

# Cost Control for Chronic Conditions: An Imperative for MA Plans

## *The Business Case for Remote Care Management (RCM)*

### Executive Summary

There is substantial evidence that remote care management (RCM) should be an integral element of Medicare Advantage (MA) health plans' efforts to achieve the optimal medical loss ratio and outstanding member satisfaction. The most influential member population of an MA health plan's medical spending is the 40% with chronic conditions who are at risk for developing even more serious and costly problems. In fact, annual healthcare spending is on average \$41,000 more for someone with three or more chronic conditions compared to someone with one or two chronic conditions.<sup>1</sup> MA health plans must implement successful stabilization and prevention programs for this population. RCM is a high value strategy because programs using RCM can build and strengthen member connections in a way that can help address the most common challenges of chronic condition management and help reduce the high costs of avoidable health problems.

## Connect the Dots to Minimize Avoidable Costs

Everything about healthcare is undergoing an extreme makeover—payment systems, models of care, quality standards and even the patients themselves, who are becoming older, sicker, and increasingly untethered from their doctors and caregiving teams. In this ever-shifting landscape, it's easy to get confused or lost. Medicare Advantage (MA) health plans caught in a labyrinth of rising expenses will find that their most fortuitous, less traveled path to better cost control is a matter of connecting the dots.

### **Chronic diseases are the No. 1 opportunity for MA plans to control medical utilization.**

The Centers for Disease Control (CDC) has called chronic diseases, "the public health challenge of the 21st century," noting that more than 75% of our national health care spending is on people with chronic conditions.<sup>2</sup>

### **MA plans' best strategy for chronic care cost control focuses on prevention and stabilization. The math all adds up.**

For MA plan members with chronic health issues, priorities must be to stabilize their conditions, prevent them from worsening, and stop them from developing into more serious problems that can be avoided. This approach encompasses health education activities that encourage healthy living, regular screenings, and diligence in managing existing diseases and related complications.

### **Stabilization and prevention efforts won't work when members are "off the grid" and disengaged from their own health.**

More and more people over 65 are responsible for self-directed care in their homes, yet are ill-equipped for the task. Too often, these disconnected members must follow complicated treatment plans with little or no ongoing support, a situation that puts them at greater risk of having expensive health setbacks. Recent research, for example, found that a "self-care deficit" in the elderly post-hospitalization population in a home health setting correlated to their bouncing back to the hospital.<sup>3</sup> In fact, one out of five hospital discharges results in a readmission within 30 days.<sup>4</sup> For Medicare members with chronic conditions, the rate climbs to 23% (for nonsurgical hospitalizations due to chronic conditions).<sup>5</sup> Readmission rates within 30 days exceed 20% for all patients with heart failure (26%), COPD (23%) and diabetes (21%).<sup>6</sup> Those rates skyrocket when looking at a longer time frame. Readmission rates within 12 months more than double for heart failure (55%), COPD (50%) and diabetes (45%).<sup>7</sup>

### **Remote Care Management (RCM) builds and strengthens member connections and helps health plans minimize the high costs of avoidable health problems.**

One of the defining characteristics of effective chronic disease management is productive connections between members and healthcare professionals. Stronger connections help MA health plans reduce some of the weaknesses inherent in self-directed care, including members' lack of awareness, knowledge, and engagement in managing their diseases.

RCM enables health plans to educate and engage members and encourage healthy behaviors. In addition, RCM programs empower members, their healthcare team, and family caregivers to more effectively monitor and manage chronic health conditions. Members are receptive to participating in such programs, as nearly 56% of boomers show a high willingness to use in-home health monitoring devices in tandem with care from their primary physicians.<sup>8</sup> Most important, remote care management technology in the U.S. could save as much as \$197 billion over the next 25 years.<sup>9</sup>

## Chronic Care Costs for MA Plans: The Worst is Yet to Come

If demographics are indeed destiny, get ready for future shock.

The first baby boomers turned age 65 in 2011; by the year 2040, America's elderly population will double to 81 million. More ominously for MA health plans, the U.S. Census Bureau reported that the nation's 90-and-older population nearly tripled over the past three decades, reaching 1.9 million in 2010. People 90 and older now comprise 4.7% of the older population (age 65 and older); by 2050, this share is likely to reach 10%.<sup>10</sup>

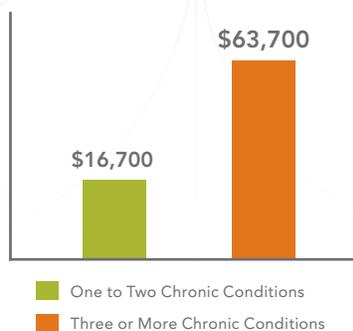
An influx of baby boomers with longer life spans translates into more health plan members who will have chronic health issues—a trend that portends potentially dire financial consequences if new care delivery programs are not deployed. Consider:

- According to a 2010 CDC/NCHS National Health Survey, more than 45% of people age 65 and older have at least two chronic health conditions—a 25% increase since its 2000 survey.<sup>11</sup>
- More than 11 million live with five or more chronic conditions.<sup>12</sup>
- People who are 65 and older and have multiple chronic conditions:
  - Account for 76% of all hospital admissions and 72% of physician visits

- Are 100 times more likely to have a preventable hospitalization than someone with no chronic conditions.<sup>13</sup>

- Total annual healthcare spending for a person with one or two chronic conditions at age 65 is about \$16,700 more than for a person of the same age with no chronic conditions.<sup>14</sup>
- Total annual healthcare spending for someone with three or more chronic conditions at age 65 is an additional \$47,000, even after accounting for the shorter life expectancy associated with having multiple chronic conditions.<sup>15</sup>

Cost of Chronic Conditions<sup>14,15</sup>



Again, the dots can be easily connected: Negligence of members with chronic health problems will lead to their developing more acute chronic conditions, resulting in higher costs. The most successful MA plans will make it a priority to proactively cultivate a member population that has a much higher proportion of members with two or fewer chronic

conditions, and will focus on enabling members to actively manage their conditions.

## Preventing Avoidable Costs

Although it's too late to prevent the onset of chronic diseases for many Medicare beneficiaries, MA health plans can still prevent (or at least delay) members' conditions from worsening and developing into more serious health issues. A proactive approach to prevent the continuing escalation of chronic care costs should address questions such as:

- *What are the avoidable costs associated with chronic diseases?*
- *What are their primary causes and risk factors?*
- *How can we help members modify their behaviors to reduce these risks?*
- *What else can we do to help members and their caregivers manage these problems and ensure timely interventions when needed?*

Numerous studies show that four modifiable behaviors—lack of physical activity, poor nutrition, tobacco use, and excessive alcohol consumption—are responsible for a large share of chronic disease costs. Also high on the list of avoidable costs for Medicare beneficiaries are hospital readmissions and expenses resulting from non-compliance to treatment regimens and/or medication.

For example:

- Almost 20% of hospitalized Medicare beneficiaries are readmitted within 30 days; more than half of these readmissions (13%) were potentially avoidable.<sup>16</sup>
- Medication non-adherence costs the U.S. healthcare system between \$100 billion and \$289 billion annually. Some 20% to 30% of prescriptions are never filled, and up to 50% of medications are not taken as prescribed.<sup>17</sup>
- Medication non-adherence is considered responsible for 33% to 69% of medication-related hospital admissions and 23% of all nursing home admissions.<sup>18</sup>

One of the primary causes for non-compliance with a care plan or medication maintenance among older people is simply a lack of understanding. In a survey of adults 50 and older who frequently use the healthcare system, 76% have left a doctor's office or hospital confused about what to do at home.<sup>19</sup> Another study found that about two-thirds of people 65 and older do not understand information they receive about their prescription medications.<sup>20</sup> With a remote monitoring solution, patients may be less confused after they return home.

Studies also show that problems are much more likely to occur when members "disconnect" from their physicians and

caregiver support team. This "disconnect"—not reporting changes in their conditions or going to the doctor when their health worsens—is a significant cost driver when a chronic illness suddenly becomes acute. A national Medicare analysis found 50% of patients who were re-hospitalized within 30 days had no intervening physician visit between discharge and re-hospitalization.<sup>21</sup>

The World Health Organization and other groups have noted that a patient's relationships with physicians and others in the healthcare system can increase adherence.<sup>22</sup> Individuals who see their providers as being supportive have an enhanced sense of well-being and motivation and are more effective in self-managing their chronic diseases.<sup>23</sup> Those who report good communication with their doctor are more likely to be satisfied with their care and more willing to share pertinent information needed for accurate diagnoses, follow advice, and adhere to the prescribed treatment.<sup>24</sup>

## **RCM: Better Connections, Better Cost Control**

These and other studies demonstrate that one of the keys to effective chronic disease management is establishing and maintaining productive connections between members and healthcare professionals. This becomes even more important

among elderly, homebound health plan members, who require hands-on attention and constant monitoring to identify notable physical, emotional, or behavioral changes. Strengthening these connections needs to be part of any strategy for controlling chronic disease costs.

Healthcare professionals, for example, should be able to manage members' conditions with easy access to near real-time patient data. Ideally, they should be informed whenever a member's health shows signs of worsening so they can quickly expedite treatment when medical intervention is required.

Stronger connections also may help MA health plans reduce some of the common shortcomings in self-directed care that often occur when members lack the knowledge, motivation, or ability to manage their diseases. Because of low health literacy rates, physical and cognitive impairments, and other factors, fewer than 30% of Medicare enrollees are "highly activated" in their own care, defined as having adopted many of the behaviors necessary to support their health.<sup>25</sup> This clearly plays a role in the fact that, while demand from Medicare beneficiaries for home healthcare is increasing, the hospitalization rate for home healthcare patients has remained near 30% for nearly a decade.<sup>26</sup> Quite simply, accepting the status quo is a recipe for failure.

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Given the time and costs involved, providing members with more face-to-face visits from their caregiving team is not a viable option. But with RCM, MA plans can facilitate these important care interactions between members and physicians, nurses, family

members, and social services. RCM programs directly involve patients as well as clinical professionals in the care process, often on a daily basis, using technology, tools, and specific disease management protocols.

By providing information such as daily health status reporting and educational videos directly to MA plan members, RCM programs can help members become more capable and confident about managing their own health. For example, the technology can show members how to properly use a blood pressure cuff or remind them to pick up a prescription refill.

RCM technology may provide numerous opportunities for health assessments, identify when patients need more medication, deliver dynamic

and effective tutorials, and facilitate remote coaching sessions with healthcare professionals. RCM solutions may enable automatic settings to inform these professionals when changes in a member's health occur, which may result in more timely and effective medical interventions. By gathering and reviewing biometric data combined with patients' qualitative feedback, healthcare professionals can take proactive action when needed. These professionals also are better able to help members overcome personal challenges and remove obstacles to their good health. Such interventions not only help members gain the confidence and skills that support healthy behaviors, but also reduce their need for more care, or more complex and expensive care.

## RCM Helps St. Vincent Health Reduce Readmissions by 75%

In the face of penalties and increasing pressure to control healthcare costs, St. Vincent Health\*—a member of Ascension Health\*, the nation's largest not-for-profit healthcare system—implemented an RCM program designed to help reduce readmissions. Three hundred patients with a primary diagnosis of congestive heart failure (CHF) or chronic obstructive pulmonary disease (COPD) were selected for the program and, upon discharge, were provided the Intel-GE Care Innovations™ Guide solution to support at-home care. Results of the study show that readmissions in the intervention group were reduced by up to 75% compared to the study control group.<sup>27</sup>

## Conclusion

### A Solution for the 40%: MA Plan Members with Multiple Chronic Conditions

For years, cost control efforts for most MA plans focused on the very small percentage of members most at risk of needing frequent and extended hospital stays. While this obviously is still of great concern, plans need to shift more of their attention to a fast-growing segment of Medicare beneficiaries—members with chronic health problems. The CDC frames the issue in blunt terms: “We cannot effectively address escalating healthcare costs without addressing the problem of chronic diseases.”<sup>28</sup>

The good news for MA plans is that a significant share of the costs associated with members’ chronic health problems can be avoided. Hospital readmissions and the need for more intensive medical interventions often can be traced to members’ non-compliance with medication or treatment regimens or unhealthy behaviors. MA plans can significantly reduce these unnecessary costs by helping members stay more connected to their healthcare regimen and healthcare professionals, who can monitor their condition and provide support or interventions as needed. RCM programs are a practical, cost-effective solution for chronic care cost control for the 30 to 40%

of members who have multiple chronic conditions.

### For More Information

Learn how Intel-GE Care Innovations™ solutions can help your company implement an effective remote care management plan designed to reduce the cost of caring for your members with chronic diseases. Visit [careinnovations.com/MApayer](http://careinnovations.com/MApayer) to see an online overview of our remote care management platform.

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These are some of many studies that have been published on the use of telehealth technology for chronic conditions. Other published studies have used a variety of different technologies and may have different results.

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