CHCS Webinar:
Targeting Interventions for the Highest-Need, Highest-Cost Medicare-Medicaid Enrollees: Health Plan Approaches
July 21, 2015

On July 21, 2015, the Center for Health Care Strategies (CHCS) held a webinar, with support from The Commonwealth Fund, which shared two health plans’ approaches to identifying their highest-need, highest-cost Medicare-Medicaid enrollees and improving their care. Speakers included representatives from Independent Care Health Plan (iCare) (Wisconsin) and Health Plan of San Mateo (California), both of which participate in PRIDE (Promoting Integrated Care for Dual Eligibles), a project to advance health plan strategies for providing high-quality and cost-effective care for Medicare-Medicaid enrollees. Following are questions submitted by attendees and answers provided by the health plans. For more information about PRIDE and resources from the project, please visit CHCS’ website www.chcs.org.

1. What does “PRM” stand for, and where can I find out pricing and other information about it?

   iCare’s predictive modeling software is called Milliman PRM Analytics. The acronym PRM stems from the tool’s early development phase. For more information, see the company’s website www.prm.milliman.com.

2. How does iCare plan to integrate the PRM tool into its electronic care management and electronic health record (EHR) systems?

   iCare is currently working with its EHR company to develop an interface that will connect both systems. Ideally, iCare would be able to incorporate individual member profiles from PRM into the EHR as clinical data.

3. Is PRM available as a mobile version? Do community health workers have access to PRM while they are out in the field?

   PRM is accessible via the web link, so it can be opened anywhere there is internet service. The data could be available to anyone on the care management team, although there is a separate charge for each user.

4. Given evidence around social determinants of health and the impact of mental illness and substance use disorders on poor health outcomes and costs, why not try to capture those data as well? Seems like these medical conditions are a very small piece of the puzzle of high costs.
The Milliman PRM Analytics tool is based on claims and utilization data. iCare would like to have its health risk assessment data, care plan, and social determinants included in the analytics. PRM does not yet have those capabilities, although Milliman is interested in adding social determinants of health information in the future. iCare agrees that information on the member’s home life and living situation is often far more predictive of future needs than relying solely on claims data. For this reason, PRM is not iCare’s sole source of data driving its interventions.

5. Could predictive analytics be part of value-based purchasing approaches or strategies for serving dually eligible individuals in non-integrated programs?

Approximately 85 percent of iCare’s dually eligible members are enrolled in a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) that provides some coordination of Medicare and Medicaid benefits, but does not integrate care as completely as iCare’s Fully Integrated Dual Eligible (FIDE) SNP. iCare is using predictive modeling to identify opportunities to improve care for dually eligible individuals enrolled in its non-integrated D-SNP program and its FIDE SNP.

6. How did HPSM gain stakeholder support for its Community Care Settings pilot program?

HPSM spent almost two years in the development of a strategy and tactics before launching the pilot program. It engaged several nursing facilities, multiple county agencies, and a very large number of housing-related providers. Plan representatives typically met one-on-one with nursing facilities, but also attended nursing facility association conferences to obtain stakeholder feedback and support. The plan undertook the pilot initiative in partnership with the county health system and expanded the partnership to include the county housing authority and, most recently, the human services department. Plan outreach to housing-related providers has been both one-on-one with organizations and through group forums that covered the intersection of housing and health care. HPSM’s engagement model for the next stage of the pilot includes hospitals and physician groups. HPSM also uses its Consumer Advisory Committee and Cal MediConnect’s Consumer Advisory Committee to engage consumers and advocacy organizations (e.g., Alzheimer’s Association, Legal Aid, HiCap, County Aging and Adult Services, Centers for Independence). The plan uses these venues to provide updates on the Pilot’s progress and obtain consumer feedback.

7. How does HPSM utilize IHSS workers (In Home Supportive Services – California’s Medicaid managed long-term services and supports program) and their unique perspectives from being in the home with health plan members in order to meet the triple aim and address needs?

HPSM has integrated and co-located an IHSS social worker team in its plan and works closely with Aging and Adult Services to leverage IHSS resources and input. IHSS providers are sometimes part of the care team and often provide valuable clinical information to case managers.

8. How does HPSM’s Community Care Settings pilot program manage situations involving behavioral health issues and/or substance abuse issues? Additionally, who pays for utilities and food -- how
does the plan ensure that the housing that is provided to members in need remains a sustainable option?

HPSM partners closely with San Mateo County’s Behavioral Health and Recovery Services agency and provides training for staff on behavioral health and substance use issues. The member is responsible for food and receives assistance with utilities, when needed. If appropriate, the member may be connected to a home-delivered meal program.

9. Would you explain how the Community Care Settings pilot program works with California’s existing housing resources and waivers? Does California have wait lists for Section 8 housing, and if so, how to does the plan get around that to provide housing for its members? How does HPSM pay for housing? If the pilot program places a homeless member in an apartment, who pays for room and board? Is it true that California’s Coordinated Care Initiative (CCI) cannot pay for housing?

HPSM’s Community Care Settings pilot program is a health care initiative, so CCI funding cannot be used for an individual’s rent. Existing 1115 waivers can provide for care and habilitation in a community setting. HPSM uses these waivers when possible and replicates them when appropriate. HPSM actively works with the local housing authority to establish set-asides of housing vouchers for populations such as the ones served under the pilot program.

10. How much of an issue is dementia management for HPSM and iCare?

Between two and three percent of iCare members suffer from dementia, requiring complex care management. HPSM involves caregivers and targets resources based on need.