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PATHWAY TO DISCOVERY FOR THE PROFESSIONAL CASE MANAGER

Collaborating for care: Embedded case managers, extending care management value

Randall Krakauer, MD, FACP, FACR
Vice President, National Medical Director
Medicare Strategy, AETNA

Patrice Sminkey
Chief Executive Officer
Commission for Case Manager Certification

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PATHWAY TO DISCOVERY FOR THE PROFESSIONAL CASE MANAGER

Agenda

- Welcome and Introductions
- Learning Objectives
- **Patrice Sminkey**, CEO, the Commission
- **Randall Krakauer**, MD, FACP, FACR, vice president, national medical director, Medicare strategy, AETNA
- Question and Answer Session

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Audience Notes

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- Please use the "chat" feature below the slides to ask questions throughout the presentations. We will pose questions after the presentation and will address as many as time permits.
- A recording of today's session will be posted within one week to the Commission's website, www.ccmcertification.org
- One continuing education credit is available for today's webinar only to those who registered in advance and are participating today.

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Learning Objectives Overview

After the webinar, participants will be able to:

- Describe the potential value of collaboration, specifically in Medicare Advantage programs;
- Explain how collaboration works to better align incentives and resources: What is important? What is the end game?
- Discuss the importance of care management and data;
- Explain the value of collaboration and the clinical team, including the role of dedicated embedded case managers; and
- Discuss the impact on quality, patient satisfaction, provider satisfaction and costs of such a program, and how it can support better care, better population health and lower costs.

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PATHWAY TO DISCOVERY FOR THE PROFESSIONAL CASE MANAGER

Introduction

Patrice Sminkey
Chief Executive Officer
Commission for Case Manager Certification

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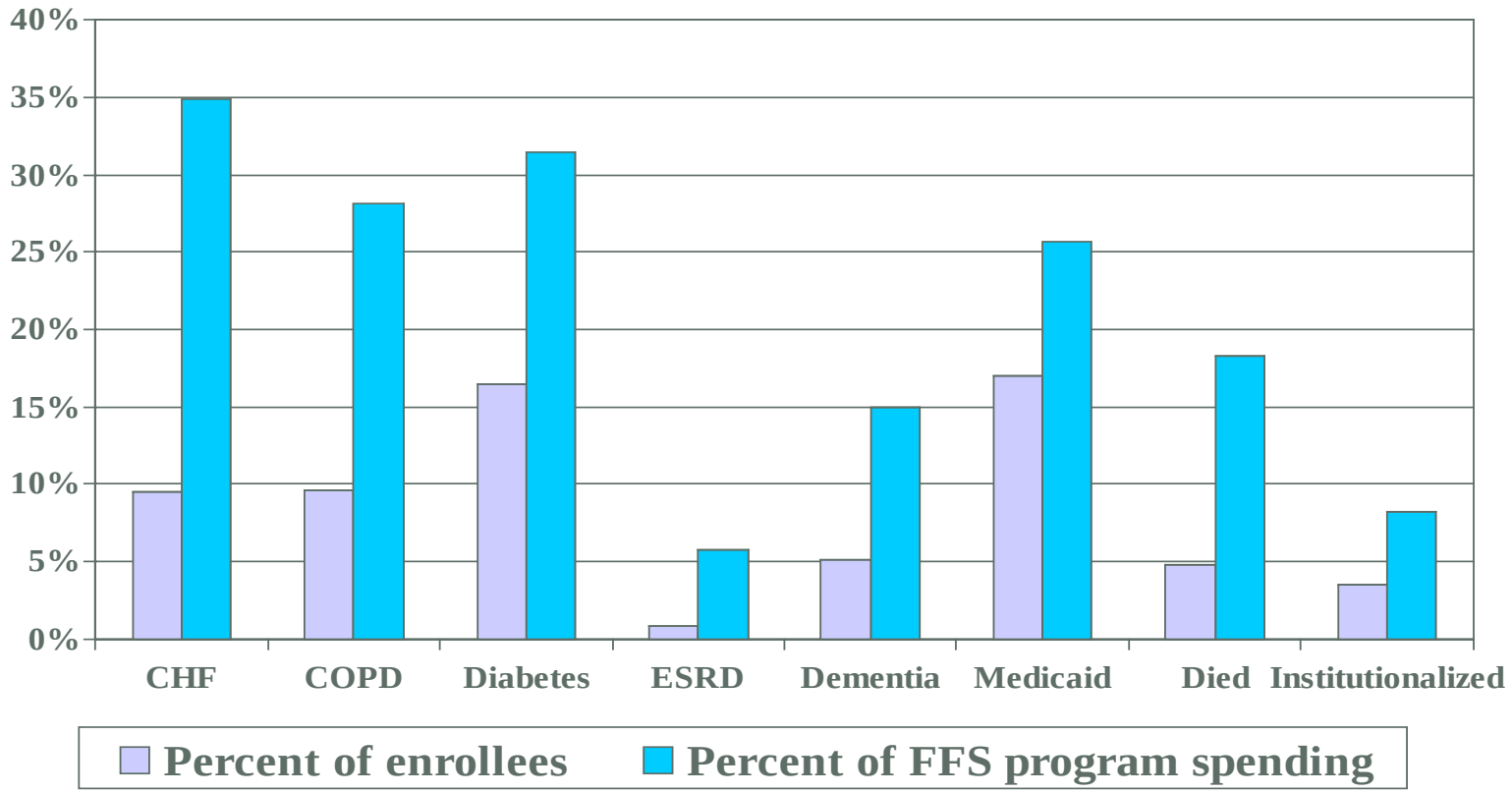
Aetna Medicare Physician Collaboration

We want you to know℠

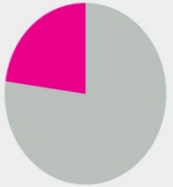
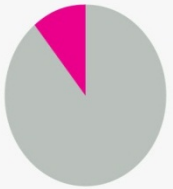
Medicare Medical Management: "Round up the Usual Suspects"



Source: C. Hogan and R. Schmidt, MedPAC Public Meeting, Washington, DC, 18 March 2004. Based on a representative sample of FFS enrollees and all their claims. Beneficiaries may be in multiple categories. Spending is for all claims costs, including treatment of beneficiaries' co-morbid conditions.

Chronic Conditions & Cost Distribution in Medicare Beneficiaries

In the elderly conditions occur in combination: cost and quality is driven by a population with multiple concurrent conditions

Chronic Co-Morbid Conditions	Percent of the Population	Percent of Total Cost	
> 4	20%	66%	
3-4	27%	23%	
0-2	53%	11%	

Source: Medicare 5% Sample, 2001

Why Older Patients Require More Medical Management

Many factors make the impact of illness greater for an older patient than a younger patient with a comparable condition. All factors must be identified and managed.

Factor	Impact
▪ Prevalence of high-risk conditions	▪ Greater burden of disease
▪ Greater incidence of comorbidities	▪ Increased need for medical care
▪ Less identifiable symptoms	▪ Greater need for surveillance
▪ Greater potential for damage from injury or condition	▪ Increased need for condition management
▪ Reduced ability to recover from injury or condition	▪ Greater need for preventive condition management
▪ Less ability to follow a medical regimen	▪ Greater intensity of medical management
▪ Less family and social support	▪ Increased need for outside help

Quality – Medical Management Approach

Enabling effective care of seniors with multiple conditions and reducing preventable hospital admissions

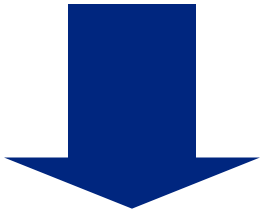
Holistic, Integrated Approach

Elements	Impact
▪ All new members receive a Health Risk Assessment (80% completion rate) **and** monthly predictive modeling ▪ Those identified receive Comprehensive Screening and Management	▪ Enables identification/management of all conditions and barriers to address the whole person ▪ Provides greatest impact with all comorbidities and issues managed concurrently
▪ Enrolled 18% of members in Care Management ▪ New programs for Home Case Management and Institutionalized members piloted	▪ Aetna **preventable admissions in core markets are going down year over year** ▪ Admissions are **below the Medicare FFS level.**
▪ Nurses, Social Workers, Behavioral Health, Disease Management Specialists are all trained in Geriatrics and Change Management	▪ Provides a uniform, effective and integrated strategy for members with multiple conditions and psychosocial barriers
▪ We provide specialized programs: – Advanced Illness – Transitional Care Management – Chronic Illness	▪ Expands successful medical management to more high risk and vulnerable populations. Disease Management is a component of a comprehensive Care Management program.

Example of Specialized Care Management Program: Aetna Compassionate Care

- Care management by specialty trained nurse case managers to handle physical, emotional, spiritual and culturally-diverse needs of patients in advanced stages of disease

- Provides:
  - Advanced planning, directives and support
  - Emotional support and pain management
  - Choices, alternatives, use of hospice care



Aetna Compassionate Care Results: Medicare

- **Program transposes traditional acute and hospice numbers**
  - **81% of Medicare members in Compassionate Care Program elected hospice care**
  - **18% deaths in acute or sub-acute facilities**
  - **82% reduction in acute days, 88% for intensive care days**
  - **High level of member and family satisfaction**

Results: Member Discussion
Example of Why Compassionate Care Shows Impact

- *Wife stated member passed away with Hospice. Much emotional support given to spouse. She talked about what a wonderful life they had together, their children, all of the people's lives that he touched - they were married 49 years last Thursday and each year he would give her a piece of jewelry. On Tuesday when she walked into his room he had a gift and card laying on his chest, a beautiful ring that he had their daughter purchase. She was happy he gave it to her on Tuesday - on Thursday he was not alert. She stated through his business he touched many peoples' lives, and they all somehow knew he was sick, and he has received many flowers, meals, fruit, cakes - she stated her lawn had become overgrown and the landscaper came and cleaned up the entire property, planted over 50 mums, placed cornstalks and pumpkins all around. She said she is so grateful for the outpouring of love. Also stated that Hospice was wonderful, as well as everyone at the doctors office, and everyone here at Aetna. She tells all of her friends that "when you are part of Aetna, you have a lifeline." Encouraged her to call CM with any issues or concerns. Closed to Case Management.*

Enhanced Value Compensation: Quality Measures

- Higher health care cost is not related to better quality (Baicker et al, Health Affairs 10/7/04)
- Will payment incentives alone (pay for outcomes) result in short-term change?

Hammurabi
1700 BC

OUTCOMES-BASED FEE SCHEDULE

This chart outlines fees and penalties for successful and unsuccessful procedures. There are no fees for unsuccessful bone setting and sinew mending because outcomes are usually not fatal; operations can be repeated until the result is satisfactory. Omission of fees for mushkenum (the middle class) indicate that the scribe failed to copy a section containing a penalty. Awelum were the upper class; wardum were slaves.

Successful operations	**Awelum**	**Mushkenum**	**Wardum**
Setting bone or mending sinew	5 shekels	3 shekels	2 shekels
General operation	10 shekels	5 shekels	2 shekels
Operation on eye	10 shekels	5 shekels	2 shekels
Unsuccessful operations			
Setting bone or mending sinew	——	——	——
General operation	loss of hand	——	slave for slave
Operation on eye	loss of hand	——	slave's price

Changing the emphasis from volume to value

Volume	Value
Denied claims, un-reimbursed admissions and other penalties as payers manage utilization	**Quality improvement increases performance-based reimbursement**
Encourages additional capacity and unnecessary care	**Improved cost structure and efficiency increases profitability**
Provider revenues contingent on volume of services	**Re-aligned financial incentives create diversified revenue sources through shared savings**
Payers and providers as adversaries	**Aligned incentives to provide appropriate care in the best setting**

Aetna Medicare Advantage

Aetna's Provider Collaboration Program aligns resources and incentives to improve outcomes, creating greater value for members and provider organizations

Provider Collaboration

Collaborative Care Management

Provides onsite embedded care managers to collaborate with physicians and assist in coordinating care for members

Performance-Based Reimbursement

Aligns incentives to engage providers in quality, identification and management of chronic conditions and reductions in avoidable utilization

Analytics and Data Sharing

Provides actionable member-level reporting and promotes exchange of health information to facilitate identification of member needs and follow-up care

Enhanced Value Proposition

Member

- Improved access to care and resources
- Increased care coordination across continuum
- Greater focus on quality and outcomes

Plan Sponsor

- Increased CMS revenue from identification and management of chronic conditions
- Improved medical cost trend

Provider

- Improved patient care coordination
- Alignment of financial incentives
- Access to actionable data

Shared Value Through Better Quality Management

- $ X pmpm for achieving all target measures. Exact measures to be mutually agreed upon. Some possible measures:
  - Diabetes Management: HbA1C at least each year
  - Follow-up visit within 30 days after a hospital discharge
  - 2x/year office visit for members with CHF, diabetes or COPD
  - Management of avoidable inpatient admissions measured against a total acute days target per 1,000
  - Annual office visit with each assigned member
- Enhanced reimbursement through better identification of chronic conditions.

Collaboration Model Overview

The Collaboration Model includes three components that are designed to better align incentives and resources for Medicare Advantage members

- **Medicare Risk Adjustment**
  - The Risk Adjustment provides the opportunity for enhanced reimbursement for management of Aetna Medicare patients with chronic conditions, which requires more time and effort.
- **Quality Measures**
  - The Quality Measures provide the opportunity for enhanced reimbursement for achieving defined quality measures for an Aetna Medicare patient population.
- **Collaborative Care Management**
  - Collaborative Care Management provides dedicated, funded Aetna resources for the management of an Aetna Medicare patient population.

Importance of Dedicated/ Embedded Case Managers

- Every group has 1 (or more, depending on size) dedicated/single point of contact RN Case Manager
- Groups with ~1,000 Aetna MA members are eligible for a full-time, embedded case manager
- Embedding discussions are beginning earlier in the implementation process, and expectation is that it is preferential to pursue embedding, if possible
- Considerations for embedding include:
  - Working environment, privacy rules
  - Connectivity to Aetna systems and group's EMR
  - Working relationships with group's care coordinators/MDs/quality managers/mid-level providers, etc.

Provider Collaboration: Medicare Advantage Clinical Team

- Specially trained geriatric RN case managers (dedicated to a physician group)
- Managers and supervisors
- Post-acute and home care Aetna nurse case managers
- Non-clinical support team
- Dedicated medical social workers
- Local Medicare medical directors

Role of CM in Provider Collaboration

- Medicare Care/Case Management in Provider Collaboration
  - Enhanced care management for Aetna MA plan members through on-site or dedicated Aetna case managers
  - Physician groups will have the benefit of a collaborative relationship with an Aetna Medicare Case Manager dedicated to their practice
  - We believe that this collaborative and positive working relationship with the physician group helps facilitate optimal care and outcomes for our members

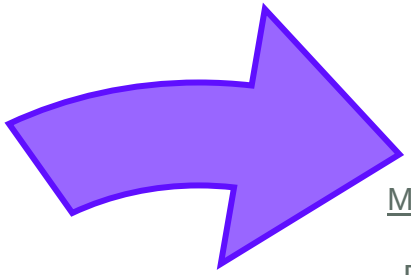
- Case Management activities may include:
  - Case identification through automation and review of weekly inpatient admission census
  - Face-to-face relationship with the physician group's clinical support staff and clinicians
  - Facilitation of timely post-discharge office visit
  - Having an extensive familiarity with local member resources and contacts that can enhance overall support and efficiency
  - Helping to achieve clinical outcomes for MA members and address Star/quality measures

Impact of Provider Collaboration

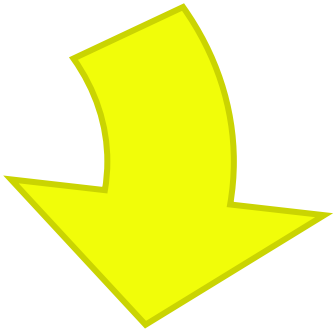
- Goal is incremental value in terms of Quality (Stars) and Efficiency (MBR)
- Reduction in acute admissions per 1,000 versus Market Results:
    - For some groups we see a reduction in acute days of 60% compared to the region for Medicare, and reduction in cost of > 25%
    - Days that do not happen = an intersection of quality and cost
    - Historically, aim for 6-8% or greater improvement over the local market
- High level of member and physician satisfaction with the program
- Facilitates transition to fully accountable care, risk-based contracting

Role of Medicare Advantage Case Manager

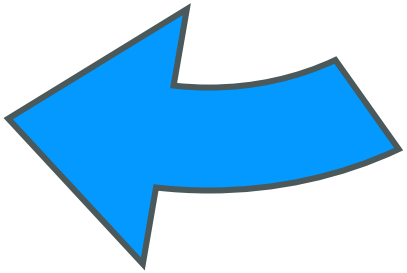
Case Management (CM)
Complex/Catastrophic
Proactive Outreach
Predictive Model
At Risk Members
Compassionate Care
DM Integration
BH Integration

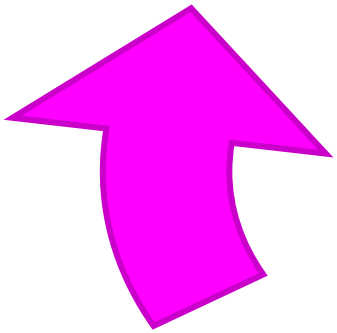


Medical Management
Hypertension
Fracture Prevention
Diabetes



Disease Management (DM)
Stars-aligned DM
Integrated with CM





Wellness Coaching
Smoking Cessation
Weight Management
Stress Management

MEDICARE ADVANTAGE

By Thomas F. Claffey, Joseph V. Agostini, Elizabeth N. Collet, Lonny Reisman, and Randall Krakauer

INNOVATION PROFILE

Payer-Provider Collaboration In Accountable Care Reduced Use And Improved Quality In Maine Medicare Advantage Plan

ABSTRACT Patient-centered, accountable care has garnered increased attention with the passage of the Affordable Care Act and new Medicare regulations. This case study examines a care model jointly developed by a provider and a payer that approximates an accountable care organization for a Medicare Advantage population. The collaboration between Aetna and NovaHealth, an independent physician association based in Portland, Maine, focused on shared data, financial incentives, and care management to improve health outcomes for approximately 750 Medicare Advantage members. The patient population in the pilot program had 50 percent fewer hospital days per 1,000 patients, 45 percent fewer admissions, and 56 percent fewer readmissions than statewide unmanaged Medicare populations. NovaHealth's total per member per month costs across all cost categories for its Aetna Medicare Advantage members were 16.5 percent to 33 percent lower than costs for members not in this provider organization. Clinical quality metrics for diabetes, ischemic vascular disease, annual office visits, and postdischarge follow-up for patients in the program were consistently high. The experience of developing and implementing this collaborative care model suggests that several components are key, including robust data sharing and information systems that support it, analytical support, care management and coordination, and joint strategic planning with close provider-payer collaboration.

Health Affairs 2012;31:2074-2083

Published Experience: Aetna Provider Collaborations

2011 Overall Utilization Management					
	NOVA	Aetna Maine	NOVA VS Aetna Maine	Maine CMS	NOVA VS Maine CMS
Acute Admits	143.5	205.1	**-30.0%**	259.0	**-44.6%**
Acute Days	657.0	982.3	**-33.1%**	1,316.0	**-50.1%**
Sub-Acute Admits	44.2	51.4	**-14.0%**	n/a	n/a
Sub-Acute Days	782.6	925.9	**-15.5%**	n/a	n/a
ER	225.0	201.5	**11.7%**	n/a	n/a
Readmit Rate	8.7%	14.9%	**-41.6%**	19.6%	**-55.6%**

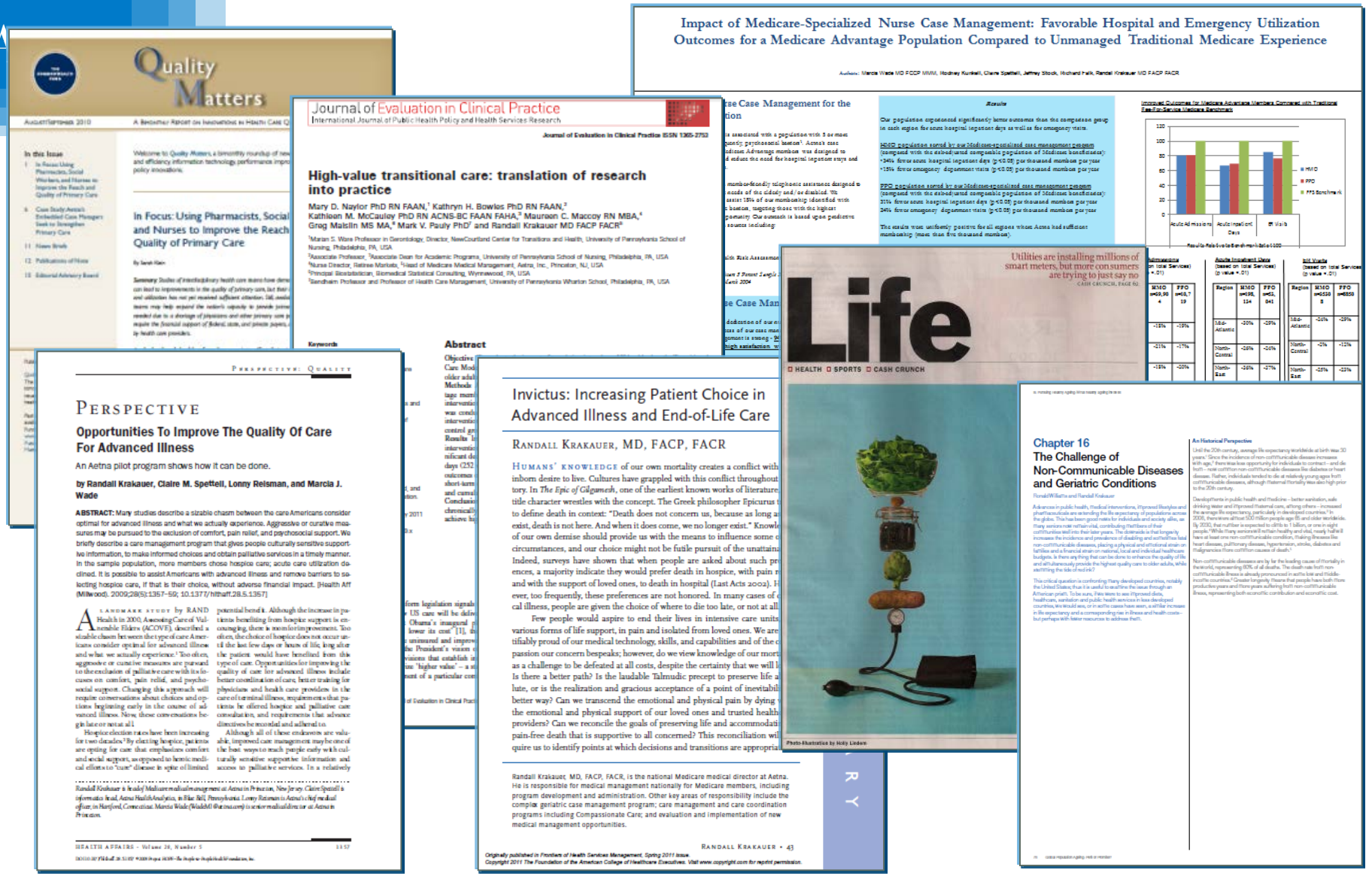
Data from Aetna Medicare-NovaHealth-InterMed collaboration in Portland, Maine

Impact for Groups with Embedded Case Managers

Results for 2013- note acute admissions are exclusive of denials. Acute admissions that do not happen are a measure of quality with significant impact on cost

Group	Effective date	Medicare Advantage Members	Acute admissions per 1000	Acute Admissions vs. CMS 2010	30 day all-cause readmission rate	Embedded case manager as of 2013
ProHealth (CT)	10/1/07	2,210	193	-46%	6%	Yes
TriValley Primary Care	1/1/10	1,228	220	-48%	9%	Yes
Intercoastal	4/1/09	1,708	132	-63%	9%	Yes

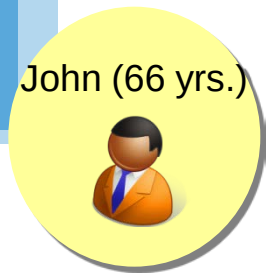
Peer Reviews



Aetna Medicare Physician Collaboration: Summary

- Collaboration changes the nature of the relationship with participating physicians
- Embedded case managers enhance the collaborative care management process, the relationship with collaborating physician, and the impact of care management
- Demonstrable incremental positive impact
- High physician and member satisfaction
- Facilitates transition to accountable care
- Creates new strategic partnership opportunities

Chronic management of chronic illness: diabetes



I need help … I have -

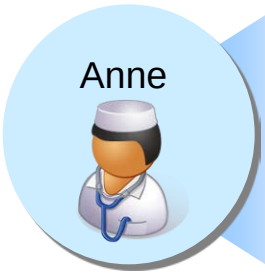
- Hypertension
- High Cholesterol
- Heart disease
- Obesity
- Gout

… and this can get worse

- Multiple chronic conditions
- Advanced Illness
- Modifiable risk factors
- Transitional care
- Pharmacy management
- Ongoing follow up
- Ongoing risk evaluation

Unmanaged progression → ~ 3 yrs | *~ 3 yrs* | *~ 3 - 5 yrs*

	1 Pre-Diabetic	2 Diabetic	3 End Organ Involvement	4 Advanced Illness
Interventions	• Define health goals • Customize plan to modify risk factors • Review medications • Work on adherence and continuous feedback	• Onsite annual health risk assessment • PCP care coordination • Monitor Blood sugar, A'C, etc. • Continuous feedback	• Care coordination for care completion • Long term case management • Holistic management	• Follow up, education, and support • Choices, options, psychosocial support
John's Impact	• Progression to Diabetes is **delayed by ~ 10 years**, OR • Diabetes **does not occur** in the lifetime!	• Progression to organ damage is **delayed by 10 years**, OR • Organ damage **does not occur** in lifetime!	• Organ damage **does not progress** • Organ damage **does not result in terminal Illness!**	• Long term engagement facilitates Compassionate Care • Effective impact on Advanced Illness



Question and Answer Session

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Thank you!

- Please fill out the survey after today's session
- Those who signed up for Continuing Education will receive an evaluation from the Commission.
- A recording of today's webinar and slides will be available in one week at http://ccmcertification.org