Medicare Advantage in Practice: Enhanced Care Models for High Need Patients

Rebekah Dube, Pharm.D.
VP, Health Plan Clinical Programs & Interim VP, Health Plan Products
Who is Martin’s Point Health Care?

A not-for-profit health care organization committed to providing the best possible health care experience to its patient and members

<table>
<thead>
<tr>
<th>Two health plans serving more than 75,000 members</th>
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<tbody>
<tr>
<td>• US Family Health Plan</td>
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<tr>
<td>• Generations Advantage</td>
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| Seven health care centers serving more than 75,000 patients across Maine and New Hampshire |

| 750+ employees who care for our members and patients each and every day |

Approximately 18% of our Health Plan members are also Patients in our Primary Care Delivery System (15% of Medicare Advantage)
Mission

To create a healthier community through authentic relationships built on trust. “People caring for people.”

Vision

Trusted for care. Chosen for service. Uniting the community in affordable health.
Triple Aim: Framework through which we Create Community Value
Overview of Martin’s Point Health Plans

Number of Members (March 2017)

Who Do We Serve?

Service Area

Quality Ratings

Generations Advantage

40,873

Provides coverage to Medicare Beneficiaries through Medicare Advantage contracts

ME & 2 NH Counties (Strafford & Hillsborough)

5 Stars 4 out of last 8 years & 4.5 stars other 4 years

US Family Health Plan

45,978

Provides TRICARE Prime benefits to military retirees & family members and active duty family members

ME, NH, VT, Upstate NY, Northern PA

NCQA: ME (5 Stars, Excellent); Other States (4.5 Stars, Commendable)
Generations Advantage Growth

Generations Advantage Growth & Maine MA Penetration

ME Medicare Advantage Penetration

<table>
<thead>
<tr>
<th>Plan Year</th>
<th># Members as of Jan 1</th>
<th>Maine MA Penetration</th>
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<tbody>
<tr>
<td>2007</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>512</td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>1,549</td>
<td>8.7%</td>
</tr>
<tr>
<td>2010</td>
<td>6,024</td>
<td>10.7%</td>
</tr>
<tr>
<td>2011</td>
<td>10,957</td>
<td>12.6%</td>
</tr>
<tr>
<td>2012</td>
<td>15,062</td>
<td>15.1%</td>
</tr>
<tr>
<td>2013</td>
<td>21,798</td>
<td>16.5%</td>
</tr>
<tr>
<td>2014</td>
<td>28,596</td>
<td>18.9%</td>
</tr>
<tr>
<td>2015</td>
<td>32,354</td>
<td>21.4%</td>
</tr>
<tr>
<td>2016</td>
<td>36,758</td>
<td>24.0%</td>
</tr>
<tr>
<td>2017</td>
<td>40,532</td>
<td>27.5%</td>
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Maine - Aging Population Presents Opportunity for Those Serving Senior Market

Percentage of Maine Population Age 65+

Source: Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine 2012 Edition, Muskie School of Public Health
Source: 2010 US Census Bureau Florida Quick Facts Sheet
http://quickfacts.census.gov/qfd/states/23000.html
Key Challenges Facing Medicare Advantage in Maine

- Access to Care
  - Primary Care; Specialties; Behavioral Health
  - Rural

- Growing competency in diagnosis coding due to relative immaturity of Medicare Advantage

- The hospital market has moved to local monopolies

- Approximately 80% of physicians in Maine are employed by a hospital system

- Year over year intensification of utilization and billing practices
Population Health Continuum

**Lower 85% Health Risk**
- Pre-disease or Early disease or Cancer Care

**Top 15% Health Risk**
- Moderate to severe disease (≥2 of DM2, ASCVD, CHF, COPD, Morbid Obesity or Unstable Mental Illness)
- Hospitalized and Severe Disease

**Measurement, Analysis and Reporting**

- Distributed, coordinated, effective population health activities
- Focused, coordinated, effective care management activities

- ↑ Predictive and HCC Risk
- ↑ Quality of Care opportunities
- ↑ PMPM Expense
- ↑ Mortality risk
- ↑ Social/Behavioral determinants
- ↑ Risk disengagement
- ↑ discoordination care
Overall Model of Care

- Chronic Care
- Behavioral Health
- Utilization Management
- Transitions of Care
- Wellness

Member
Congestive Heart Failure Telemonitoring Program

- Population:
  - “Stage C” of Heart Health Program population

- Monitoring through home-based unit to identify management of CHF on day-to-day basis

- Initial population of approximately 400 members

- Outcomes to this point: (12 months post-initial engagement)
  - Readmission rate dropped to 11.9% vs. 21.7% pre-engagement
  - Discharges per 1000 dropped by 15%
Integrated Care Connection Program

• **Designed** to improve the coordination of care for Martin’s Point patients with chronic conditions

• **Initial Population:**
  – Members of our Medicare Advantage Plan who are also Patients in Martin’s Point’s Primary Care Delivery System
  – COPD, Heart Failure, or Diabetes + Utilization (ER or Inpatient Admission) in past 12 months
  – Exclude ESRD, Hospice, Advanced Stages of Cancer

• **Visit Structure:**
  – Initial intensive visit with Population Health Nurse with Physician/NP joining
  – Referral to other services (e.g. pharmacy, arrangement of social support)
  – Follow-up based on care plan progression

“We see you, we hear you, we care.”
### Integrated Care Connection Program (cont.)

**Evaluation of Outcomes (Triple Aim Framework)**

<table>
<thead>
<tr>
<th>Experience of Care</th>
<th>Health of Population</th>
<th>Cost of Care</th>
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| • Patient “confidence” question  
  • Patient phone survey post program completion  
  • Patient completion of ICC “Table of Contents” & Patient Goals Met | • Clinical quality measures such as:  
  • A1c control  
  • Immunizations received  
  • Spirometry testing  
  • Preventive such as:  
  • AWV or PE scheduled  
  • Advanced Care Directives  
  • Medication Adherence | • Utilization measures:  
  • ER  
  • Inpatient  
  • Re-admissions  
  • SNF admissions  
  • PMPM (longer term) |

**Provider and Patient/Member Feedback**
On the Horizon…

- Continued Expansion & Refinement of Current Programs
- Home-Based Care Program
- Partnerships with Area Agencies on Aging
- Working with our local Health System Partners
In Closing…

• The aging of our population only continues

• Challenges with access to care will continue to present themselves

• Continue to focus on improving the health of our populations and bringing community value through the Triple Aim