Developing Tools for Better Medical Management of Medicare Populations

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Medicare enrollment in HMOs got off to a quick start but has ebbed recently, principally because health plans found that the elderly joining their plans were costing the plan more than what the federal government was willing to pay. For the MCOs that want to continue to participate in Medicare+Choice, it is imperative for them to understand, in as much detail as possible, the potential health care costs of their enrollees.

Managing the costs of caring for elderly enrollees on a fixed budget, as payers and at-risk providers must, is one of the greatest challenges for managed health care. To predict and hopefully manage the health costs of these enrollees, health care executives need both a better understanding of the innate risks involved and better methods for stratifying enrollees according to health risk. Not only are health care costs for Medicare beneficiaries higher than for commercial enrollees, but also the nature of variable cost risks assumed are frequently misunderstood by those new to the business of managing the care of elderly enrollees. Although HMOs used to be able to count on a certain amount of positive selection among Medicare risk enrollees, that is no longer the case. The demographics of Medicare risk enrollment have changed, making careful medical management of senior HMOs imperative. By all indications, Medicare HMO enrollees are older and sicker than ever before.[1]

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THE EVOLUTION OF MEDICARE HMO ENROLLMENT

Medicare-risk HMOs now cover approximately 18% of the nation's elderly.[2] Expanding rapidly since their inception as small demonstration projects in the mid-1980s, their enrollment grew more than 25% per year in 1996 and 1997.[3] It is little wonder they proved so popular among the elderly: They offer richer benefits at a lower price than comparable traditional Medicare with supplemental Medigap coverage. With traditional fee-for-service Medicare covering only part of hospital and physician costs, many beneficiaries spend as much as $1,000 per year to expand their coverage. In comparison, an average premium for full HMO coverage was $11.39 a month in 1998. In that year, 70% of all Medicare HMOs charged no added premium to beneficiaries (i.e., "zero-premium" plans), and another 17% charged less than $40 per month.[4] Not only has Medicare HMO coverage been less expensive, but it has also often added valuable benefits not generally available under traditional coverage, such as vision care and payment for prescription drugs.

Medicare HMOs differ from commercial managed care plans in at least one key respect: They are a retail product rather than a wholesale one. Whereas commercial HMO enrollment is sold through employer group contracts, Medicare risk enrollees sign up individually. The retail nature of the product means that it is subject to rapid shifts in enrollment, particularly since Medicare beneficiaries have been free to enroll and disenroll at will. Commercial enrollment tends to be relatively stable, since enrollees are usually able to change coverage only once a year, and only after a plan has been reselected by their employers' human resources department. Providers in the California market, where Medicare HMOs have enjoyed sizable enrollments for many years, report that savvy seniors found they could enroll in a plan long enough to exhaust the limits of their drug coverage and then move to another plan to begin their coverage anew. In addition, family members may become involved in the purchasing decision. The children of beneficiaries, more comfortable with the concept of HMO coverage, may encourage their parents to enroll in Medicare HMOs to take advantage of better benefits at lower cost.

It was commonly assumed that Medicare HMOs benefited from positive selection until 1997; that is, health plans attracted a greater portion of healthy members compared with the traditional Medicare setting.[5] Early adopters of HMO coverage were, in fact, younger and healthier than average Medicare beneficiaries.[6] The U.S. General Accounting Office (GAO) found evidence that the Health Care Financing Administration, in Baltimore, was losing money in the early years of Medicare HMOs; the GAO estimated that the government was overpaying to the tune of $2 billion annually.[7] The original methodology used in setting HMO payment rates to the government was intended to build in savings, setting Medicare risk premiums at 95% of the expected fee-for-service payment. If HMO enrollees were healthier than average beneficiaries, however, they would actually have cost the government far less under the old indemnity system of payment. Two studies published in 1996 found that HMO beneficiaries' costs were actually 12% to 37% lower than costs for Medicare fee-for-service beneficiaries.[8] Aside from the evidence amassed by such studies, HMOs were clearly running sizable profits in the early years of Medicare HMOs and were well able to afford to offer the enriched benefits of vision care, drug cost coverage, and preventive care programs.

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Those enriched benefits ultimately worked against the cherry-picking advantage early Medicare risk plans enjoyed. Naturally, those enrollees who are sickest have the most to gain from higher benefit coverage, especially drug coverage, since traditional Medicare does not cover drug costs. The government's statistics show that today's Medicare HMO enrollees are not necessarily youthful. Almost half of new risk-plan enrollees have been Medicare-eligible for more than five years, a proportion that has been growing since the early 1990s.[9] This is an indication that Medicare risk–plan enrollees have been growing older as a group.

In 1998, Medicare HMOs and providers with capitated contracts to serve the elderly began reporting losses and poor financial results.[10,11] These difficulties were exacerbated by several changes in the Medicare program under the provisions of the Balanced Budget Act of 1997. The renamed Medicare+ Choice program called for payment increases to HMOs in relatively higher-reimbursed areas to be capped at 2% annually, with uncertain changes to the risk-adjustment methodology used in setting HMOs' capitated rates. It has been estimated that between 90% and 95% of all Medicare risk plans will see their payments drop because of risk adjustment.[12]

The projected downward adjustment in payment, combined with clear evidence of failure in many markets under the existing payment methodology, led many HMOs to reduce their investment in Medicare risk plans. By the end of 1998, many Medicare HMOs found their financial situation was so poor they believed it was necessary to terminate their Medicare HMO business altogether. As a result, 440,000 Medicare HMO beneficiaries were forced to find another HMO (if one was available) or return to indemnity coverage.[13]

Though this created tremendous disruption for beneficiaries covered by a terminated plan, many of those seniors will seek coverage under other HMOs. Few in the industry believe this is the end of the Medicare risk business. It does, however, speak to the seriousness of the

need for top-notch medical management of Medicare beneficiaries to control costs. Payment for coverage of Medicare enrollees is unlikely to get better over the next five years. Risk stratification of senior enrollees can be a key tool for focusing limited resources where they will do the most good. There are two tasks that will help providers and payers manage the care of their enrollees: (1) assessment of elderly enrollees by dividing seniors into groups according to their health risks and (2) stratification of treatment in determining appropriate courses of care according to those health risks and needs.

ASSESSING HEALTH RISK AMONG THE ELDERLY

Categorizing the elderly according to health risk may involve the use of several methods of data collection. Initially, many plans and providers may rely on actuarial or demographic data for a rough-cut estimate of a population's health risks. Broad categories, such as age, sex, and ethnicity, are often used to make initial estimates of the costs and health needs of a group of enrollees. Such data are relatively crude, however, and do not allow a provider or payer to plan treatment according to individual needs. For that, most health care organizations rely on surveys, often in conjunction with office visits, to better determine the needs and conditions of individual enrollees.

The main goal of enrollee screening and stratification is to identify the frail elderly. Elderly patients with limited mobility, chronic disease, or dementia have health needs quite different from average enrollees. Such patients are at much greater risk of hospitalization and high medical costs, and early identification of these enrollees may help to control, or even reduce, utilization and medical costs. In addition, frail enrollees may not be suited to the same kinds of screening and aggressive treatment appropriate for healthier beneficiaries. Further, health providers may wish to identify enrollees at moderate risk who may be helped through certain kinds of screening or lifestyle modification programs.

In making a risk assessment for the purpose of stratifying enrollees, any survey tool is better than none. In the effort to develop the perfect (and perfectly detailed) survey tool, providers should remember that even the simplest questionnaire will add to the caregivers' understanding of the patients' needs (Sidebar). For example, in screening for depression, Kaiser Permanente, headquartered in Oakland, California, and Group Health Cooperative of Puget Sound, in Seattle, initially use a simple three-question survey, which may then be followed up with more detailed questions once a problem is discovered.[14] The Carle Clinic, located in Urbana, Illinois, had good results for 10 years during which it used a relatively brief survey for screening the health risks of elderly patients. To identify patients who were potentially at high risk for utilization, clinic staff used a simple tool asking nine questions. Although this tool adequately identified frail patients, it was inadequate for other purposes, and has been expanded to 52 questions as of 1998. The new, expanded questionnaire is better for collecting detailed clinical data, for identifying patients who may be at moderate risk, and for initiating outcomes monitoring.[15]

In assessing health risks of the elderly, social factors are just as important as clinical ones. Any assessment tool should be designed to give caregivers insight into potential problems in the home life of enrollees. Living alone, without any assistance from a caregiver, is a risk factor for seniors who are less mobile. Educational issues may also affect the ability of the elderly to care for themselves. Noncompliance with medication instructions, for example, is often a serious problem in treating the elderly. Many patients may stop a course of drug treatment prematurely because of side effects, lack of apparent results, or cost, without notifying their physicians.

Techniques for collecting data on enrollee health status are undergoing evolution in the current market. Most early questionnaires were developed as in-house tools by the clinics and physicians who used them, but, as Medicare HMO enrollment has grown, an increasing number of outsourcing firms offer to collect and evaluate enrollee information. Clinicians who work with Medicare HMO patients report they are sometimes more willing to provide health information than commercial enrollees. Doctors Health System, a physician practice management company in Owings Mills, Maryland, with more than 20,000 senior HMO enrollees in 1998, has had excellent results with mailed surveys. This organization found that 98% of its enrollees responded to a health risk

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Screening for conditions that contribute to frailty in elderly enrollees must go beyond searching for active disease conditions, such as cardiovascular disease, cerebrovascular disease, or cancer. For the greatest preventive or health-promoting effect, clinicians should also screen for risk factors that may lead to disability in the elderly.

Screening guidelines have been formulated by the U.S. Preventive Services Task Force and the Agency for Health Care Policy and Research (now the Agency for Healthcare Research and Quality) in Chevy Chase, Maryland. They recommend using screens that can be shown to have proven effectiveness or consistent benefit. The Table shows those mentioned as the most effective methods of evaluation.

SCREENING GUIDELINES FOR DETERMINING FRAILTY AND DISABILITY AMONG ELDERLY PATIENTS

Function	Screening Test
Hearing	Hearing Handicap for the Elderly
Vision	Snellen Acuity Test
Functional status	Activities of Daily Living Instrumental Activities of Daily Living
Balance and gait	Balance and Gait Evaluation Get Up and Go Time Manual Performance Test
Home safety	Home Safety Screen
Mental status	Mini-Mental State Examination Short Portable Mental Status Questionnaire Alzheimer's Disease Assessment Scale
Geriatric depression	Beck Depression Inventory Zung Depression Scale Geriatric Depression Scale

For a good summary of currently recommended screens, see Mouton CP, Espino DV: Problem-oriented diagnosis: Health screening in older women. *Am Fam Phys* 1999;59:1835-1842.

assessment questionnaire that was sent out in the mail (personal communication, Alan Kimmel, MD, Doctors Health System, Owings Mills, Maryland, April 3, 1998). Collecting such information by telephone may be more problematic. Health status information is sensitive, and health care organizations that telephone enrollees may find the impersonality of a telephone interview works against them. Without clear identification of the connection between their health care provider and the caller, seniors may refuse to divulge health status information.

Questionnaires and surveys to assess health risks are useful, but other screening tools require a visit by the enrollee to a PCP. Many providers and HMOs report using the initial visit of a new enrollee to perform an evaluation of the patient's prescription drug use. These appointments are sometimes called a "brown bag visit," because enrollees are asked to bring all drugs they are currently taking. Such screening efforts may uncover chronic conditions, duplications in prescriptions, or even adverse drug interactions. These evaluations are especially important for seniors who have just entered HMO care from the traditional Medicare system. For these patients, this may be the first time such coordination of their drug regimens has ever occurred.

STRATIFYING TREATMENT ACCORDING TO HEALTH RISK

The result of risk assessment should be to prescribe a path of treatment for each enrollee. Appropriate care will vary according to risk factors that capture life expectancy and health status of individual Medicare risk beneficiaries. Frail enrollees with life expectancies of two to 10 years, for example, may not benefit from aggressive screening and treatment of some illnesses. Prostate cancer is common among elderly men, but

treatment is not always warranted, because these patients may be too weak or the progress of the disease too slow for treatment to result in improved outcomes.

In contrast, frail patients may receive benefits from programs designed to monitor and treat chronic disease and conditions, which complicate care of the elderly and increase costs. Disease management programs designed to treat chronic illnesses have been touted as a great potential source of savings, but without proper assignment of enrollees to the programs that will help them most, such efforts and expense are of little use. Traditional indemnity care, with its emphasis on acute care interventions, is seldom adequate to manage chronic disease, but this is where the strengths of managed care become most apparent. As evidence mounts that such programs offer an opportunity both to improve patient outcomes and reduce overall care costs, many HMOs have invested in developing multidisciplinary disease management initiatives. Programs for managing diabetes, cardiac conditions, depression, and hypercholesterolemia are in widespread use among HMOs.[16]

Disease management is not a panacea for all high-cost conditions. Although many programs in diabetes and arthritis management improve coordination of care and even better patient outcomes, they have shown mixed results in their ability to lower care costs. Given the cost to establish chronic care management, this raises the bar for a monetary return on investment. Careful screening of enrollees can help payers and providers assign the appropriate care programs to them. With proper assessment of seniors to determine which programs will do the most good, payers can assure themselves and their enrollees of getting the maximum benefit for their investment.

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