

Amid the clinical and financial transformation in healthcare, one area that continues to elude health plans is the appropriate management of care for members with multiple chronic conditions (MCCs).

If your organization has struggled to implement effective care management solutions for MCCs, consider the complexities the following real-life patient faces.

Joe is an 85-year-old man with congestive heart failure (CHF), diabetes, chronic obstructive pulmonary disease (COPD), depression, and coronary heart disease (CHD). He lives alone in a two-story house he bought in 1962. His wife died two years ago, but his daughter, Sara, visits every Saturday to stock his kitchen, review his medications, and check in on him. Joe tries to see his primary care provider (PCP) twice a year, but struggles to schedule his appointments, and needs assistance getting to and from the clinic. He canceled his last two appointments because Sara wasn't available to drive

him to the office. Joe has been to the ER three times this year for shortness of breath, and was admitted twice: once for pneumonia and once for a CHF exacerbation. He had a fall three months ago and bruised his hip badly, but did not fracture it. To manage his chronic conditions, Joe is on 14 different medications, but controls his regime independently. Sara admits that her father's memory is failing, and that he should probably be in a nursing home. She is unaware of any advance care planning or documentation and doesn't know where she can go for help.

Joe is not unique. There are millions of frail patients with MCCs, and the number is only growing: [a RAND study](#) found that 81% of people 65+ had multiple chronic conditions, and with [Medicare enrollment expected to grow](#) to nearly 80 million by 2030, the number of people with MCCs can be expected to grow significantly.

These patients are expensive, too. According to a HealthScape analysis of select Medicare Advantage (MA) markets, members with six or more chronic conditions average more than \$30,000 a year in medical expense, almost 4x as expensive as the average Medicare beneficiary.

The traditional office-based primary care practice is simply not equipped to manage this MCC population. Fortunately, innovative delivery models—such as those described in this HealthScape brief—are being custom-built specifically to address MCC members, and are generating a track record of dramatically improving Medical Loss Ratio (MLR), increasing access, enhancing quality, and generating high patient satisfaction. Health plans or other risk-bearing entities that partner with—or borrow from—these delivery models are well-positioned to weather the MCC storm.

Why Health Plans Struggle with Complex Chronic Care Management

Caring for MCC members requires significant investment in longitudinal care and health maintenance. Unfortunately, there are significant structural limitations in the way care is delivered to this population.



Site of care can be problematic for MCC patients

Most PCPs and specialists continue to deliver care in office-based settings. While this may work for the majority of Americans, this historic model of care is problematic for more than [8-10 million Americans with MCCs](#) who are homebound, bedbound, or otherwise challenged to leave their home and access care on a regular basis. Patients who struggle to leave their home are more likely to see their physician less frequently than desired, and are more likely to resort to the ER as their primary access point into the healthcare system.

Delivering care for MCC patients in their own home—as opposed to a medical office—confers additional clinical advantages. A seasoned provider can do a pantry check to inform diet modification recommendations or a safety assessment to reduce fall risks. Medication management becomes much more effective in the patient's home, where a physical reconciliation can be completed. The presence or absence of family or neighbors sheds light on the patient's social support system. And the intimacy of a patient's living room enables a level of rapport and trust that cannot be matched in the office setting.

Regulatory Support for Chronic Care Management

Last September, the Senate unanimously passed the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017. In a recent market alert from HealthScape, we explore the key modifications to the historical care delivery model for this population that are presented in this bill. [Read more here.](#)



Care is not coordinated across specialists and facilities

MCC patients typically have a PCP and four or more specialists driving their care. PCPs often lack the bandwidth to properly coordinate activities across all the specialist and sub-specialist domains, resulting in duplicative care, conflicting medication regimes, and confused patients. The lack of coordination among medical practitioners is exacerbated by the lack of coordinated treatment between medical and behavioral health providers. This problem is magnified in the MCC population, where the industry estimates more than two-thirds of patients have co-existing medical and behavioral health conditions, but fewer than one-third of those patients are followed by both medical and behavioral primary care providers. This limited coordination becomes even more cumbersome when the coordination occurs across provider groups or organizations, as interoperability challenges preclude seamless data exchange.



Financial incentives are not aligned with the traditional PCP network

Despite migration toward value-based contracting, most MCCs continue to be managed under a fee-for-service (FFS) model. Providers are typically not financially motivated to customize their practice for the needs of MCC patients, as they typically make up a small percentage of an average panel. Conducting home visits is a money-losing proposition for FFS-based PCPs because of the inherent inefficiencies associated with field-based care. Although reimbursement for chronic care management and advance care planning is helpful, the dollar value is not high enough to trigger wholesale restructuring of practices or delivery models. Reimbursement for investments made in coordinating social work activities, dietary support, or care coordination remains limited.



Primary care practices no longer have the clinical competencies for complex chronic care

The FFS model prizes volume over value, which has inexorably led to office-based appointments that are shorter and shorter. Primary care providers—typically internists or family medicine practitioners—squeeze more patients into a day, which has forced them to address the first two or three problems on a patient's list, and either defer the rest to a subsequent visit or refer to a specialist for follow-up. Patients with compensated and stable CHF are referred to cardiology for medication management; pulmonologists manage patients with intermittent COPD flare-ups. This fragmentation not only increases the risk of uncoordinated care but has also atrophied clinical competencies of PCPs who were historically well-equipped to manage patients with MCCs.

Disrupting the Traditional Primary Care Model

Risk-bearing organizations, including payers and health systems, are increasingly ready to invest in custom programs to manage MCC members, but most have struggled to translate investment dollars into better clinical and financial outcomes. Industry leaders are recognizing that management of MCC members requires more than just a bolt-on house call program or an upside risk sharing arrangement with community providers.

An effective, integrated model requires the following elements:



A patient-centric, tailored model of care

- Ease of access, either through home visits or tailored transportation benefits.
- 24/7 availability, where the patient’s care team must be ready to deploy care at all hours, becoming the patient’s credible and trustworthy alternative to the ER.
- A support mindset that empowers the patient and their caregivers in setting and following a plan of care.
- Navigation to community-based resources that address social and behavioral challenges, and provide support along the patient’s entire care continuum.



Specialized expertise

- Physicians trained in chronic care management, especially as those conditions manifest in the frail and elderly population.
- Integrated expertise across the medical, behavioral, and palliative care domains.
- Dedicated social work resources, often the initial step of providing support with access to services and assistance beyond the basics.



Advanced technology and analytics

- Technology-enabled care that empowers team-based collaboration, and that is designed to optimize care pathways, not billing or reimbursement.
- Advanced stratification (based on claims mining and physician screening) to align scarce provider resources with the highest-risk patients.
- Thoughtful screening criteria to ensure that the right set of chronically ill patients qualify for programs.



Aligned risk-based payment

- A risk-based model with shared savings between provider and payor to align incentives and enable providers to invest in the capabilities outlined above.

Lessons from the Industry: Approaches to Managing MCC Patients Vary

Recognizing that these competencies are critical to complex chronic care management success, a few companies have emerged over the years, each with a unique approach on the traditional primary care delivery model.

The following section provides a summary of six different organizations' approaches to managing MCC patients, followed by a deep dive into Landmark Health's unique model, derived from HealthScape's exclusive interview with Landmark's CEO.

Customizing the clinic-based model for MCC patients

Iora Health

Iora Health is a clinic-based, interdisciplinary team model that offers medical care to a broader population of clinically complex patients. Iora partners with a diverse set of customers (including health plans, unions and employers) and takes full risk, benefiting financially only through improvement in clinical quality and cost of care. Iora has a tailored model that leverages physician providers and non-physician health coaches as primary connection points with patients, identifying and addressing unhealthy habits, managing chronic conditions, and acting as the patient's health advocate.

Care Management Plus from Intermountain Healthcare

Care Management Plus uses a "care manager" embedded in a PCP office to enhance care for patients with complex needs. These care managers go through specialized training programs and can spend additional time with patients since they are not driven by the FFS model. With support from information technology tools, care managers develop a care plan, provide self-care management coaching for patients and caregivers, and refer patients to necessary community-based resources.

Delivering in-home care for MCC patients

Independence at Home

Independence at Home (IAH) is a test program designed by the Center for Medicare & Medicaid Innovation (CMMI) that delivers home-based primary care to Medicare beneficiaries with MCCs. Participating practices provide in-home visits over a five-year period (which concluded in October) using interdisciplinary teams directed by physicians and nurse practitioners. If providers meet quality standards and financial targets, they receive an incentive payment from CMS. In the first performance year, [an analysis found](#) that practices saved over \$25 million, or an average of \$3,070 per beneficiary.

ElderPAC

Based in Pennsylvania, ElderPAC combines in-home primary care through an IAH-certified program with community-based services through Medicare and Medicaid Programs of All-Inclusive Care for the Elderly. An interdisciplinary team consisting of an MD or NP from Penn Medicine, a case manager from Philadelphia Corporation on Aging (PCA), and a community nurse from Home Health Agency serves institutionally qualified dual eligibles.

MedStar

MedStar’s medical house call program in Washington, D.C., offers team-based primary care to patients in their home. Eligible participants must be 65+, live in one of seven zip codes, have a functional limitation that makes it hard to visit a PCP, and have insurance that will cover house calls. Providers are available 24/7, and utilize a mobile electronic health record and regional health information exchange to manage care. They also emphasize transitional care, end-of-life care, and caregiver/family support. [By one analysis](#), this amounted in \$12,000 in savings per beneficiary.

VA Home-Based Primary Care

For more than 40 years, the VA has been providing home-based primary care to chronically ill veterans. A care team comprised of clinicians, nurses, social workers, dietitians, psychologists, pharmacists, and rehabilitative therapists work together to provide integrated health services, support and education for caregivers, and referrals to community-based resources. Participants are chosen based on cost and chronicity, unlike Medicare’s home health benefit requirements. [The program has reported](#) a 24% decrease in cost of care and higher satisfaction and functional status among participants.

Deep Dive into Home-Based Primary Care Provider Landmark Health

[Landmark Health](#), headquartered in Huntington Beach, CA, is a mobile provider group focused on delivering in-home medical care services to the most chronically ill. Since its formation in 2014, Landmark has grown to oversee \$1.5B in medical expense and is responsible for more than 55,000 patients in 14 markets across the country. Through this experience, Landmark has demonstrated improvements in quality, reduced avoidable utilization by 30-40%, and achieved high patient satisfaction (Net Promoter Score© of 91). It partners with—and is delegated full risk from—health plans and other risk-bearing entities across the country.



“At first glance, the Landmark model appears straightforward,” states Adam Boehler, Landmark Founder and CEO. “We bring medical care to chronically complex patients, where they reside and when they need it. However, the success of our model comes from aligning the entire business around our mission of delivering in-home care to patients with multiple chronic conditions. Our risk-based financial model, homegrown EMR, provider recruiting, training and enculturation, advanced stratification and analytics all work together to enable our success.”



Key Elements of Landmark's Model



Patient-Centric, Tailored Model of Care

- **Complements current points of care:** While most other models require patients to switch PCPs, Landmark's model complements and augments, but does not replace, the existing PCP.
- **Identifies non-health-related barriers:** By visiting the home, providers can identify and mitigate environmental risks. Landmark providers complete home safety environments, do pantry checks, and assess patients in their own home. Providers can also assess the patient's support network and evaluate medication management competency. Landmark patients are also routinely checked for changes in functional status.
- **Emphasis on care coordination:** Providers build a care team around the patient and integrate social services connectivity, behavioral health, palliative care, and advance care planning.
- **Expanded access:** Providers spend an hour on average with patients, forming a long-term relationship based on trust and intimacy. Landmark is available 24/7, giving patients an in-home medical alternative to the ER.
- **Caregiver empowerment:** Landmark focuses on member and family engagement by emphasizing health literacy, symptom detection and management, and advance care planning.



Specialized Expertise

- **Chronic care training:** Landmark providers complete specialized training programs to learn the clinical competencies necessary for chronic care management. Example modules include treating depression in the elderly, fall risk management, COPD management, and geriatric medication management.
- **Interdisciplinary approach:** Landmark providers receive integrated support from their colleagues, including behavioral health professionals, social workers, pharmacists, nurse care managers, and dietitians. All members of Landmark's IDT are fully employed within the medical group.
- **Patient engagement:** Landmark bears risk on its assigned patients, but enrollment into the Landmark program is voluntary. Landmark has developed a suite of outreach tools—including customized scripting, marketing collateral, and community outreach—to enhance patient engagement. All outreach is conducted by Landmark employees, and the program secures an opt-in rate of 50% or more.



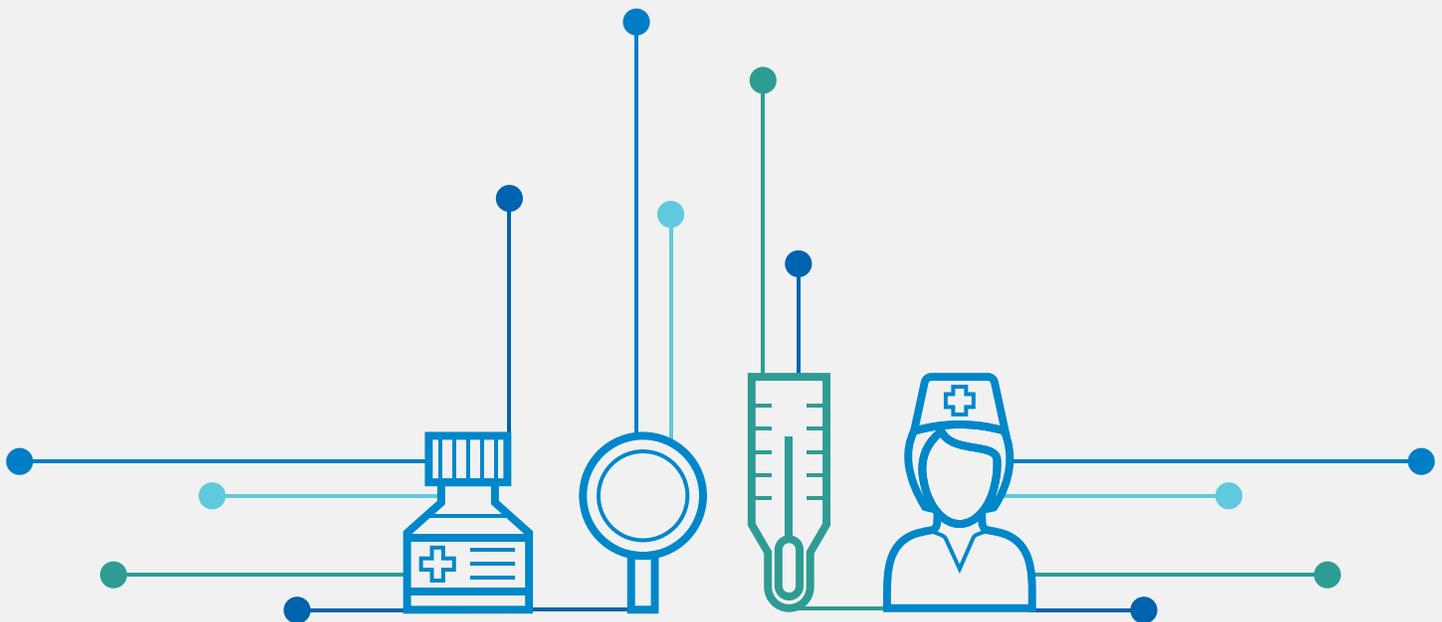
Advanced Technology and Analytics

- **Advanced analytics and stratification:** Landmark uses disease-based criteria to identify and continuously refresh its target patient cohort. It uses in-house predictive analytics to identify patients at high risk of hospital admission and combines that with data-driven assessments of acuity.
- **Interoperable technology:** Landmark custom built a mobile, proprietary, offline EMR, which enables offline documentation during a home visit. The EMR is used by all members of the Landmark team, and also enables clinical documentation exchange with community providers.



Aligned Risk-Based Payment

- **Shared savings arrangements:** Landmark takes full downside risk on its fees, and benefits financially only when it delivers measurable and material improvement in MLR, clinical quality, and patient satisfaction. Landmark typically is assigned a cohort of patients that has six or more chronic conditions.



Landmark Health Delivers Early Success: Health Plan Partner Results

Since its original inception and continuing into its first major risk-based relationship, Landmark has met its objective of enhancing the medical outcomes of highly complex patients by managing care in a new and accountable fashion. As demonstrated in their initial contract with CDPHP, a leading provider of health benefits in Upstate New York, Landmark agreed to deliver home-based medical care for CDPHP's most frail and chronically ill patients.

Since the inaugural house call, Landmark has delivered over 28,500 home visits to CDPHP members, and the number of patients under Landmark's active management has grown to almost 2,800 high-risk, chronically ill patients across the Albany metropolitan area.



97% of CDPHP members engaged in Landmark's program would recommend it to a friend.



Landmark has met or exceeded 100% of all gap closure targets since the inception of the program, and has contributed to CDPHP's strong performance with respect to STARS. Example quality measures include blood pressure control, diabetes HbA1c and nephropathy screening, and flu vaccination.



Year 1

A 22% increase in average risk score in year one and a 20% increase in average risk in year two. This improvement in clinical documentation resulted in appropriate and enhanced risk adjustment for CDPHP.



Year 2



Landmark reduced hospitalizations across its total cohort by 14%. Adjusting for its effective engagement rate, hospitalization volume dropped by as much as 40% on patients managed by Landmark.

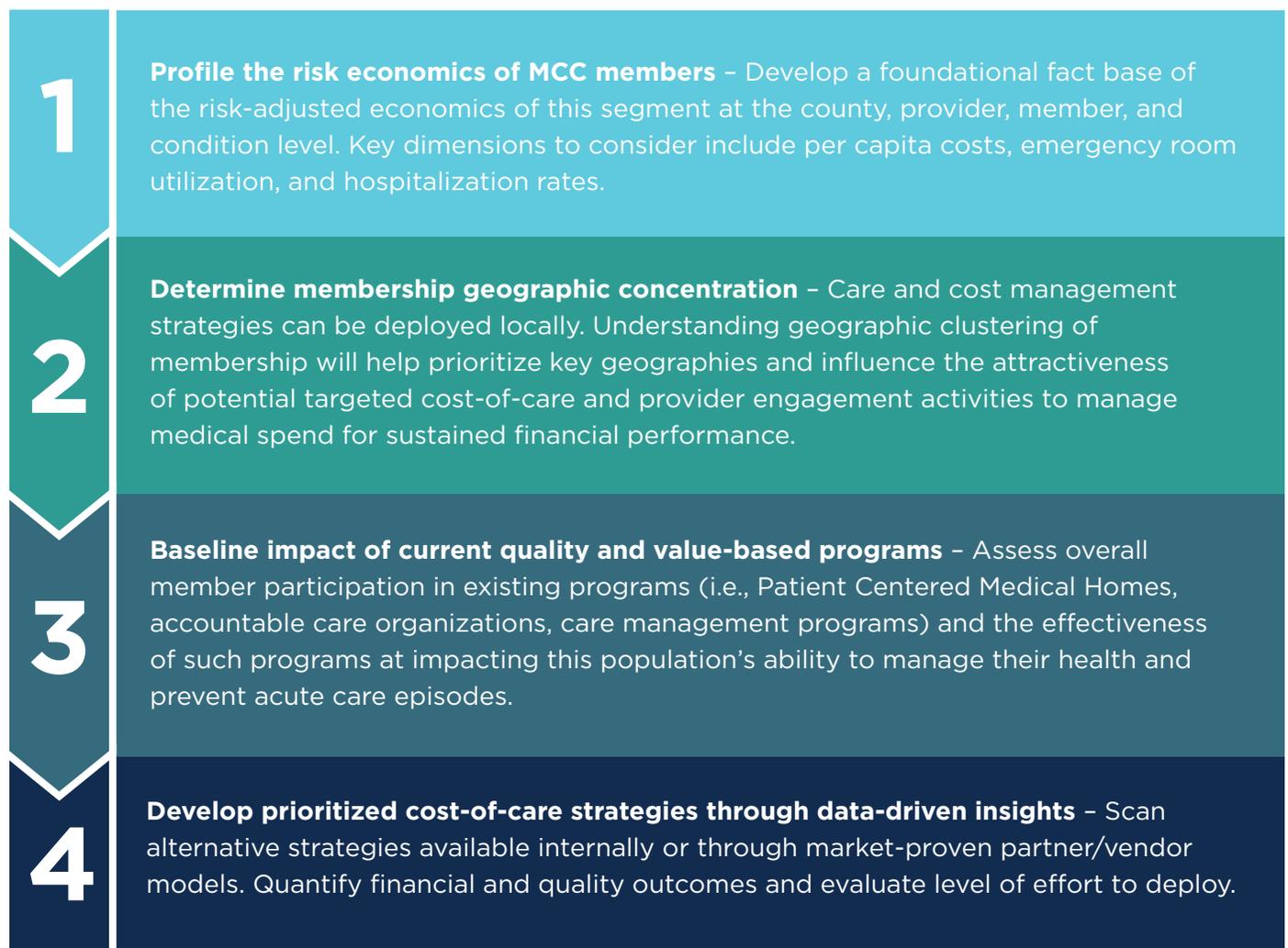
“ Through our partnership with Landmark, we are able to deliver a truly distinctive service — 24/7 in-home medical care — to our most complex and chronically ill members, at no cost to them. Landmark delivers a fantastic member experience and has made a significant impact in driving improvement in total cost of care. ”

-Tracy Langlais
Senior Vice President of Medical Affairs Operations, CDPHP

How Can Health Plans Evaluate the Right Model?

The concentration of medical costs within this small group of patients makes it an attractive priority area for health plans. In some instances, a more surgical application of chronic care management solutions within a concentrated geography or patient base can deliver significant MLR improvement.

HealthScape uses a quick four-step diagnostic to understand the opportunity:



Do you need an evaluation of members with MCCs and new or existing models for chronic care delivery? Schedule a call with HealthScape to see how we might be able to help.

Contact **Michelle Werr** at mwerr@healthscape.com or **(630) 546-5044** for more information.



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