using a patient-centered approach, focused on the needs and personalized goals of the patient (patients participating in the program), reduces care fragmentation while lowering Medicare and patient out-of-pocket costs.
- Care coordination and assisting the patient and family with navigation beyond just medical treatment increases patient satisfaction and supports the ability to live independently longer.
- This approach is promising and can be implemented in the current fee-for-service environment while the transition to a fee-for-value delivery system is under way.

THE PROBLEM

One of the greatest problems facing health care in America today is the rapidly increasing number of older adults struggling with multiple chronic conditions. These "poly-chronics" see many different health care providers in many care settings. According to the Congressional Budget Office,[1] annual growth in health care spending has outpaced growth in Gross Domestic Product (GDP) by an average of 1.5% since 1985, and net government expenditures for health care are projected to increase from 4.6% of GDP in 2013 to 8% in 2038 — more than half of which would be spent on Medicare.[2]

Of the 50 million Americans covered by Medicare, 20% choose to purchase a Medicare supplement insurance plan (typically referred to as a "Medigap" plan) to help defray out-of-pocket expenses from copayments, coinsurance, and deductibles associated with Medicare coverage.[3,4,5] Consumer surveys indicate that beneficiaries value the supplemental benefit because it fills gaps in their Medicare coverage without restricting the providers they can see.

While older Medicare beneficiaries generate some of the highest health care costs due to their numerous health conditions and are at risk for poor outcomes, more could be known about the complexity of issues this population faces. In order to better serve this population and achieve a more coordinated care management experience, additional research is needed to understand their demographics, lifestyle choices, socioeconomics, family/caregiver support systems, condition prevalence, and — most important — what these individuals want and hope for as they face health issues that come with aging. Until recently, very few attempts have been made to help fee-for-service beneficiaries with multiple health issues effectively manage their health by providing care coordination. New and better tools and/or services specifically developed for the aging population are critical to meet this growing demand for healthier and less costly aging.

[1]Congressional Budget Office. The 2013 Long-Term Budget Outlook, available at http://cbo.gov/sites/default/files/cbofiles/attachments/44521-LTBO2013_0.pdf.

[2]deBruyn J. "Blame the ACA as Health Care Spending Increases Relative to GDP" (Nov. 5, 2013), Triangle Business Journal, available at http://www.bizjournals.com/triangle/news/2013/11/05/blame-the-aca-as-health-care-spending.html.

[3]The Henry J. Kaiser Family Foundation. Total Number of Medicare Beneficiaries, available at http://kff.org/medicare/state-indicator/total-medicare-beneficiaries.

[4] AHIP Center for Policy and Research. Trends in Medigap Coverage and Enrollment, 2012 (May 2013), available at http://www.ahip.org/trends-medigap-coverage-enroll2012.

[5] Jaffe S. "Officials Looking to Cut Federal Spending Eye Medigap Policies" (Nov. 21, 2011), Kaiser Health News, available at http://www.kaiserhealthnews.org/stories/2011/november/22/medigap-and-federal-policies.aspx.

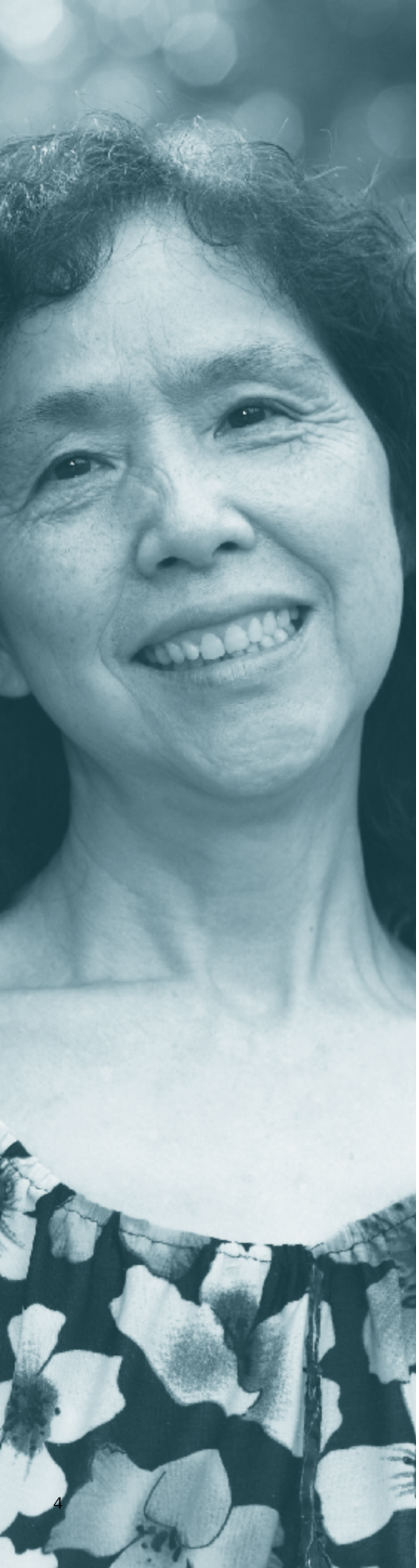
KEY FINDINGS

1. While not a silver bullet for improving quality or reducing costs, a consumer-engagement strategy can work toward these goals. It requires building a trusted relationship and focusing on living well at home, inclusive of the patient's personal environment, family, and caregivers. This is not an easy task, but keeping the focus on the patient's needs can yield better outcomes and reduced costs.

2. Programs that focus on the coordination of care delivered through the consumer have been underutilized to date, but with the right approach they can address the fragmentation and growing costs of health care.

3. To date, the Medigap population — as a potential opportunity to address Medicare fee-for-service program challenges — has been largely ignored despite the population being nearly two-thirds the size of the Medicare Advantage population, and about the size of the dual-eligibles population.

4. The Medigap plans can be utilized/considered for more than simply transactional secondary payer activities.



A UNIQUE APPROACH

While some Medicare Advantage plans have demonstrated improved cost and quality with care-coordination efforts, many have questioned whether this could be achieved within the Medigap plans while still preserving freedom of choice to beneficiaries. Unlike Medicare Advantage plans, fee-for-service Medicare and Medigap plans do not have the traditional levers of narrow provider networks, negotiated fees, and benefit design to help facilitate provider navigation. In contrast, fee-for-service Medicare and Medigap plans (for those consumers who enroll in them) preserve freedom of choice with the standardized Medicare benefit structure, which means consumer engagement in health management support becomes the dominant lever for improvement.

Those who serve the aging population have long known about the problems associated with caring for individuals with chronic conditions — a population that is challenged to stay independent for as long as possible. To address this, AARP Services Inc. (ASI, a taxable subsidiary of AARP) and UnitedHealthcare (UHC) joined forces as part of a health care transformation initiative, with the goal of gaining a better understanding of the characteristics, needs, and general health of older adults who purchase Medigap coverage. Equally important, the initiative strove to test whether UHC could enhance care coordination and the delivery of services to Medigap insureds with complex needs, while managing costs and improving their quality of care. After several years of monitoring the program, results suggest that delivering care coordination through a Medigap plan has great potential in creating concrete change in the current health system.

THE PROGRAM

In 2008, pilot programs ("pilots") were created, focusing on Medicare beneficiaries with chronic diseases who enrolled in AARP™ Medicare Supplement Insurance Plans insured through UnitedHealthcare. The objectives of the pilots were to improve the experience of care, make a meaningful difference in the AARP Medicare Supplement Plan insureds' daily lives, and demonstrate a social impact — the latter of which could be accomplished by improving care affordability through the provision of guidance, navigational help, and support to address both the health and the other personal needs of participating insureds. While the pilots sought to examine how well existing tools and services benefited this population, a critical goal was to test new approaches. This "test and learn" philosophy was implemented to reveal both successes and failures among all pilot features to help keep pace with the changing world of health care delivery and make adjustments as needed.

The pilots utilized various case management, disease management, and depression management program components to determine how best to support the care of AARP Medicare Supplement Plan insureds with complex needs. Participation was voluntary and was provided at no

additional cost to the insureds. Those selected ("participants") were at least 65 years of age and the more complex patients (that is, they had multiple conditions and/or life-threatening illnesses). Each participant was supported through a trained team of nurses, social workers, behavioral health specialists, and medical directors. Initial care assessments were performed either in the home or over the phone.

ASI and UHC believed that a consumer-centric approach focusing on care coordination and navigation, beyond just medical treatment, would not only help the consumer but could also reduce variation and provider costs — and ultimately, Medicare program costs. Resources were built around the patient's needs and personal goals. Importantly, sometimes these goals were oriented toward social, rather than clinical, objectives, such as attending a granddaughter's graduation or being able to live at home. Participants received personalized care plans developed by their nurse/case manager in collaboration with their physician and caregiver(s). In some pilots, trained social workers assisted participants with social services, such as facilitating in-home assessments, coordinating meals and social activities, and identifying transportation options. In others, technology and innovation played an important role, with initiatives that included in-home monitoring devices for patients with congestive heart failure.

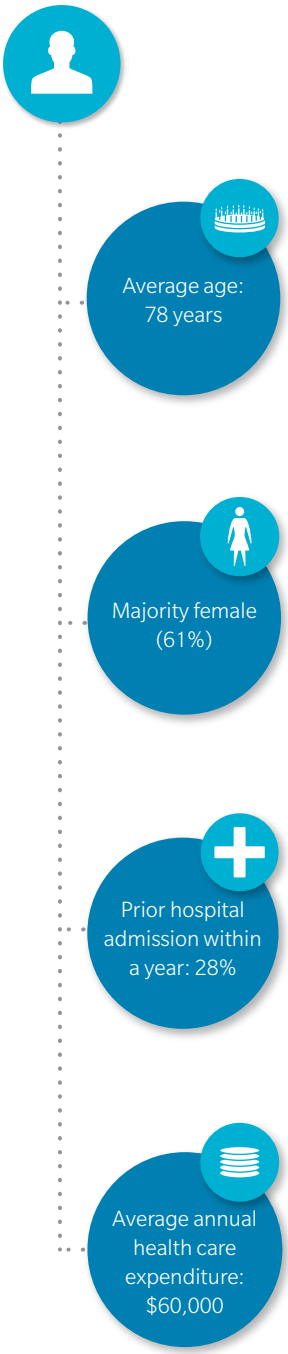
PILOT RESULTS

The evaluation of the pilot programs showed that comprehensive case management, depression care, and remote monitoring of congestive heart failure in particular hold the greatest promise in transforming health care for older individuals with some of the most prevalent health conditions. Standalone telephonic disease management, however, was not successful in reducing costs and it did not adequately address issues of greatest concern to Medigap users, their families, and caregivers in terms of coping successfully at home and staying independent while dealing with serious health conditions.

Between 2009 and 2012, more than 28,000 AARP Medicare Supplement Plan insureds participated in the pilot programs. Approximately 7,000 active participants were enrolled in the pilots each month. Along with a high satisfaction rate among participants, other noteworthy findings included:

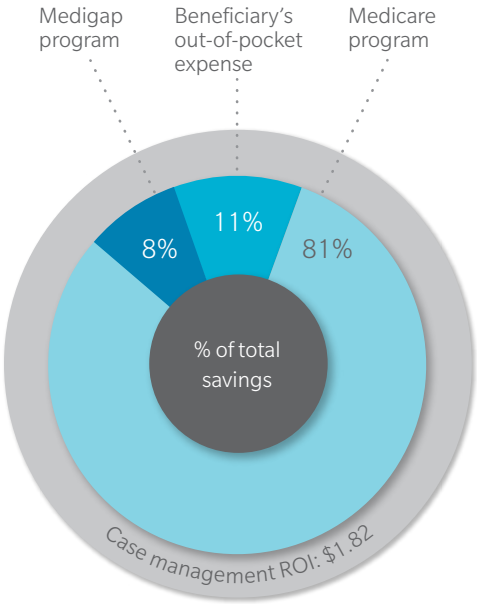
- Financial results tended to be more favorable for those participants who received the most intensive interventions through case management ($1.82 ROI) and depression management ($1.67 ROI), as compared to the disease management programs and telephonic case management, which did not result in a positive return on investment.
- Savings accrued predominantly to the Medicare program itself (81% of total savings) and to a lesser extent to the Medigap program (8%) and the beneficiary's out-of-pocket expense (11%).

PILOT PARTICIPANT PROFILE



- Participants who received interventions that included a component of remote monitoring by nurses experienced a significant reduction in hospital readmissions.
- Participants who received face-to-face case management were more likely to keep up with recommended annual office visits and laboratory tests and avoid drugs not suitable for the elderly — and they demonstrated better understanding of how to better manage their conditions after participating.
- Participants in the face-to-face case management program experienced a reduction in hospital readmissions and were more compliant with office visits.
- Clinical support for depression resulted in an average reduction in overall depression symptoms.

SAVINGS DISTRIBUTION



Of significant importance is the revelation that patients feel they are more than merely discrete "diseases" — they see themselves as individuals trying to succeed with multiple complex conditions. AARP Medicare Supplement Plan insureds valued the pilots because they provided a means to stay independent at home. Specifically, the program showed that individuals needed and wanted as much support with nonmedical aspects of care — such as transportation, social-network development, home improvement, and nutrition — as with medical aspects of care. High participant satisfaction rates, increased use of appropriate services, and a greater understanding of what insureds perceived as quality care were demonstrated when the program delivered care that centered on those things that insureds valued as meaningful and necessary to coping and living successfully. Furthermore, participants reported that their quality of life improved as a result of participating in the pilots, and they also said they were better able to manage their pain.

Building on the promising findings to date and making adjustments based on lessons learned, ASI and UHC have evolved these programs into a new, more comprehensive program. The new focus of the program is aimed at providing "whole person" support by focusing on both physical and mental health, with a special emphasis on targeting a participant's personal goals and needs, such as living independently.

The new comprehensive care management program consists of both telephonic and in-home care management support, to include co-morbid depression care and remote monitoring for those insureds with congestive heart failure. Care management is provided by a team of clinical support staff, led by a licensed registered nurse, who is the engaged insured's primary point of contact and care-coordination navigator. In order

to achieve the insureds preference to live well at home, the "whole person" approach includes, but is not limited to, services outside of the typical medical management of various conditions, such as:

- Assessment of medical and psychosocial needs and strengths.
- A plan of care based on the participant's personal goals.
- Assessment and support of caregiver(s) needs.
- Social worker services (for example, helping arrange financial assistance, transportation, and other logistical planning).
- Home safety checks, with home improvement referral services as needed.
- Nutritional advice, with meal preparation services, as needed.
- Advance-care planning, including medication review and management.
- Specialty and ancillary referrals (for example, dental, vision, hearing, and/or physical therapy services).
- Social support and networking.
- Use of "storytelling" to assist with improving the individual's sense of self-worth.

IMPLICATIONS FOR FUTURE OPPORTUNITIES AND HEALTH CARE POLICY

This study shows that:

- The perceptions and experiences of fee-for-service Medicare as a traditional, transaction-based system can shift to a personalized service that incorporates partnership, family support, and navigational help while preserving freedom of choice to match individual values (that is, the ever-pressing goal of transforming US health care into a fee-for-value model).
- The consumer-engagement approach can improve health outcomes and health care affordability, bringing savings for the Medicare program and reduced cost for the AARP Medicare Supplement Insurance Plan policyholder through reduced out-of-pocket expenses and stable premiums. More research and efforts are warranted to support additional private/public partnerships, such as between traditional Medicare and Medigap plans, to improve the well-being of Medicare beneficiaries and affordability of Medicare. A program such as the pilots described in this paper is something that can be implemented in the current fee-for-service environment while the transition to fee for value is under way.

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Mercer was retained by AARP Services Inc. (ASI) to provide guidance on the program evaluation design of care management pilot programs for Medicare beneficiaries enrolled in AARP Medicare Supplement Insurance Plans insured through UnitedHealthcare and to help interpret the results of the program evaluation based on information and materials provided by UnitedHealthcare. Mercer was retained by ASI to produce this paper, including the development of the content, layout, and final production.

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