aerial™

BALANCING ACT

Managing Outcomes and Costs for Medicare & Medicaid Populations

Adjusting care for the needs of each unique patient population

Population health initiatives typically assume that members can participate in their own care on a basic level—for example, arriving at medical appointments, picking up prescriptions and taking medications as directed. Yet those assumptions may not hold true for Medicare and Medicaid members. Their lives differ from the lives of those with commercial insurance, which makes cost-effective care management uniquely challenging—and even more important.

Most Medicare members are age 65 or older, and they many face issues such as memory loss or the inability to drive, which can compromise care-plan adherence. These members often face socioeconomic complications as well; 63 percent of people over age 50 must choose between purchasing food and medical care.

In addition to facing similar socioeconomic challenges, Medicaid members may have adherence barriers caused by behavioral health conditions. Case in point: As recently as 2015, roughly 9.1 million adults with Medicaid had a mental illness, and more than 3 million had a substance use disorder.

63% of people over the age of 50 must choose between food and medical care

10K people will reach age 65 each day through 2019

27% Medicaid + CHIP population growth in recent years

Keeping these populations healthy and avoiding adverse events may require care managers to think—and manage—beyond the realms of traditional care delivery. Although healthcare organizations still need to connect members with the right clinical resources, they may also need to connect them with a taxi service so they can get to appointments or with food assistance programs to ensure a healthy diet, for example.

These factors pose unique information and care management challenges. Success will ultimately lie in educating and connecting with members at a personal level to build realistic care plans that yield better outcomes at lower costs.

medecision® Liberating.

Step-by-step approach to overcoming patient care barriers

With these distinct Medicare and Medicaid concerns in mind, healthcare organizations need new ways to improve health outcomes by addressing both clinical and non-clinical barriers to health. Health plans and providers must identify at-risk and rising-risk members, educate them and connect with them at a personal level to build realistic care plans they can—and will—follow. Here's how:

STEP 1

Identify and stratify Medicare / Medicaid populations

Stratifying Medicare and Medicaid populations is slightly different than for other populations because most are already high-risk, high-cost members. The key is to zero in on not only those who consume the highest levels of care but also those who are trending toward financially and clinically costly complications, such as chronic disease and comorbidities.

The better you understand these sub-populations or microsegments, the more effectively you can manage and deliver care. One of the most fundamental challenges faced in care management is understanding factors such as:

How many discrete population microsegments do you have?

What characteristics define these population microsegments?

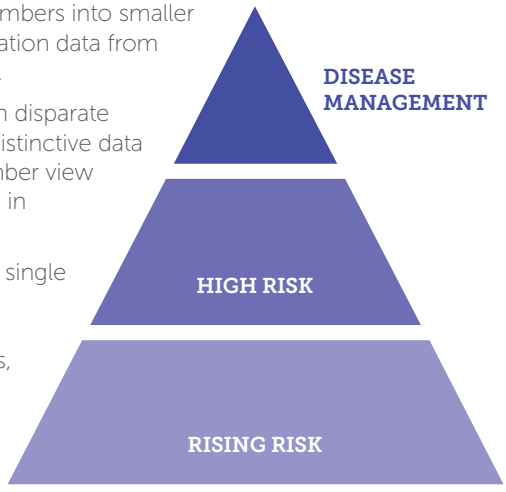
What are the needs of each discrete population microsegment?

Answering these questions requires the ability to divide Medicare or Medicaid members into smaller sub-populations or microsegments. But first, you must aggregate member population data from multiple sources, including individual claims and clinical data across care settings.

The problem for many organizations, of course, is the lack of integration between disparate systems. Each of your existing health IT systems likely has its own database and distinctive data structures. There is no one system in which a comprehensive, consolidated member view exists. A single member might be listed as John Doe in one system, John Q. Doe in another and Jonathan Doe in a third.

While your infrastructure eventually may allow multiple systems to interact with a single shared database, that is probably not a viable near-term solution. A more viable approach might involve an intermediary solution that connects into each existing database, understands and navigates each source system's unique data structures, and creates a "virtual" consolidated database.

A consolidated database would lend itself to the ability to run deep analysis that micro-segmentation requires. It would also help identify the characteristics that comprise each distinct population microsegment. With that data in hand, analytics and data modeling could be used to stratify members who are both high-risk and rising-risk to help prioritize and target resources.



MEDICARE / MEDICAID POPULATIONS STRATIFICATION

Micro-segmentation and analysis is crucial to

- Create and manage programs targeted at helping distinct population microsegments
- Determine which individuals would benefit most from prioritized engagement and care
- Determine whether your management efforts are truly meeting members' needs
- Analyze what you might do differently to improve outcomes

STEP 2

Take action with analytics-driven interventions

With a virtual consolidated database in place, analytics tools can help gain the insights needed to drive care. One key point to consider is that well-delivered care ultimately depends on two distinct types of analytics tools operating in tandem: traditional and real-time.

Traditional analytics tools are designed to discern patterns and trends in the static historical record. They can provide numerous critical insights that facilitate care management. However, they are not designed to work on real-time data.

By contrast, real-time analytics tools are designed to monitor the streaming data integrated from a variety of places such as lab systems, physicians' offices, and even telemetry systems in hospitals. These tools analyze the information and trigger actions in response to defined events, suggested patterns and the like.

Of course, analytics tools in and of themselves are of limited usefulness. To drive timely and appropriate care delivery, these tools must be connected to a platform that can translate insights into action in flexible and highly configurable ways.

An analytics tool that detects a negative change in one member's lab results, for example, might trigger an alert that prompts a care manager to enroll the member in a wellness program. The same lab change for a different member in a different microsegment might instead trigger the delivery of a text message that includes a link to an educational video for the person to watch.

The key is for the platform to be flexible enough to respond to the demands of different health conditions and to accommodate the needs and preferences of different members.

This flexibility may also need to extend beyond the scope of "traditional" care services to account for social determinants of health. Some Medicare and Medicaid members, for example, may no longer be able to drive or may lack a car to travel to a doctor's office. The care management system may need to be able to prompt the care manager to contact a designated taxi company to provide members with a ride to their appointments.

This level of care management may involve higher utilization than usual, but return on investment comes through improved outcomes. For example, it's far more cost-effective to arrange transportation to follow-up clinical appointments than to pay for ambulance service to an emergency room.

STEP 3

Measure and report to drive further improvement

Tapping into a virtual consolidated database not only aids in analytics that drive interventions but also makes it easier to comply with federal, state and other reporting requirements because all the necessary data is in one place.

Measurement and reporting activities for Medicare and Medicaid members closely resemble those for members in commercial health plans but with a higher level of complexity. Consequently, designing care plans in alignment with HCC coding and reporting opportunities also makes reporting easier and more effective. Data must support specific requirements and compliance reports for programs such as Star, PQRS/GPRO, ACOs and HEDIS.

An individualized approach for government populations

Managing Medicare and Medicaid populations requires an individualized and member-centric approach. By identifying and addressing the unique needs of Medicare and Medicaid members sooner, care managers can drive more effective interventions that reduce readmissions and overall care costs.

With the right data and analytics solutions in place, care managers can create care plans that account for individual clinical, socioeconomic and behavioral conditions, aligning with HCC coding and reporting opportunities. They can also engage members and their care communities at a more appropriate level with strategies best suited to each individual. Those strategies might include social messaging, integrated goal setting, self-assessments or education.

It all starts with information aggregation and analytics-driven interventions. With them, health plans and providers can confidently manage clinical and financial risk while improving care quality, optimizing revenue and facilitating efficient collaboration.

As an integrated health solutions company with over three decades of experience, we partner with risk-bearing organizations to manage **12.4 million+ Medicare Advantage and Medicaid members** within our HITRUST CSF®-certified Aerial™ offering.

But, it's not enough to deliver technology. We are driven to create real solutions that solve real problems with the goal of improving the care and outcomes of everyone involved. Let us show you how.

610-540-0202 | salesinfo@medecision.com | AerialHealth.io

medecision®
Liberating.

