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Strategies for Medicaid Care Management Programs

ACG International Risk Adjustment Conference

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Topics

- Predictive modeling overview
- Methodologies for identifying high-cost individuals
- Predictive modeling results for Medicaid populations
- Care management application



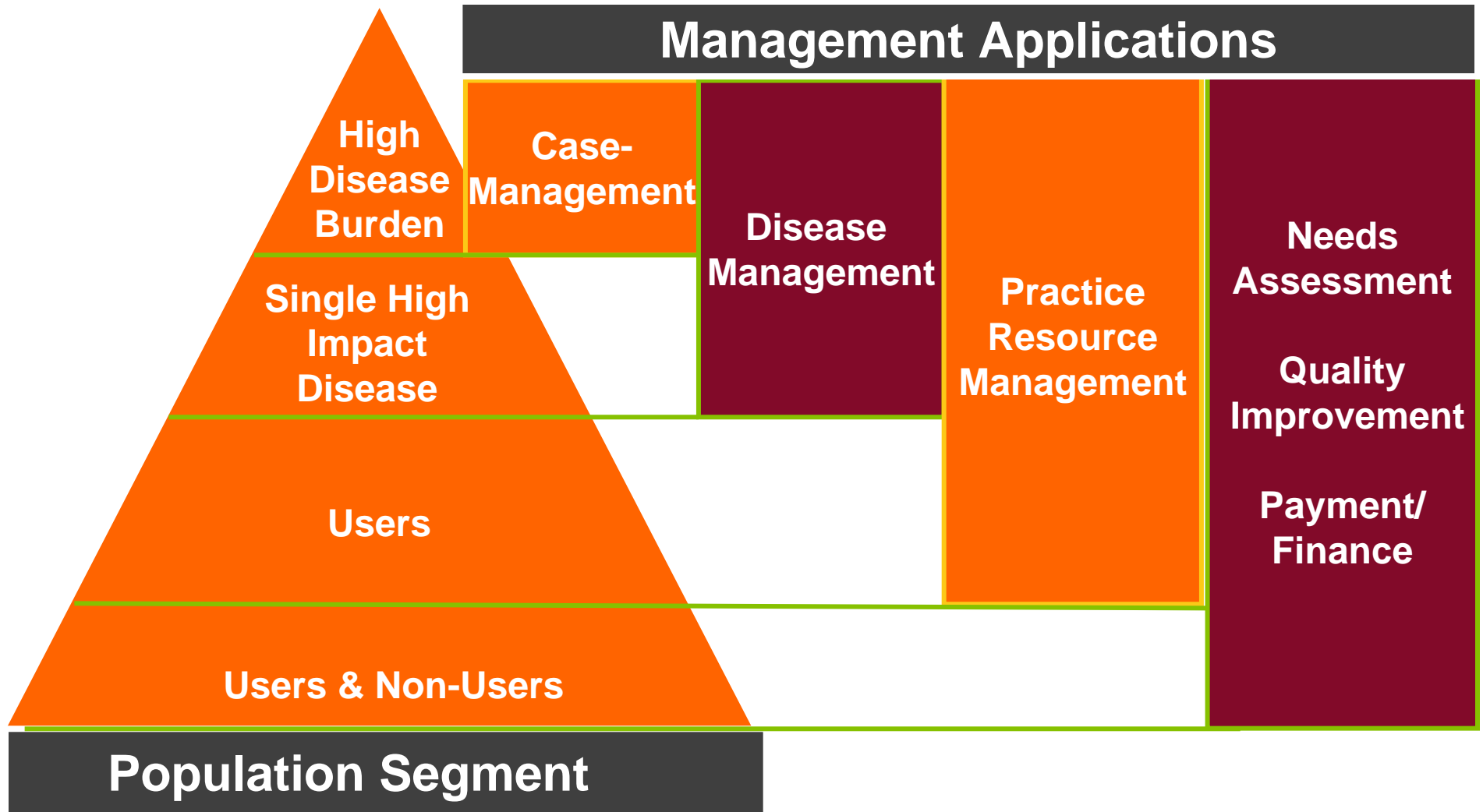
The \$64,000 Question

- Does predictive modeling work?
 - Definitely, yes; predictive modeling techniques have proven to be very successful in identifying members that will be expensive in future time periods.
- Is predictive modeling perfect?
 - No, most models will generate some false positives, and identify people that will not be among the most expensive in the next time period.
- Are predictive modeling results improving?
 - Yes, the models are getting better, and health plans are developing more effective strategies to mine the data.

Predictive Modeling Objectives

- Identify members that are projected to be high-cost in the future for additional interventions, in an effort to reduce their future expenditures.
 - Members must have ongoing health care needs.
- Stratify members by their projected health care needs to be able to determine the appropriate intervention.
- Identify members that are currently inexpensive and are at the early stages of a disease onset, that would have not been identified by more traditional risk adjustment techniques.

The Risk Measurement Pyramid



Medicaid Case Study

- A review of a state's fee-for-service Medicaid population was performed to better understand underlying population and identify care management opportunities.
- The ACG model was used to accomplish these goals using the national normative weights developed using commercial data.

Measure	Year 1	Year 2	Percent Change
Total \$ PMPM	\$282.38	\$399.54	41.5%
Concurrent Risk Score	2.01	3.07	52.7%



Medicaid Case Study

- The ACG system calculates a risk score for each member, and also assigns each member to one of 110 mutually exclusive risk groups.
- The distribution of members across the risk groups can also be used to evaluate the health status of the members and identify members for care management programs.
- This comparison can be simplified by looking at the distribution of members across the six Resource Utilization Bands (RUBs).
- RUBs group ACGs with similar expected costs.

RUB Group Distribution

RUB Group	Year 1 Members	Year 1 % Members	Year 2 Members	Year 2 % Members
Non-User	3,332	19.6%	1,389	11.0%
Administrative	1,718	10.1%	1,047	8.3%
Low	4,479	26.3%	3,119	24.8%
Medium	5,435	31.9%	4,585	36.4%
High	1,557	9.1%	1,800	14.3%
Very High	507	3.0%	658	5.2%
Total	17,028		12,598	

RUB Group Expenditures

RUB Group	Year 1 Total \$ PMPM	Year 2 Total \$ PMPM	Percent Change
Non-User	\$ 37.36	\$ 19.93	-46.7%
Administrative	\$ 38.54	\$ 43.70	13.4%
Low	\$ 116.48	\$ 125.66	7.9%
Medium	\$ 286.40	\$ 291.37	1.7%
High	\$ 812.48	\$ 842.48	3.7%
Very High	\$ 2,660.79	\$ 2,458.83	-7.6%
Total	\$ 282.38	\$ 399.54	41.5%



Prevalence of Chronic Conditions

Prevalence of Chronic Conditions

- The ACG grouper also identifies members with chronic conditions that are amenable to care management interventions.
- These chronic condition markers can be used to evaluate the prevalence of chronic conditions within a population.
- The chronic conditions that are identified by the ACG grouper are:
 - Arthritis, Asthma, Back Pain, COPD, CHF, Diabetes, Depression, Hyperlipidemia, Hypertension, Ischemic Heart Disease (HD) and Renal Failure.
- Members with multiple chronic conditions would have a marker for each condition.

Prevalence of Chronic Conditions

- To avoid counting a member in multiple disease categories, a chronic condition hierarchy was used to assign each member to 1 chronic disease category.
- The hierarchy that was used to assign members is as follows:
 - Renal Failure, CHF, COPD, Ischemic HD, Depression, Asthma, Diabetes, Hyperlipidemia, Hypertension, Arthritis, and Low Back Pain.
- The number of members identified with each chronic condition, after applying this hierarchy is provided on the next table.

Prevalence of Chronic Conditions

Hierarchical Assignments

Chronic Condition	Year 1		Year 2	
	# of Members	Percent of Members	# of Members	Percent of Members
Arthritis	122	0.7%	128	1.0%
Asthma	1,060	6.3%	1,052	8.4%
Back Pain	629	3.7%	618	4.9%
CHF	77	0.5%	96	0.8%
COPD	182	1.1%	242	1.9%
Depression	494	2.9%	578	4.6%
Diabetes	324	1.9%	290	2.3%
Hypertension	357	2.1%	355	2.8%
Ischemic HD	116	0.7%	176	1.4%
Renal Failure	36	0.2%	48	0.4%
None	13,339	78.3%	8,669	68.8%
All Members	17,028		12,598	

Chronic Conditions Expenditures

- Utilization rates will vary among members within each chronic condition category depending upon their health status.
- The cost and complexity of caring for a patient with any of these chronic conditions will be affected by the number of comorbidities that each member has, which will impact their health status.
- These factors can be accounted for by examining the RUB group assignment for members with chronic conditions.
- The following slides profile the health care utilization of the members in each chronic condition category based upon their RUB group assignment.

Health Care Utilization

Asthma

RUB Group	Total Members	Total \$ PMPM	Inpatient \$ PMPM	Physician \$ PMPM	Rx \$ PMPM	ER \$ PMPM	Inp Days 1,000 PY	Physician Visits 1,000 PY	Scripts 1,000 PY	ER Visits 1,000 PY
Year 1										
Low	162	\$125	\$18	\$15	\$33	\$3	98	2,967	8,439	241
Medium	640	\$262	\$52	\$50	\$64	\$16	253	8,763	15,870	985
High	209	\$870	\$393	\$144	\$103	\$36	2,196	17,671	25,464	1,910
Very High	49	\$3,892	\$1,286	\$369	\$333	\$36	9,074	30,949	42,629	1,623
Total	1,060	\$527	\$171	\$77	\$79	\$19	1,017	10,609	17,799	1,078
Year 2										
Low	115	\$106	\$8	\$18	\$34	\$2	27	3,270	7,881	161
Medium	643	\$263	\$33	\$50	\$71	\$15	205	8,816	16,350	829
High	237	\$947	\$251	\$136	\$133	\$33	1,278	17,817	27,475	1,644
Very High	57	\$3,583	\$1,743	\$318	\$293	\$50	8,589	30,244	53,973	2,220
Total	1,052	\$580	\$173	\$80	\$93	\$19	883	11,402	19,975	1,015

Care Management and Predictive Modeling



Care Management and Predictive Modeling

- The chronic condition markers can be used to identify members that are candidates for care management programs.
- The number of members with chronic conditions can be used to determine if there is sufficient membership to institute a care management program.
- The challenge is to identify a subset of members within each chronic condition that would benefit from a care management program.
- Members whose condition is stable and have few comorbidities may have moderate health care needs.
- Complex members with multiple comorbidities will have significant health care needs and could benefit from the focus on the care offered by a case management program.



Care Management and Predictive Modeling

- The ACG system offers multiple measures that can be used to identify the subset of members that would benefit the most from a care management program.
- The ACG system calculates a predictive modeling (PM) score for each member.
- The PM score represents the probability that they will be in the top 5% most expensive members the following year.
- A PM score of 0.95 indicates that there is a 95% chance that a member will be among the top 5% most expensive members the next year.
- These scores can be used to identify a subset of members within each chronic condition that have significant health care needs.

Care Management and Predictive Modeling

- The PM scores range from 0 to 1.
- Members with a PM score of 0.9 or higher will likely be very expensive the next year, but this score will identify a small number of members.
- Selecting a lower PM score will identify more members, but some of these members will have lower costs in the following year.
- The following table identified members as high-risk if they had a PM score of 0.6 or higher.
- The table looks at a cohort of members that were enrolled in both years.
- Member Year 1 PM score is related to Year 2 expenditures.

Year 1 PM Score Year 2 Utilization

Chronic Condition	Low PM Score in Year 1						High PM Score in Year 1					
	Total Members	Total \$ PMPM	Inpatient \$ PMPM	ER \$ PMPM	Inpatient Days 1,000 PY	ER Visits 1,000 PY	Total Members	Total \$ PMPM	Inpatient \$ PMPM	ER \$ PMPM	Inpatient Days 1,000 PY	ER Visits 1,000 PY
Arthritis	75	\$584	\$82	\$16	715	566	2	\$1497	-	\$15	-	1,000
Asthma	674	\$375	\$80	\$16	411	882	21	\$5,066	\$1,055	\$76	9,731	2,622
Back Pain	366	\$441	\$110	\$26	625	1,204	12	\$1,890	\$593	\$57	2,656	2,754
CHF	30	\$1,695	\$774	\$13	5,155	536	14	\$2,788	\$1,555	\$63	17,455	1,488
COPD	107	\$642	\$189	\$27	2,063	1,182	20	\$1,908	\$590	\$36	4,608	1,468
Depression	272	\$809	\$199	\$33	1,169	1,491	31	\$1,577	\$565	\$57	5,692	2,465
Diabetes	192	\$622	\$103	\$23	793	1,019	8	\$2,054	\$483	\$40	6,308	1,385
Hyper-lipidemia	185	\$408	\$86	\$13	780	620	4	\$3,393	\$1,595	\$100	12,766	4,851
Hypertension	214	\$484	\$153	\$13	889	674	7	\$1,946	\$1,087	\$77	5,440	3,360
Ischemic HD	66	\$902	\$265	\$18	1,934	751	12	\$956	\$26	\$38	105	1,579
Renal Failure	4	\$136	-	-	-	-	10	\$2,665	\$568	\$50	3,310	1,241
None	7,010	\$255	\$76	\$10	429	559	24	\$1,939	\$674	\$20	3,966	979
Total	9,195	\$318	\$88	\$13	523	654	165	\$2,368	\$728	\$51	6,123	2,011

Care Management and Predictive Modeling

- The PM score identified a small subset of members within each chronic condition that had dramatically higher expenses in Year 2.
- Asthmatics with a high PM score cost \$5,066 PMPM in Year 2; members with a low PM score cost \$376.
- The separation between the PM groups is smaller for the CHF chronic condition group.
- All members with a high PM score cost \$2,368 in Year 2; members with a low PM score cost \$318.
- The PM score offers one method for identifying an expensive subset of members within each chronic condition.
- Another alternative is to look at a member's RUB group assignment.
- The following table relates a member's Year 1 RUB group assignment to their Year 2 expenditures.

Year 1 RUB Assignment

Year 2 Utilization

Chronic Condition	Non-User RUB	Administrative RUB	Low RUB	Medium RUB	High RUB	Very High RUB
Arthritis	-	-	\$270	\$485	\$789	\$1,064
Asthma	-	-	\$178	\$329	\$575	\$3,279
Back Pain	-	\$31	\$232	\$406	\$620	\$1,641
CHF	-	-	-	\$1,192	\$1,756	\$2,994
COPD	-	-	\$30	\$488	\$897	\$1,285
Depression	-	-	\$742	\$663	\$841	\$1,759
Diabetes	-	-	\$663	\$581	\$746	\$1,137
Hyperlipidemia	-	-	\$169	\$422	\$409	\$1,293
Hypertension	-	-	\$176	\$395	\$554	\$2,092
Ischemia HD	-	-	-	\$946	\$412	\$1,299
Renal Failure	-	-	\$1,300	-	\$2,265	-
None	\$199	\$94	\$174	\$402	\$397	\$1,093



Care Management and Predictive Modeling

- Another measure created by the ACG system that can be used to identify a subset of high-cost members is to look at the number of comorbidities that a member has.
- Members with multiple chronic conditions will be more complex to treat and generally have more significant health care needs.
- The table on the following slide relates the number of chronic condition markers a member had in Year 1 to their expenses in Year 2.
- Members with 4 or more chronic conditions in Year 1 were significantly more expensive than members with 0 or 1 chronic condition.

Year 1 Number of Chronic Conditions Year 2 Utilization

# of Chronic Conditions	# of Members	Total \$ PMPM	Inpatient \$ PMPM	ER \$ PMPM	Inpatient Days 1,000 PY	ER Visits 1,000 PY
0	7,034	\$260	\$77	\$11	439	560
1	1,456	\$505	\$123	\$18	819	904
2	472	\$734	\$209	\$28	1,459	1,250
3	231	\$866	\$215	\$31	1588	1,331
4	98	\$1,041	\$275	\$37	2,114	1,466
5	43	\$1,387	\$348	\$33	3,645	1,038
6	19	\$1,546	\$474	\$37	3,587	1,304
7	4	\$2,166	\$735	\$43	10,957	1,304
8	1	\$1,717	-	\$69	-	2,000
9	1	\$639	-	-	-	-
10 +	1	\$3,324	\$1,223	-	11,000	-



Care Management and Predictive Modeling

- Another measure created by the ACG system is the number of hospital-dominant conditions that a member has.
- A hospital-dominant condition is a diagnosis that has a high probability of requiring the member to be hospitalized in the following year.
- The higher the number of hospital-dominant conditions a member has, the greater their health care needs will be in the following year.
- The following table relates a member's Year 1 number of hospital-dominant conditions to their Year 2 expenditures.
- Members with 1 or more hospital-dominant conditions were significantly more expensive the following year.

Year 1 Hospital-Dominant Conditions Year 2 Utilization

# of Chronic Conditions	# of Members	Total \$ PMPM	Inpatient \$ PMPM	ER \$ PMPM	Inpatient Days 1,000 PY	ER Visits 1,000 PY
0	8,960	\$315	\$86	\$12	518	632
1	309	\$1,004	\$237	\$35	1,395	1,673
2	58	\$1,790	\$709	\$66	5,577	2,446
3	25	\$2,874	\$1,406	\$44	15,629	1,984
4	5	\$1,810	\$1,120	\$78	5,091	1,455
5	2	\$3,493	\$1,005	\$121	5,400	2,400
6 +	1	\$6,690	\$4,102	\$31	57,000	1,000



Care Management and Predictive Modeling

- The combination of PM score, RUB group, number of chronic conditions, and number of hospital-dominant conditions can be used to identify a subset of members that will be high-cost in the following year.
- The following table uses the Combined Risk Index to identify high-cost members based on their Year 1 ACG information.
- The Combined Risk Index is then related to their Year 2 health care utilization.

Year 1 Combined Risk Index

Year 2 Health Care Utilization

Chronic Condition	Low PM Score in Year 1						High PM Score in Year 1					
	Total Members	Total \$ PMPM	Inpatient \$ PMPM	ER \$ PMPM	Inpatient Days 1,000 PY	ER Visits 1,000 PY	Total Members	Total \$ PMPM	Inpatient \$ PMPM	ER \$ PMPM	Inpatient Days 1,000 PY	ER Visits 1,000 PY
Arthritis	68	\$561	\$59	\$16	446	529	9	\$960	\$223	\$17	2,423	923
Asthma	643	\$341	\$73	\$16	382	873	52	\$2,788	\$581	\$48	4,698	1,735
Back Pain	353	\$397	\$109	\$26	635	1,184	25	\$1,732	\$351	\$43	1,431	2,215
CHF	17	\$1,372	\$627	\$6	4,000	317	27	\$2,563	\$1,322	\$46	12,807	1,238
COPD	80	\$519	\$139	\$16	1,675	716	47	\$1,422	\$455	\$49	3,860	2,070
Depression	248	\$721	\$143	\$30	931	1,406	55	\$1,624	\$647	\$56	4,755	2,408
Diabetes	178	\$624	\$112	\$24	859	1,021	22	\$1,080	\$161	\$26	2,103	1,128
Hyper-lipidemia	171	\$390	\$89	\$12	852	552	18	\$1,246	\$411	\$42	2,913	2,155
Hypertension	200	\$401	\$90	\$13	526	647	21	\$1,795	\$1,087	\$37	5,943	1,886
Ischemic HD	44	\$640	\$186	\$15	843	618	34	\$1,265	\$285	\$30	2,724	1,215
Renal Failure	2	\$224	-	-	-	-	12	\$2,322	\$494	\$43	2,880	1,080
None	6,955	\$252	\$75	\$10	843	618	79	\$1,023	\$333	\$24	2,090	1,287
Total	8,959	\$297	\$81	\$12	477	633	401	\$1,621	\$508	\$39	3,869	1,699



Care Management and Predictive Modeling

- Within each chronic condition category the Combined Risk Index identifies a cohort of significantly more expensive members.
- High-risk asthmatics had a total cost of \$2,788 in Year 2, low-risk asthmatics cost \$341.
- The relative cost of members in the high-risk category was 5.5 times the cost of members in the low-risk category.
- This relationship varied from a high relative cost of 10.4 in the Renal Failure category to a low of 1.71 in the Arthritis category.
- Parameters of the Combined Risk Index can vary to identify more members, which will result in less separation between the high- and low-risk group, or identify a smaller subset that will have greater separation.



Care Management Application Case Study: Medicaid FFS



Care Management Applications for ACGs:

- Risk scores can be used to identify members with high predicted concurrent and prospective scores. These members can be expected to be high-cost now and into the future.
- ACG groups and RUB groups can be used to identify members with multiple significant health problems.
- Predicted modeling scores identify members who are predicted to be high-cost in the annual time period following the risk assignment period.
- EDC groups can be used to identify members with chronic conditions that will likely need services in the future.
- Hospital-dominant conditions identify members, who will likely require hospitalizations in the near future.
- Combinations of these factors can be used to identify members who will likely have high health care utilization in the future.
- Helps to identify specific patients at risk and to develop appropriate interventions to both improve clinical outcomes and potentially avoid or decrease future utilization patterns and costs

Care Management Profile Examples

Profile Area	Case 1	Case 2
Age	47	40
Gender	Male	Female
Risk Score	17.2	26.6
Predictive Modeling Score	0.93	0.93
Hospital-Dominant Conditions	2	2
Frailty	No	Yes
Arthritis	No	No
Asthma	Yes	No
Congestive Heart Failure	Yes	Yes
Chronic Renal Failure	No	Yes
Congestive Obstructive Pulmonary Disease	No	No
Depression	No	Yes
Diabetes	Yes	No
Hyperlipidemia	Yes	No
Hypertension	Yes	Yes
Ischemic Heart Disease	Yes	No
Low Back Pain	No	No

Factors to Consider When Selecting Disease Category

- Prevalence rates of disease conditions
- Service utilization levels and costs associated with each condition
- Existence of evidence-based treatment guidelines
- Generally recognizable problems in therapy documented in the literature or large variation in practice
- Large number of patients exists whose therapy could be improved
- Preventable acute events
- The potential of cost savings within a relatively short period
- The ability of behavior change to impact the disease conditions



Considerations when Choosing a Care Management Program:

- Each program may be used by itself or in combination with any other.
- Individual components within each program should be selected for use based upon program goals and available resources.
- The largest opportunities to achieve substantial and early cost savings lie in decreasing ER usage, inpatient admissions, readmissions or length of hospital stays.
- Care improvements exist in implementing strategies that decrease member disease burden, elicit member behavior change and support compliance with evidence-based guidelines.

Top 10 Disease Conditions Identified As Most Prevalent in Year 2

(Members with a Risk Score of > .60)

- Low Back Pain
- Asthma
- Hypertension
- Hyperlipidemia
- Depression
- Arthritis
- Diabetes
- Ischemic Heart Disease
- Congestive Obstructive Pulmonary Disease
- Congestive Heart Failure
- Chronic Renal Failure



Disease Focus: Why Asthma?

- Clinical Guidelines
 - Nationally Recognized & Accepted
 - Readily Available
- Volume
 - Largest # Members
 - Greatest %
- Dollars
 - Total PMPM approx. \$600
- Impactable
 - ER Usage
 - Avoid Triggers
 - Medication Management
- Short Term Return
 - Manage Costs
 - Improve Outcomes



Care Management Intervention Strategies



Care Management Strategy: Why the Interest?

- Manage Costs
- Manage Inefficiencies
- Patient Focused Approach to Care Delivery & Coordination
- Improve Outcomes
- CMS Support



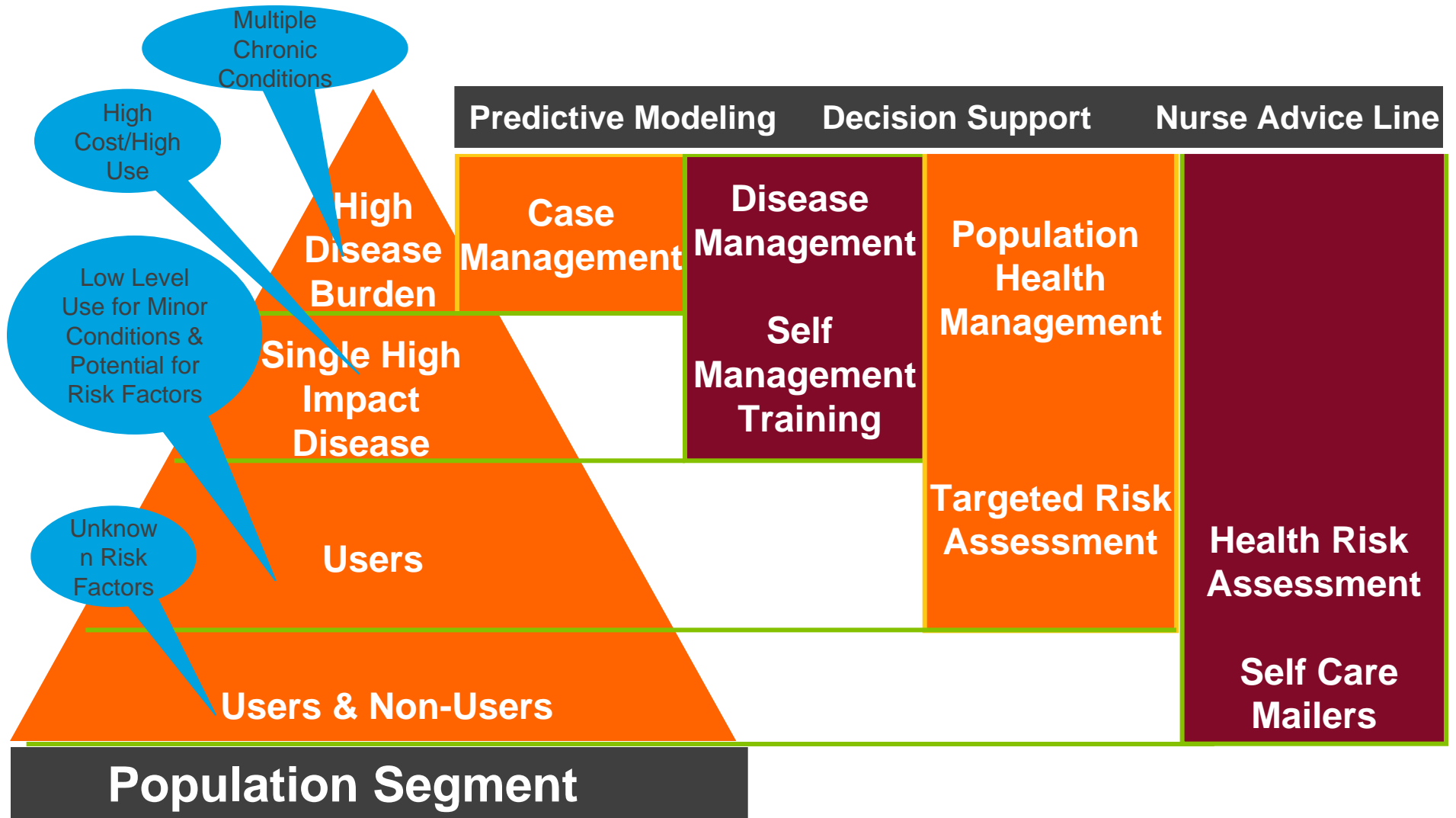
Member Complexity

When considering Care Management strategies it is essential to understand clinical relationships, interactions and frequency of conditions within the targeted population.

Managing Comorbidities

Year 2											
Number of Members with other Chronic Conditions	Renal Failure	CHF	COPD	Ischemic HD	Depression	Asthma	Diabetes	Hyperlipidemia	Hypertension	Arthritis	Low Back Pain
Renal Failure		16	11	13	6	6	15	23	34	9	12
CHF	16		36	59	6	26	49	56	94	17	35
COPD	11	36		64	55	100	53	126	154	70	122
Ischemic HD	13	59	64		35	42	91	167	198	53	93
Depression	6	6	55	35		103	67	136	155	101	251
Asthma	6	26	100	42	103		65	114	166	100	223
Diabetes	15	49	53	91	67	65		283	326	86	157
Hyperlipidemia	23	56	126	167	136	114	283		540	186	292
Hypertension	34	94	154	198	155	166	326	540		256	388
Arthritis	9	17	70	53	101	100	86	186	256		258
Low Back Pain	12	35	122	93	251	223	157	292	388	258	

Strategies for Managing Increasing Member Complexity



Disease Management



What is Disease Management?

“Disease Management is a system of coordinated health care interventions and communications for populations with conditions for which patient self-care efforts are significant.”

--Disease Management Association of America (DMAA)



Typical Disease Management Programs

- Asthma
- Congestive Obstructive Pulmonary Disease
- Congestive Heart Failure
- Ischemic Heart Disease
- Diabetes
- Depression
- Anxiety
- Hypertension
- Hyperlipidemia



Disease Management Components for Success

- Decreasing treatment variability
- Closing the gap between current treatment patterns and optimal treatment guidelines
- Provider adherence to nationally accepted guidelines
- Clinical pathways available to direct interventions
- Appropriate adjustments are made to guidelines to account for multiple co-morbid conditions or unique member situations
- Guidelines, translated into layman's language, are shared with members as a means of supporting self-care behaviors
- Member & Provider Buy-In

Case Management



What is Case Management?

“Case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes.”

—Case Management Society of America (CMSA)

Typical Cases Managed

- Terminally Ill (Cancers)
- Major Trauma (Accidents, Loss of Limb, Traumatic Brain Injury)
- Physical Disability (Quadriplegia, Spina Bifida)
- Fatal Conditions (HIV/AIDS)
- Sudden Event (MI, Stroke)
- Chronic Conditions (CHF, Asthma, Diabetes)
- High Risk (Pregnancies, Preemies)
- Complex Cases (Comorbidities, Psycho/Social/Economic Issues)
- Transplants (Organ, Skin, Corneal)



Case Management Success

- Decreased Utilization
- Improved Clinical Conditions
- Provider & Member Buy-In
- Collaboration Across Disciplines
- Financial Savings primarily achieved through coordination of interventions among complex care providers & benefit management

Population Management

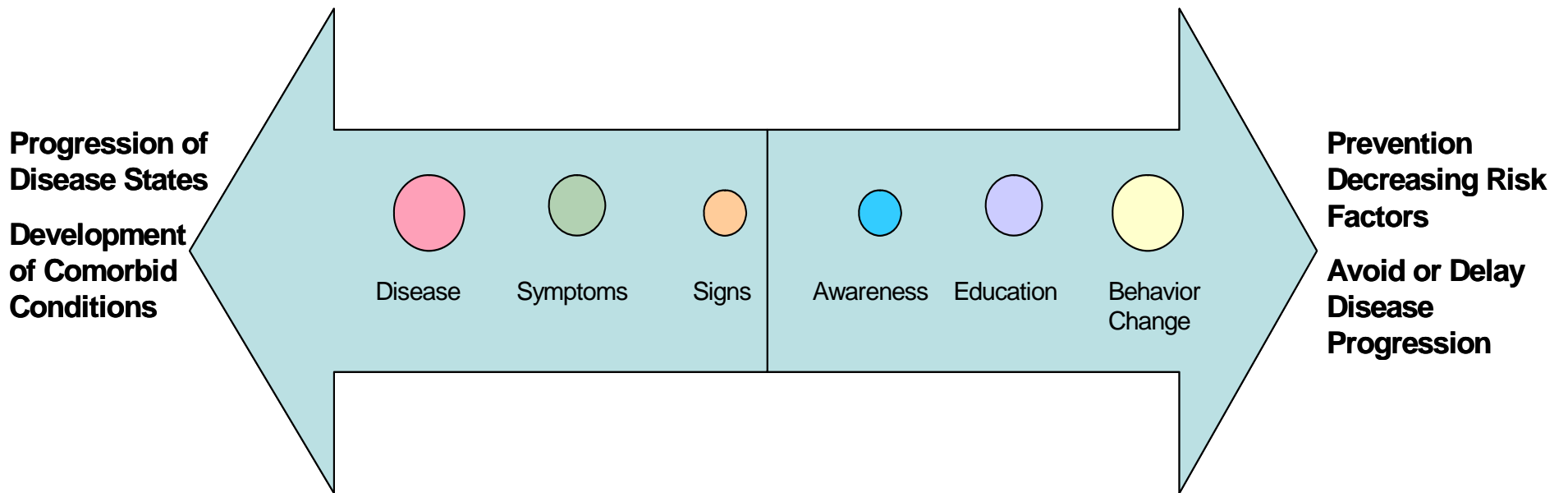


Key Principles: Total Health Management

- Address entire health care continuum
- Everyone in Population
- Emphasize Long-Term Behavioral Change & Risk Modification
- Data Driven Programs
- Not limited to single disease condition

Health Care Continuum

Health Care Continuum



Behavior and Lifestyle



Behavioral Change: Necessary for Success

- Lifestyle and behavior choices result in creating risk factors that can lead to illness or chronic disease.
- 1 of 2 people with Chronic Disease do NOT comply with Treatment Plan
 - Disease Progression
 - Increased Use of Health Care Resources
 - Annual Impact to US Health Care System = \$100 - \$150 BILLION

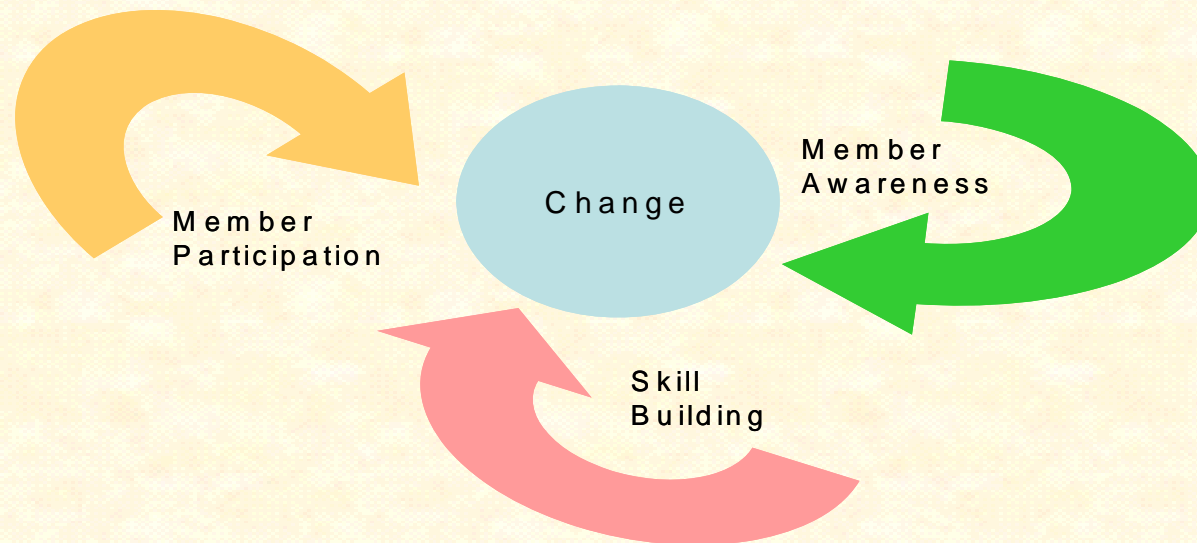
Behavioral Modification

Behavior Change Framework

Member Participation and Engagement in Disease or Population Health Management are Critical to Realizing Savings.

Participation drives program impact and ROI

- Participation requires behavior change within an overall cultural shift
- Behavioral change is a process guided by a systematic approach
- Behavior change processes are time and resource intense



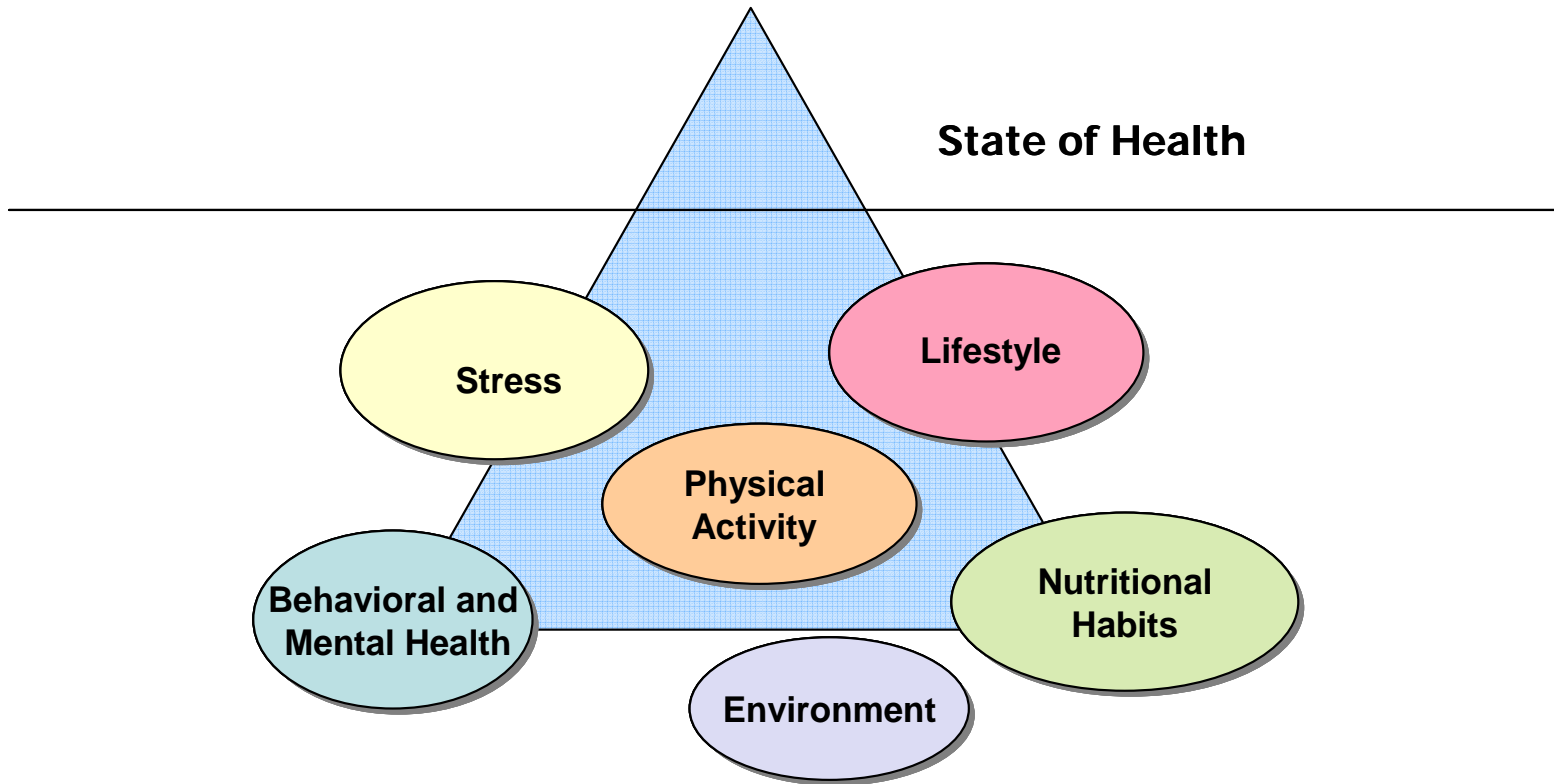
Stages of Change



CDC—Strategy of Change http://www.cdc.gov/nccdphp/dnpa/physical/everyone/stages_of_change/index.htm

Risk Factors

Factors Influencing Health

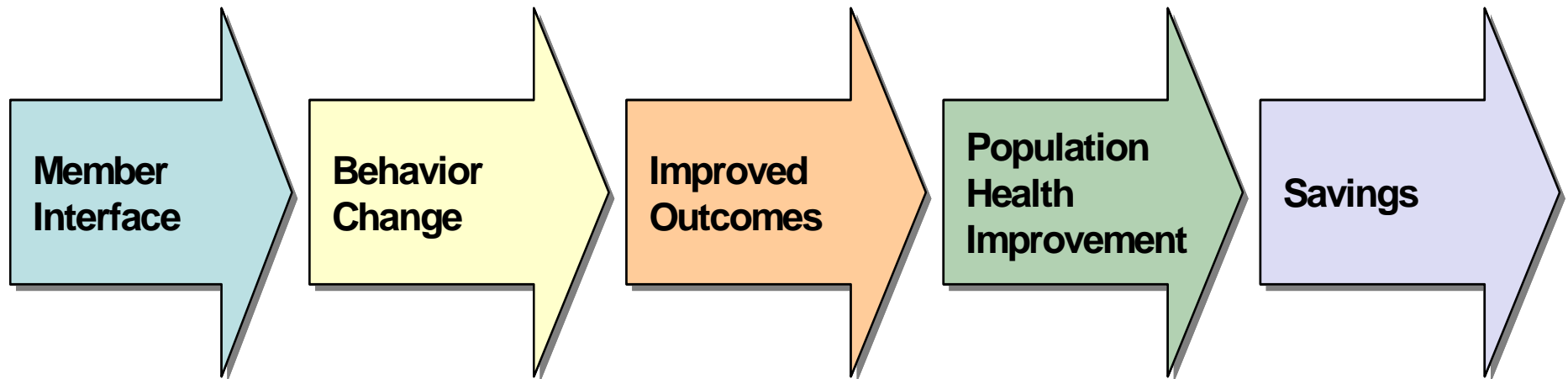




Impact of Risk Factors

- Those with Lifestyle Risk Factors cost 10% - 70% more than those not at risk
- Managing risk factors can:
 - Decrease the disease burden to the individual
 - Improve quality outcomes
 - Decrease the consumption of costly resources

Methodology: Managing Risk Factors



Barriers to Care



Member's Involvement & Buy-In Necessary

- Active participation
- Understand the importance of compliance with the treatment plan
- Understand their condition
- Identify and avoid trigger points
- Reduce Risk Factors
- Utilize tools and self-help materials provided to assist in taking an active role in self-care



Medicaid Specific Barriers to Care

- Transportation
- Language
- Literacy Level
- Medical Literacy
- Knowledge Gaps
- Economic Issues
- Lack of Technology
- Demographics
- Provider Reimbursement

Recommendations

Option #1: Disease Management Program

Build, Buy or Assemble Comparison

Build
<p>Benefits of Building a Disease Management Program</p> <ul style="list-style-type: none"> • Maintain control of member and provider transactions • Control over program components and can tailor to meet your own needs avoiding lack of differentiation
<p>Challenges of Building a Disease Management Program</p> <ul style="list-style-type: none"> • Highly complex • Requires additional staff • Not always able to achieve • Economies of scale particularly for specialized conditions • Time required to build a full service program • Costs of building service components, such as call centers, case/disease management staff, additional support staff, and technology requirements

Buy
<p>Benefits of Buying a Disease Management Program</p> <ul style="list-style-type: none"> • Beneficial for highly specialized, high impact conditions, such as high-risk pregnancies, end-stage renal disease, or rare conditions • Economies of scale • Speed of implementation and ability to market expertise • Buying is an attractive option when building a chronic program from scratch as the program can be implemented while building internal capabilities
<p>Challenges of Buying a Disease Management Program</p> <ul style="list-style-type: none"> • Unique member needs or organizational values may not be addressed • More complex management of member and provider processes • Risk of fragmentation • Internal administrative costs remain or may increase

Assembling
<p>Benefits of Assembling a Disease Management Program</p> <ul style="list-style-type: none"> • Assembling is a combination of building and buying program components • Tailoring those purchased components to integrate with the specific values and expectations of the organization • Can develop integration of program components with other organization processes • Speed of implementation and ability to market expertise
<p>Challenges of Assembling a Disease Management Program</p> <ul style="list-style-type: none"> • Risk of fragmentation • More complex management of member and provider processes • Internal administrative costs remain or may increase



Option #2: Proactive Care Management Program

- Traditional health care management focuses on treating existing illness or disease. Proactive Care Management focuses interventions along the health care continuum from optimal health to illness.
- Options include building a program, contracting with a vendor to provide a program or a combination of building and outsourcing/assembly.
- Program strives to proactively teach self-help behaviors that promote health, decrease development of risk factors, avoid behaviors that trigger acute events and help avoid disease development or to slow disease progression.
- For proactive care management programs to be successful, a careful analysis of the required skills and resources must occur.
- Due to the focus on prevention, behavioral change, and compliance with evidence-based guidelines additional resources not currently in place may be required.

Measuring Success



Indicators of Success

- HEDIS &/or HEDIS-like Scores
- Client-Specific Goals
- Enrollment
- Satisfaction
 - Member
 - Provider
- Utilization of Resources
 - ER
 - Inpatient
 - Rx

Next Steps



Currently In Progress

- Case Management Program Gap Analysis
- Systems Review
- Evidence-based practice guidelines
- Provider Education
- Review practice models
- Analysis of Routine reporting/feedback loop
- ER Strategy



Questions

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